

APPLICATION INFORMATION

Applicant Name_____

BASELINE DATA

Social Security #_____ D.O.B._____

Address_____

Agency Affiliation_____ Tele.#_____

Address_____

Duration of affiliation Months:_____ Years_____

Certificates or licenses you presently hold:

Supervisor evaluations (which will be sent directly to the Certifying Body) pg.21& 22.

Name_____

Agency_____

Location_____

Name_____

Agency_____

Location_____

Individuals who will be forwarding their letters of professional reference to the Board other than your supervisor(s): pg. 23, 24, & 25.

Name_____ Tele.#_____

Address_____

Name_____ Tele.#_____

Address_____

Name_____ Tele.#_____

Address_____

ASSURANCE AND RELEASE

I _____, of _____ do hereby submit the following information, assurances and release relating to my initial certification or renewal of certification/licensure with the Rhode Island Board for the Certification of Chemical Dependency Professionals (RIBCCDP), Rhode Island Board for Licensing of Chemical Dependency Professionals (RILBCDP), and the Rhode Island Department of Health (RIDOH).

I acknowledge and understand in answering the following questions that submitting fraudulent, deceitful or misleading statements will be grounds for denial or revocation of certification or renewal of certification.

1) Have you ever applied for certification/licensure as a chemical dependency professional in another state?
____yes ____no

2) Have you ever had any action taken against your certification/license?
____yes ____no

If the answer to Number Two (2) is Yes, please provide details on reverse side

3) Have you ever been disciplined in any way by a Certification/Licensing Board or Professional Organization?
____yes ____no

If the answer to Number Three (3) is yes, please provide details on reverse side.

I hereby certify that I have read this entire application and that all the material contained herein is true, accurate and complete. I further understand that any intentionally false or misleading statements or omissions shall result in the denial or revocation of my certification/license or renewal of certification/license.

I hereby certify that all information contained in this application and any supporting documents is true to the best of my knowledge. I further certify that I do not use any controlled substances or any alcoholic beverages to the extent that the use impairs my ability to conduct with safety to the public the practice authorized by the license for which I am applying.

I hereby certify that I have read and subscribed to the Ethical Standards and Code of Conduct for Chemical Dependency Professionals prescribed by RIBCCDP.

—I authorize RIBCCDP, RILBCDP, and RIDOH its members, officers and employees, to investigate my background as it relates to the statements contained in my application and further consent to the release of information by third parties to RIBCCDP, RILBCDP, and RIDOH which information relates directly to my application and statements contained therein so long as said information remains confidential.

—I further agree to hold RIBCCDP, RILBCDP, and RIDOH its members, officers, employees and examiner's harmless and free from all liability from complaints, causes of action, suits, claims, demands and damages of every nature or kind pertaining or arising out of or relating in any manner whatsoever to actions taken by RIBCCDP, RILBCDP, and RIDOH in investigating my application and making a determination regarding my certification.

—I further authorize the RIBCCDP, RILBCDP, and RIDOH to release all documentation/information of application for certification/renewal along with all documentation of ethics complaints, Disciplinary Hearings, and disciplinary sanctions taken against me by the Department of Health, the ICRC/AODA and the Rhode Island Board of Licensing for Chemical Dependency Professionals. Furthermore, I understand and acknowledge that any sanctions imposed against my LCDF/LCDFS by the RILBCDP/RIDOH will also be imposed against my RIBCCDP issues certification(s).

I have read and understand the above.

Print Name: _____

Witness: _____

Signature: _____

Date: _____

Address: _____

City, State, Zip _____

TRAINING AND EDUCATION DOCUMENTATION

The Training and Education Resume forms should be used to document specific courses, trainings, seminars, and inservice experiences which demonstrate the acquisition of knowledge and skill competencies deemed necessary to perform the related work functions.

Additional copies of these forms may be photocopied as needed. Copies of transcripts, certificates of completion, and other descriptive or verifying materials must be attached directly to the form upon which the training event is listed.

TRAINING AND EDUCATION RESUME

Title	Location/Sponsor Date	Duration in Hours
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Westchester County SAC Training Course (REQUIRED)		30
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Skill Knowledge/Core Functions Addressed:

Program development, program delivery & planning, school based training/prevention programming, identification and assessment of substance abusers and children of substance abusers, intervention with adolescent substance abusers and CASAs, case management and referral, school based outreach, training and prevention, networking with community, prevention programming, record keeping/monitoring, public presentation/training.

If you have completed this required training, check Yes

Title	Location/Sponsor Date	Duration in Hours
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Confidentiality of Drug & Alcohol Patients Records (42 CFR, Part 2) (REQUIRED)	DSA	12
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Skill Knowledge/Core Function Addressed:

If you have completed this required training, check Yes

Title	Location/Sponsor Date	Duration in Hours
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Ethics (REQUIRED)		6
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Skill Knowledge/Core Function Addressed:

If you have completed this required training, check Yes

Title	Location/Sponsor Date	Duration in Hours
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HIV/AIDS/Viral Hepatitis (REQUIRED AFTER JANUARY 1, 1994)		6
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Skill Knowledge/Core Function Addressed:

If you have completed this required training, check Yes

TRAINING AND EDUCATION RESUME

Title	Location/Sponsor	Duration in
	Date	Hours

Skill Knowledge/Core Functions Addressed:

Title	Location/Sponsor	Duration in
	Date	Hours

Skill Knowledge/Core Functions Addressed:

Title	Location/Sponsor	Duration in
	Date	Hours

Skill Knowledge/Core Functions Addressed:

TOTAL HOURS _____
(MUST TOTAL 60 HOURS)

PLEASE PHOTOCOPY AS NEEDED

SERVICE HOURS DOCUMENTATION

The forms which follow, are to be used by the applicant to document experience and supervision relative to the 12 Core Functions.

Additional pages may be photocopied as needed. It is recommended that applicants provide supervisors with a copy of Knowledge and Skill Competencies Section to assist them in submitting forms on your behalf which are timely and represent a well informed evaluation of your performance.

Certificates of completion, transcripts, college catalogue course descriptions, syllabi, and any other support materials used to verify or explain training and education listed must be attached directly to the appropriate form, and are not to be submitted apart from, or under separate cover. The Board will not assume responsibility for accepting or collating such materials if not included, as directed, in the applicant's original submission package.

SUPERVISOR EVALUATION

TO THE SUPERVISOR:

The Certifying Body believes that credentialing should be competency based and determined by using a broad reference base for input, including the observations of qualified supervisors.

Your evaluation and recommendations will be utilized along with other criteria to determine this applicant's eligibility and appropriateness for credentialing as a Student Assistance Counselor.

Forms are included for supervisors to document their observations of candidates performing the core functions and to rate the performance of applicant's overall competency in these areas.

If you, the Supervisor, cannot rate an applicant truthfully on 15 or more items listed on the Skills Assessment Checklist, please return this form to the applicant. A prompt response is appreciated so as not to delay the applicant, should another reference be called for by the Board, in evaluating the applicant's portfolio for certification.

A candidate must receive an experience rating average of 3 to be eligible for certification.

All completed forms should be returned promptly to the Certifying Body for portfolio inclusion.

DOCUMENTATION OF CORE FUNCTIONS

Applicant: _____

Location: _____

Dates: _____

To be completed by Supervisor:

- RATING: 5 - Excellent
4 - Good
3 - Acceptable
2 - Needs Improvement
1 - Unacceptable

	Rating	C.S. #Hours	C.S. Min#
1. Individual Assessment	_____	_____	10
2. Clinical Intervention Skills	_____	_____	10
3. Referral Skills	_____	_____	10
4. Case Management Skills	_____	_____	10
5. School Based Training/Prevention Programming	_____	_____	10
6. Resource Development	_____	_____	10
7. Networking	_____	_____	10
8. Record Keeping/Monitoring	_____	_____	10
9. Social Policy Impact	_____	_____	10
10. Program Planning	_____	_____	10
11. Program Delivery	_____	_____	10
12. Program Evaluation	_____	_____	10

I have provided clinical supervision to this applicant in the performance of these Core Functions and have rated their performance accordingly.

Supervisor _____ Tele.# _____

Signature _____ Date _____

Candidate must receive a performance rating of 3 to be eligible for certification. Candidate must have a minimum of 10 hours Clinical Supervision in each Core Function with a minimum of 120 hours total.

CLINICAL SUPERVISORS
SKILLS ASSESSMENT CHECKLIST

If you cannot rate an applicant truthfully on 15 or more of the items listed on the Skills Assessment Checklist, please return this form to the applicant. A prompt response is appreciated so as not to delay the applicant, should another reference be called for by the Board, in evaluating the applicant's portfolio for certification.

To be completed by a Clinical Supervisor:

Rating: 5) Excellent 4) Good 3) Acceptable 2) Needs Improvement 1) Unacceptable
NO) Not Observed

A candidate must receive an average of 3 in rating skills assessment to be eligible for certification.

Attribute or Skill:	Rating #
Exhibits knowledge of chemical dependency	_____
Exhibits knowledge of human development	_____
Exhibits knowledge of basic helping skills	_____
Exhibits knowledge of prevention modalities and strategies	_____
Exhibits knowledge of special needs and high risk populations	_____
Exhibits knowledge of health promotion and wellness models	_____
Exhibits skill in developing prevention programs	_____
Exhibits skill in delivering prevention programs	_____
Exhibits skill in assessing school service needs	_____
Exhibits skill in engaging students and family members when appropriate	_____
Exhibits skill in running groups	_____
Exhibits ability to work cooperatively with school based colleagues and professionals	_____
Exhibits ability to maintain professional objectivity	_____
Exhibits ability to interact effectively with school administration and faculty	_____
Exhibits ability to exercise initiative	_____
Exhibits ability to network effectively with other agencies	_____
Exhibits ability to outreach with the local community	_____
Exhibits ability to interact with genuineness and respect	_____
Exhibits ability to utilize skills such as active listening, summarizing, reflecting	_____
Exhibits ability to engage in productive problem solving	_____
Exhibits responsibility with regard to work commitments	_____
Exhibits responsibility with regard to making appropriate referrals	_____
Exhibits responsibility with regard to agency and federal confidentiality guidelines	_____

To the best of my knowledge, this accurately reflects this applicant's skills as I have observed them.

Date _____ Signature: _____

Title _____ Tele # _____

STUDENT ASSISTANCE PROGRAM COUNSELOR

PROFESSIONAL REFERENCE FORM

TO: _____

FROM: _____ DATE: _____

I am in the process of applying for certification as a Student Assistance Counselor in the State of Rhode Island.

As someone who has been in a position to observe my work in the area of adolescent development, substance abuse treatment, mental health or behavioral related counseling, you may assist me by completing the enclosed form (s).

My application will not be reviewed until my professional references are received, therefore, prompt response would be most appreciated.

If you are unable to complete this reference, please return it to me as soon as possible. Otherwise, please mail it directly to:

R.I.B.C.C.D.P.
31 Smith Avenue - 3 Rear
Greenville, RI 02828

Sincere Thanks,

Applicant's Signature

TO: The Certifying Board for Student Assistance Counselors

FROM: _____(Name)

_____ (Agency/Affiliation)

_____ (Address)

_____ (Telephone)

RE: _____ (Applicant)

PROFESSIONAL REFERENCE - SKILLS ASSESSMENT CHECKLIST

If you cannot rate an applicant truthfully on 15 or more of the items listed on the Skills Assessment Checklist, please return this form to the applicant. A prompt response is appreciated so as not to delay the applicant, should another reference be called for by the Board, in evaluating the applicant's portfolio for certification.

To be completed by a Recognized Observer

Rating: 5) Excellent 4) Good 3) Acceptable 2) Needs Improvement 1) Unacceptable
NO) Not Observed

A candidate must receive an average of 3 in rating skills assessment to be eligible for certification.

Attribute or Skill:	Rating #
Exhibits knowledge of chemical dependency	_____
Exhibits knowledge of human development	_____
Exhibits knowledge of basic helping skills	_____
Exhibits knowledge of prevention modalities and strategies	_____
Exhibits knowledge of special needs and high risk populations	_____
Exhibits knowledge of health promotion and wellness models	_____
Exhibits skill in developing prevention programs	_____
Exhibits skill in delivering prevention programs	_____
Exhibits skill in assessing school service needs	_____
Exhibits skill in engaging students and family members when appropriate	_____
Exhibits skill in running groups	_____
Exhibits ability to work cooperatively with school based colleagues and professionals	_____
Exhibits ability to maintain professional objectivity	_____
Exhibits ability to interact effectively with school administration and faculty	_____
Exhibits ability to exercise initiative	_____
Exhibits ability to network effectively with other agencies	_____
Exhibits ability to outreach with the local community	_____
Exhibits ability to interact with genuineness and respect	_____
Exhibits ability to utilize skills such as active listening, summarizing, reflecting	_____
Exhibits ability to engage in productive problem solving	_____
Exhibits responsibility with regard to work commitments	_____
Exhibits responsibility with regard to making appropriate referrals	_____
Exhibits responsibility with regard to agency and federal confidentiality guidelines	_____

To the best of my knowledge, this accurately reflects this applicant's skills as I have observed them.

Date _____ Signature: _____

Title _____ Tele # _____

DOCUMENTATION OF SUPERVISED EXPERIENCE

NOTE: Please document a minimum of 1 year full time (2,000) hours as a Student Assistance Counselor on this page

APPLICANT NAME _____

EXPERIENCE VERIFICATION/SUPERVISOR EVALUATION

Supervisor Name: _____ Title: _____

Agency: _____

Address: _____

Telephone #: _____

Number of months _____ years _____ you have known applicant.

I _____, herein certify that

_____ has been supervised as a
(Applicant's Name)

Student Assistant Counselor, at _____

for _____ hours*, from _____ to _____.

This facility is licensed/accredited/recognized by _____

_____ as a _____

effective as of _____.

***hours must be documented cumulatively (total of hours worked)**

The space below is provided should you wish to make additional comments, observations, recommendations, or reservations regarding this applicant.

To the best of my knowledge, the information I am submitting reflects this applicant's skills as I have supervised them.

Date: _____ Signature: _____

**RHODE ISLAND BOARD FOR THE CERTIFICATION OF
CHEMICAL DEPENDENCY PROFESSIONALS
31 Smith Avenue – 3 Rear
Greenville, RI 02828
(401)349-3822**

**CODE OF ETHICS
AND
DISCIPLINARY PROCEDURES**

**For Counselors in Training
Provisional Chemical Dependency Professionals
Chemical Dependency Professionals
Licensed Chemical Dependency Professionals
Licensed Chemical Dependency Clinical Supervisor
Recognized Clinical Supervisors
Student Assistance Counselors
Prevention Professionals
Criminal Justice Professionals
Co-Occurring Disorder Professionals**

I have read and understand the RIBCCDP Code of Ethics and Disciplinary Procedures in its entirety.

I do accept all of the Principles of the Rhode Island Board for the Certification of Chemical Dependency Professionals' Code of Ethics and Disciplinary Procedures as prescribed by the RIBCCDP.

Signed: _____

Date: _____