Experience:

Two (2) years full time work experience in behavioral health and chemical dependency treatment. A Master’s, Bachelor’s, or Associate’s from an accredited educational facility, in a relevant field (Social Services, Social Work, Addiction, Human Services, Psychiatric Nursing, Psychology) may be submitted for consideration as a substitute for one (1) year of the two (2) years of required experience. The degree may also allow the applicant to take fewer required courses. This is considered by the Commission on a case by case basis.

Educational Requirements:

The following is a list of the coursework required for the non-degreed track for certification:

- Ethics taken within last 2 years (3 hours)
- Confidentiality taken within last 2 years (3 hours)
- Infectious Diseases & HIV/AIDS (6 hours)
- Documentation (12 hours)
- Intro to Client Centered Counseling (12 hours)
- Working with Diverse Populations (12 hours)
- Prevention & Community Development (8 hours)
- Intro to Family Systems (15 hours)
- Psycho-physiology (12 hours)
- DSM Practice Application (12 hours)
- Co-Occurring Disorders (12 hours)
- Conducting Therapeutic Group (16 hours)
- Family Systems Part II (15 hours)
- Community Development Approach to Prevention (12 hours)
- Community Resources Use & Case Management (8 hours)

- Intro to Addictive Behavior (8 hours)
- Crisis Intervention (8 hours)
- Intro to Group Counseling (8 hours)
- Case Study/Clinical Case Management (16 hours)
- Recovery, Health, & Wellness (8 hours)
- Intro to Co-Occurring Disorders (8 hours)
- Motivational Interviewing (16 hours)
- ASAM Practice (12 hours)
- Recovery, Health & Wellness II (8 hours)
- Applied Crisis Management (8 hours)
- Traditional Health Based Practices (8 hours)

The following is a list of the coursework required for the degreed track for certification:

- Ethics taken within last two years (3 hours)
- Confidentiality taken within last two years (3 hours)
- Traditional Health Based Practices (8 hours)
- Intro to Behavioral Health
  - Mental Health (8 hours)
  - Substance Abuse/Dependency (8 hours)

Please note that the degree must be one of the degrees listed above under “experience,” and understand that the acceptance of the degree and the requirements for certification based on that degree are considered by the Commission on a case by case basis. The degree must be from an accredited college.

If information is omitted, the application will be considered incomplete and will not be processed. Only ORIGINALS of this document will be accepted and ALL errors must be initialed.
Counselor Competency Practicum:

Completion of a 100-hour practicum is required for the BHC I, and must be supervised by a certified Behavioral Health or Chemical Dependency Counselor who has certification at least one level higher than that of applicant, in accordance with the criteria on the Counselor Competency practicum form.

Recertification:

Certification is for a period of two years. Application for re-certification must be made prior to expiration and may be done online at akcertification.org. The applicant should complete at least 40 hours of continuing education in the Behavioral Health field, to include 3 hours each of Ethics and Confidentiality, every two years. The certificates of completion for these classes are not required to be submitted for recertification, but the applicant should keep them and be prepared to submit them if asked.

APPLICATION PROCEDURE

1. The applicant fills out pages 4-11, and gives pages 12-15 each to the person indicated on the form, to complete and mail directly to ACBHC.

2. Send copies of successfully completed trainings and/or have the college mail the original college transcripts directly to ACBHC. Make certain that each completed course is listed on the “Training Hours Tally Sheet” including the syllabus or course description if the class content is not perfectly clear in the transcript or certificate of completion. Please list coursework, and do not write “see transcripts” on this form.

3. Use the forms provided for the Supervisor Recommendation, Employer Verification and Counselor Competency Practicum. These forms must be mailed directly to ACBHC by the person completing them. The Counselor Competency Practicum form must be completed by a person certified at least one level above the applicant’s current certification. It is the last two pages of the application and should be mailed directly to ACBHC by the person who completed the form. The Employer Verification form in the application should be completed by the applicant’s supervisor or the Human Resources person, in order to verify the candidate’s completion of the work experience requirement. The person filling out this form should include a job description for the applicant’s position, if the title is not that of Behavioral Health or Chemical Dependency Counselor.

4. Write your name at the top of each tally page. List all of your training courses on the tally sheet pages. Total the number of training hours on the last page of the tally sheet. Sign and date the last page of the tally sheet. Make copies of all of your certificates and submit them to ACBHC along with your tally sheet and completed application.

5. All the forms in the application should be completed and submitted in their original form, no copies or faxes will be accepted for these pages. The course work certificates, a copy of candidate’s picture ID, and the current resume may be copies or faxes.

If information is omitted, the application will be considered incomplete and will not be processed. Only ORIGINALS of this document will be accepted and ALL errors must be initialed.
Alaska Commission for Behavioral Health Certification
Application for BHC I Certification

6. The initial certification fee is $195.00, and the re-certification fee is $180.00, renewable every two years.

APPLICATION CHECK LIST FOR
BEHAVIORAL HEALTH COUNSELOR I (BHC I)

The application must include the following, in original form, filled out by the applicant:

- Application General Information form
- Training Tally Sheet - Please include all relevant trainings in chronological order, documenting dates, titles, and hours completed. Incomplete Tally Sheets will be returned to the applicant for proper completion except in the case of the applicant having taken the classes after submitting the application. Please fill this out completely, and do not put “see transcript.”
- ACBHC Ethical Standards - Code of Ethics - Initialed, signed and dated.
- Authorization for Data Collection
- Current Résumé
- Clear, legible, and current copy of State or other valid picture identification
- Payment in the amount of $195.00 for initial certification (this may be paid online)

The following will each be submitted directly to ACBHC by the person who completes them:

- One Supervisor Recommendation form
- Counselor Competency Practicum Form completed by a person certified at least one level above applicant’s current certification level
- Employer Verification Form completed by either the applicant’s supervisor or Human Resources person at the agency where the applicant has gained required experience
- College transcripts if applicable, sent by college or university

If information is omitted, the application will be considered incomplete and will not be processed. Only ORIGINALS of this document will be accepted and ALL errors must be initialed.
APPLICATION FOR CERTIFICATION
GENERAL INFORMATION
(PLEASE PRINT)

Name: ____________________________________________
Mailing Address: ___________________________________
City, State Zip: ____________________________________
Home Phone: ___________________ Cell Phone: ____________
Personal E-Mail: _________________________________
Business E-Mail: _________________________________
Employer: _______________________________________
Employer Address: ________________________________
City, State Zip: __________________________________
Business Phone: ________________ Business Fax: ________
Date/State of past certification: ________________

Would you accept a lower level of certification than the BHC I?
Yes ______ No ________

I, (print name) ____________________________, have provided accurate and truthful information
on all the enclosed application material for certification and acknowledge that omission of the requested
information as well as providing false information will result in denial of my certification or removal of
my certification at a later date, as it becomes known.

Signature ___________________________ Date __________
(Form not complete without signature)

Mail the completed application to:

ACBHC
P.O. Box 220109
Anchorage, AK 99522-0109

If information is omitted, the application will be considered incomplete and will not be processed. Only ORIGINALS
of this document will be accepted and ALL errors must be initialed.
<table>
<thead>
<tr>
<th>Category</th>
<th>Course Title</th>
<th>Hours</th>
<th></th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0.00</td>
<td>Total Hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HIV/AIDS & Bloodborne Pathogens 8 Hours**

<table>
<thead>
<tr>
<th>Category</th>
<th>Course Title</th>
<th>Hours</th>
<th></th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0.00</td>
<td>Total Hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Behavioral 8 Hours**

<table>
<thead>
<tr>
<th>Category</th>
<th>Course Title</th>
<th>Hours</th>
<th></th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0.00</td>
<td>Total Hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**application within two years of your**

<table>
<thead>
<tr>
<th>Category</th>
<th>Course Title</th>
<th>Hours</th>
<th></th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0.00</td>
<td>Total Hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**eligibility 2 Hours**

<table>
<thead>
<tr>
<th>Category</th>
<th>Course Title</th>
<th>Hours</th>
<th></th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0.00</td>
<td>Total Hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**eligibility 2 Hours**

<table>
<thead>
<tr>
<th>Category</th>
<th>Course Title</th>
<th>Hours</th>
<th></th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0.00</td>
<td>Total Hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Course Title</td>
<td>Hours</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>-------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Disorders &amp; Hours</td>
<td>Introduction to Co-Occurring</td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systems 12 Hours</td>
<td>Introduction to Family</td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development 8 Hours</td>
<td>Prevention and Community</td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recovery, Health &amp; Wellness</td>
<td>8 Hours</td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Management 8 Hours</td>
<td>Community Resources &amp; Case</td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Hours</td>
<td>Course Title</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------</td>
<td>--------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Family Systems Part II</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management 16 Hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management 16 Hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management 16 Hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total CEU Hours: 0.00
Alaska Commission for Behavioral Health Certification
Application for BHC I Certification

BACKGROUND DISCLOSURE FORM FOR APPLICANTS

☐ (For initial certification) In my lifetime, I:

☐ (For re-certification) Since the issuance of my last certificate on __________, I:

1. Have had my professional certification or licensure revoked? ☐ Yes ☐ No
   State: ______________ Date: __________ Type: __________

2. Have been terminated or left from either a paid or volunteer position as a result of an ethics complaint? ☐ Yes ☐ No

3. Have been arrested or detained for anything other than misdemeanor traffic (not DUI or DWI related) charges? ☐ Yes ☐ No

4. Have been convicted of a misdemeanor or felony? ☐ Yes ☐ No

5. Have been convicted, by any disciplinary board, city/state/federal/military/international court of law, of sexual assault, sexual abuse, sexual exploitation, physical abuse or physical assault to any persons? ☐ Yes ☐ No

6. Have been found by an administrative office or court to have committed fraud related to Medicaid, Medicare, insurance entitlement (social security, temporary assistance, public assistance or other billing fraud)? ☐ Yes ☐ No

7. Have any civil or criminal charges pending? ☐ Yes ☐ No

8. Am currently incarcerated* for any misdemeanor or felony? ☐ Yes ☐ No

Answering "Yes" to any of the above questions does not automatically bar you from certification. If you have answered yes to any of the above items, explain (dates, case number(s), time and place(s) of incarceration, special dispositions and other related information) on a separate attached sheet of paper.

I, (print name) __________________________ have provided accurate and truthful information on this form and acknowledge that omission of the requested information, as well as providing false information will result in denial of my certification or removal of my certification at a later date as it becomes known.

Signature __________________________ Date __________

*** "Incarcerated" is defined as being in a jail, halfway house, work release program or any other form of court or corrections-imposed custody (probation to include misdemeanor, parole, furlough, SIS or deferred sentence).

Mail the completed application to:

ACBHC
P.O. Box 220109
Anchorage, AK 99522-0109

If information is omitted, the application will be considered incomplete and will not be processed. Only ORIGINALS of this document will be accepted and ALL errors must be initiated.
ACBHC ETHICAL STANDARDS
Adopted by ACBHC from the NAADAC Code of Ethics

Initial where indicated as you read each section, and sign the document at the end.

Principle 1: Non-Discrimination

I shall affirm diversity among colleagues or clients regardless of age, gender, sexual orientation, ethnic/racial background, religious/spiritual beliefs, marital status, political beliefs, or mental/physical disability.

- I shall strive to treat all individuals with impartiality and objectivity relating to all based solely on their personal merits and mindful of the dignity of all human persons. As such, I shall not impose my personal values on my clients.
- I shall avoid bringing personal or professional issues into the counseling relationship. Through an awareness of the impact of stereotyping and discrimination, I shall guard the individual rights and personal dignity of my clients.
- I shall relate to all clients with empathy and understanding no matter what their diagnosis or personal history.

Principle 2: Client Welfare

I understand that the ability to do good is based on an underlying concern for the well-being of others. I shall act for the good of others and exercise respect, sensitivity, and insight. I understand that my primary professional responsibility and loyalty is to the welfare of my clients, and I shall work for the client irrespective of who actually pays his/her fees.

- I shall do everything possible to safeguard the privacy and confidentiality of client information except where the client has given specific, written, informed, and limited consent or when the client poses a risk to himself or others.
- I shall provide the client his/her rights regarding confidentiality, in writing, as part of informing the client of any areas likely to affect the client’s confidentiality.
- I understand and support all that will assist clients to a better quality of life, greater freedom, and true independence.
- I shall not do for others what they can readily do for themselves but rather, facilitate and support the doing. Likewise, I shall not insist on doing what I perceive as good without reference to what the client perceives as good and necessary.
- I understand that suffering is unique to a specific individual and not of some generalized or abstract suffering, such as might be found in the understanding of the disorder. I also understand that the action taken to relieve suffering must be uniquely suited to the suffering individual and not simply some universal prescription.
- I shall provide services without regard to the compensation provided by the client or by a third party and shall render equally appropriate services to individuals whether they are paying a reduced fee or a full fee.

If information is omitted, the application will be considered incomplete and will not be processed. Only ORIGINALS of this document will be accepted and ALL errors must be initialed.
Principle 3: Client Relationship

I understand and respect the fundamental human right of all individuals to self-determination and to make decisions that they consider in their own best interest. I shall be open and clear about the nature, extent, probable effectiveness, and cost of those services to allow each individual to make an informed decision of their care.

- I shall provide the client and/or guardian with accurate and complete information regarding the extent of the potential professional relationship, such as the Code of Ethics and professional loyalties and responsibilities.
- I shall inform the client and obtain the client’s participation including the recording of the interview, the use of interview material for training purposes, and/or observation of an interview by another person.

Principle 4: Trustworthiness

I understand that effectiveness in my profession is largely based on the ability to be worthy of trust, and I shall work to the best of my ability to act consistently within the bounds of a known moral universe, to faithfully fulfill the terms of both personal and professional commitments, to safeguard fiduciary relationships consistently, and to speak the truth as it is known to me.

- I shall never misrepresent my credentials or experience.
- I shall make no unsubstantiated claims for the efficacy of the services I provide and make no statements about the nature and course of addictive disorders that have not been verified by scientific inquiry.
- I shall constantly strive for a better understanding of addictive disorders and refuse to accept supposition and prejudice as if it were the truth.
- I understand that ignorance in those matters that should be known does not excuse me from the ethical fault of misinforming others.
- I understand the effect of impairment on professional performance and shall be willing to seek appropriate treatment for myself or for a colleague. I shall support peer assistance programs in this respect.
- I understand that most property in the healing professions is intellectual property and shall not present the ideas or formulations of others as if they were my own. Rather, I shall give appropriate credit to their originators both in written and spoken communication.
- I regard the use of any copyrighted material without permission or the payment of royalty to be theft.
Principle 5: Compliance with Law

I understand that laws and regulations exist for the good ordering of society and for the restraint of harm and evil, and I am aware of those laws and regulations that are relevant both personally and professionally and follow them, while reserving the right to commit civil disobedience.

- I understand that the determination that a law or regulation is unjust is not a matter of preference or opinion but a matter of rational investigation, deliberation, and dispute.
- I willingly accept that there may be a penalty for justified civil disobedience, and I must weigh the personal harm of that penalty against the good done by civil protest.

Principle 6: Rights and Duties

I understand that personal and professional commitments and relationships create a network of rights and corresponding duties. I shall work to the best of my ability to safeguard the natural and consensual rights of each individual and fulfill those duties required of me.

- I understand that justice extends beyond individual relationships to the community and society; therefore, I shall participate in activities that promote the health of my community and profession.
- I shall, to the best of my ability, actively engage in the legislative processes, educational institutions, and the general public to change public policy and legislation to make possible opportunities and choice of service for all human beings of any ethnic or social background whose lives are impaired by alcoholism and drug abuse.
- I understand that the right of confidentiality cannot always be maintained if it serves to protect abuse, neglect, or exploitation of any person or leaves another at risk of bodily harm.

Principle 7: Dual Relationships

I understand that I must seek to nurture and support the development of a relationship of equals rather than to take unfair advantage of individuals who are vulnerable and exploitable.

- I shall not engage in professional relationships or commitments that conflict with family members, friends, close associates, or others whose welfare might be jeopardized by such a dual relationship.
- Because a relationship begins with a power differential, I shall not exploit relationships with current or former clients for personal gain, including social or business relationships.
- I shall not under any circumstances engage in sexual behavior with current or former clients.
- I shall not accept substantial gifts from clients, other treatment organizations, or the providers of materials or services used in my practice.

If information is omitted, the application will be considered incomplete and will not be processed. Only ORIGINALS of this document will be accepted and ALL errors must be initialed.
Principle 8: Preventing Harm

I understand that every decision and action has an ethical implication leading either to benefit or harm, and I shall carefully consider whether any of my decisions or actions has the potential to produce harm of a physical, psychological, financial, legal, or spiritual nature before implementing them.

- I shall refrain from using any methods that could be considered coercive such as threats, negative labeling, and attempts to provoke shame or humiliation.
- I shall make no requests of clients that are not necessary as part of the agreed treatment plan.
- I shall terminate a counseling or consulting relationship when it is reasonably clear that the client is not benefiting from the relationship.
- I understand an obligation to protect individuals, institutions, and the profession from harm that might be done by others. Consequently, I am aware that the conduct of another individual is an actual or likely source of harm to clients, colleagues, institutions, or the profession, and that I have an ethical obligation to report such conduct to competent authorities.

Principle 9: Duty of Care

I shall operate under the principle of Duty of Care and shall maintain a working/therapeutic environment in which clients, colleagues, and employees can be safe from the threat of physical, emotional or intellectual harm.

- I respect the right of others to hold opinions, beliefs, and values different from my own.
- I shall strive for understanding and the establishment of common ground rather than for the ascendency of one opinion over another.
- I shall maintain competence in the area of my practice through continuing education, constantly improving my knowledge and skills in those approaches most effective with my specific clients.
- I shall scrupulously avoid practicing in any area outside of my competence.

I have read and I agree to abide by the above nine (9) Principles of Ethical Standards. I understand that violation of any part of these standards may cause an investigation by ACBHC that could result in my certification being denied or revoked.

Printed Name: __________________________________________

Signature ___________________________________________ (Form not complete without signature)  Date __________________________

Mail the completed application to:

ACBHC
P.O. Box 220109
Anchorage, AK 99522-0109

If information is omitted, the application will be considered incomplete and will not be processed. Only ORIGINALS of this document will be accepted and ALL errors must be initialed.
Alaska Commission for Behavioral Health Certification
Application for BHC I Certification

AUTHORIZATION FOR DATA COLLECTION

I hereby authorize the Commission for Behavioral Health Certification to collect and maintain my name, application forms and other relevant personal information in the Counselor Registry. I further understand that I have access to my own personal information provided by me and may request and/or correct and/or secure a copy of any portion thereof.

Print Name: ____________________________________________

Signature: ______________________ Date: ________________
(Form not complete without signature)

AUTHORIZATION FOR RELEASE TO STATE
AND / OR NATIONAL REGISTERS

Name of Counselor: ______________________________________

Employer: _____________________________________________

Address: _____________________________________________

City, State Zip: ________________________________________

Business Telephone: ___________________________ E-mail: ________________

Behavioral Health or Chemical Dependency Counselor Level/Dates: ________________

Highest Academic Degree: ______________________________________

Mailing Address: _________________________________________

City, State Zip: _________________________________________

Home Telephone: ___________________________ E-mail: ________________

Signature: ______________________ Date: ________________

Mail the application to:
ACBHC
P.O. Box 220109
Anchorage, AK 99522-0109

If information is omitted, the application will be considered incomplete and will not be processed. Only ORIGINALS of this document will be accepted and ALL errors must be initialed.
For Applicant: ____________________________

I, ____________________________ have known the candidate for ________ years/months and can attest to the following qualifications for certification as a Behavioral Health Counselor I.

I understand that this form serves as a reference. I have attached ______ additional pages in order to address my knowledge of this applicant’s competence in each of the twelve foundations and practice dimensions.

1. Understanding Addiction
2. Treatment Knowledge
3. Application to Practice
4. Professional Readiness
5. Clinical Evaluation
6. Treatment Planning
7. Referral
8. Service Coordination
9. Counseling
10. Client, Family, and Community Education
11. Documentation
12. Professional and Ethical Responsibilities

I recommend the applicant for certification as a Behavioral Health Counselor I

☐ Yes ☐ No If no, explain: ____________________________

I attest that the information provided above and in the attached pages is true and complete to the best of my knowledge.

Signature ____________________________ Date __________

Printed Name ____________________________ Title ____________________________ Name of Agency ____________________________

Address ____________________________ City/State/Zip ____________________________

E-mail ____________________________ Telephone ____________________________

The person who completes this form must mail it directly to:

ACBHC
P.O. Box 220109
Anchorage, AK 99522-0109

If information is omitted, the application will be considered incomplete and will not be processed. Only ORIGINALS of this document will be accepted and ALL errors must be initialed.

BHC I Application Page 12 Revised: 02/15/17
EMPLOYER VERIFICATION OF EXPERIENCE FORM

Applicant’s Name: ________________________________

The applicant is applying to the Alaska Commission for Behavioral Health Certification for certification as a Behavioral Health Counselor I. Please fill out this form to document the applicant’s employment in your agency and return it directly to ACBHC. **This information must be on file before the applicant’s certification can be processed.** Your cooperation is very much appreciated.

Please complete the following:

Volunteered or Employed from: __________ to __________ (mo/day/yr) (mo/day/yr)

Number of hours worked per week __________

Number of weeks per year __________

Job Title: ____________________________________________

* If the job title is not that of a Behavioral Health Counselor, attach an official organizational job description to this Verification of Employment/Volunteer Experience. Average percentage of the duties that were Behavioral Health related (Education, Prevention, Treatment or Aftercare) __________%*

Agency: ____________________________________________

Address: ____________________________________________

City/State/Zip: _______________________________________

I certify that all of the above material is true, to the best of my knowledge.

Signature: _______________________________________

Print Name: _______________________________________

Title: ___________________________ Date: ____________

The person who completes this form must mail it directly to:

ACBHC
P.O. Box 220109
Anchorage, AK 99522-0109

If information is omitted, the application will be considered incomplete and will not be processed. Only ORIGINALS of this document will be accepted and ALL errors must be initialed.
Alaska Commission for Behavioral Health Certification
Application for BHC I Certification

Behavioral Health Counselor I Competency Practicum Evaluation Form
Evaluation of Knowledge, Skills and Attitudes

Applicant’s Name ____________________________________________

Practicum Site ______________________________________________

Dates of fieldwork: (from) ___________________________ (To) ___________________________
(month/day/year) (month/day/year)

<table>
<thead>
<tr>
<th>Competency Area</th>
<th>Hours Supervised</th>
<th>Rating</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Developing</td>
<td>Proficient</td>
</tr>
</tbody>
</table>

**Trans disciplinary Foundations**

1. Understanding Addiction
2. Treatment Knowledge
3. Application to Practice
4. Professional Readiness

**Professional Practice Dimensions**

1. Clinical Evaluation
   1a. Screening
   1b. Assessment
2. Treatment Planning
3. Referral
4. Service Coordination
   4a. Implementation of Treatment Plan
   4b. Consulting
   4c. Continuing Assessment & Treatment Planning
5. Counseling
   5a. Individual
   5b. Group
   5c. Families & Significant Others
6. Client, Family & Community Education
7. Documentation
8. Professional & Ethical Responsibilities

**OVERALL RATING**

Total Practicum Hours (At least 100 Hours) | Please continue to next page

If information is omitted, the application will be considered incomplete and will not be processed. Only ORIGINALS of this document will be accepted and ALL errors must be initialed.
Alaska Commission for Behavioral Health Certification
Application for BHC I Certification

Behavioral Health Counselor I Competency Practicum Evaluation Form
(page 2)

Applicant Name: ________________________________

Comments: (please be specific regarding competencies)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Supervisor Signature __________________________ Date __________

Certification Title: ___________________________ Number: ________

Supervisor Name (print): ______________________ Title __________

Name of Agency ________________________________

Street or Mailing Address __________________________

City/State/Zip Code ______________________________

Telephone __________ Fax __________ E-mail __________

The person who completes this form must mail it directly to:

ACBHC
P.O. Box 220109
Anchorage, AK 99522-0109

If information is omitted, the application will be considered incomplete and will not be processed. Only ORIGINALS of this document will be accepted and ALL errors must be initialed.