

Alaska Commission for Behavioral Health Certification Application for CDC II Certification

CHEMICAL DEPENDENCY COUNSELOR II REQUIREMENTS & APPLICATION PROCEDURE

The Chemical Dependency Counselor II is “able to conceptualize and incorporate addiction services across a broad range of disciplines, and demonstrates the greatest level of skill. These counselors will have achieved the highest level of professional qualifications and/or credentials. In most work environments, they may provide some or all of the clinical supervision.” SAMHSA Tap 21

Experience:

Four (4) years full time work experience in chemical dependency treatment. A Master’s, Bachelor’s, or Associate’s degree 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 four (4) 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 two years (3 hours)
Confidentiality taken within last two years (3 hours)
Infectious Diseases & HIV/AIDS (6 hours)
Introduction to Addictive Behavior (8 hours)
Documentation (8 hours)
Crisis Intervention (8 hours)
Introduction to Client Centered Counseling (12 hours)
Introduction to Group Counseling (8 hours)
Working with Diverse Populations (12 hours)
Community Resources Use & Case Management (8 hours)
Recovery, Health, Wellness & Balance (8 hours)
Psycho-physiology (12 hours)
Motivational Interviewing (16 hours)
DSM Practice (12 hours)
ASAM Practice (12 hours)
Co-Occurring Disorders (12 hours)
Special Issues in Behavioral Health Services (16 hours)
Documentation Quality Assurance (12 hours)

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

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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)
Infectious Diseases & HIV/AIDS (6 hours)
Introduction to Addictive Behavior (8 hours)
Special Issues in Behavioral Health Services (16 hours)
Documentation Quality Assurance (12 hours)

Please note that the degree must be in a relevant field, such as Social Services, Social Work, Addiction, Human Services, Psychiatric nursing, Psychology, and may be submitted for consideration as a substitute for one (1) year of the four (4) years of required experience. 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.

Counselor Competency Practicum:

Completion of a 100-hour practicum is required for the CDC II, and **must be supervised by a certified chemical dependency counselor who has certification at least one level higher than that of applicant and at least that for which the applicant is applying, in accordance with the criteria on the Counselor Competency practicum form.** This is a two page form. If needed, the competencies for counselors at each level of certification may be found in the Counselor Competencies document, which is obtained by emailing ACBHC or may be found on the ACBHC website.

Required Qualifying Examination:

In order to be considered for the CDC II, the applicant must provide proof of having taken and passed the NCAC I, NCAC II, or the MAC examination. This exam may not be administered to any person not yet certified by ACBHC as a CDC I.

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 must 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.

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APPLICATION PROCEDURE

1. The applicant fills out pages 5-12, and gives pages 13-18 each to the person indicated on the form, to complete and mail directly to ACBHC. **Please do not print application on both sides because it goes into separate parts of the application file.**
2. Send copies of successfully completed trainings and/or have the college email/mail the original educational transcripts directly to ACBHC. Make certain that each completed course that you wish to count towards your certification is listed on the "Training Hours Tally Sheet." Include the syllabus or course description if the class content is not perfectly clear in the transcript or on the certificate of completion.
3. Use the forms provided for the Professional Affiliate Recommendation letters, 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 or at least at the level for which the applicant is applying.** The Counselor Competency Practicum form consists of the last two pages of the application and should be mailed directly to ACBHC by the person who completes 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 satisfaction 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 Chemical Dependency Counselor. More than one employer may complete this if the experience is from different places of employment.
4. Write your name at the top of each tally sheet 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.
6. The initial certification fee is \$210.00, and the re-certification fee is \$195.00. This certification is renewable every two years. **These fees are non-refundable.**

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APPLICATION CHECK LIST FOR CHEMICAL DEPENDENCY COUNSELOR II (CDC II)

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. Training certificates may be copies.
- _____ Original college transcripts if applicable, sent to ACBHC directly by college or university
- _____ Background Disclosure Sheet
- _____ 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 \$210.00 for initial certification (this may be paid online or by mail)

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

- _____ Two (2) Professional Affiliate Recommendation forms
- _____ One Supervisor Recommendation form
- _____ Counselor Competency Practicum Form (100 hours) completed by a person certified at least one level above the applicant's current certification level and at least at the level for which the applicant is applying
- _____ Employer Verification Form completed by either the applicant's supervisor or Human Resources person at the agency where the applicant has gained required experience

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**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 you applied for?

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**

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CDC II

Category	Date	Course Title	Hours
Ethics not more than two years old 3 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
Confidentiality not more than two years old 3 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
Introduction to Addictive Behavior 8 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
Infectious Diseases & HIV/AIDS 6 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
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Documentation 8 Hours			
Category	Date	Course Title	Hours
Total Hours			0.00

Crisis Intervention 8 Hours			
Category	Date	Course Title	Hours
Total Hours			0.00

Introduction to Client Centered Counseling 12 Hours			
Category	Date	Course Title	Hours
Total Hours			0.00

Introduction to Group Counseling 8 Hours			
Category	Date	Course Title	Hours
Total Hours			0.00

Working with Diverse Populations 12 Hours			
Category	Date	Course Title	Hours
Total Hours			0.00

Category	Date	Course Title	Hours
Community Resource Use & Case Management 8 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
Recovery, Health, Wellness & Balance 8 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
Psycho-Physiology 12 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
Motivational Interviewing 16 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
DSM Practice Application 12 Hours			

Total Hours					0.00

Category	Date	Course Title	Hours
ASAM Practice 12 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
Co-Occurring Disorders 12 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
Special Issues in Behavioral Health Services (16)			
Total Hours			0.00

Category	Date	Course Title	Hours
Documentation and Quality Assurance 12 Hours			
Total Hours			0.00

Total CEU Hours

0.00

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BACKGROUND DISCLOSURE FORM FOR APPLICANTS

(For initial certification) In my lifetime, I:

OR

(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, please write a letter of explanation stating what happened in each case, what the outcome was in court, what you have done to correct the situation, and what you have done to ensure this will not happen again. Explain (dates, case number(s), time and place(s) of incarceration, special dispositions and other related information) on a separate attached sheet of paper. **Failure to disclose this information will delay your application, and not disclosing the criminal history on this form may jeopardize your application being approved.*****

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).

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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

Initial _____

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

Initial _____

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.

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Principle 3: Client Relationship

Initial _____

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

Initial _____

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.

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Principle 5: Compliance with Law

Initial _____

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

Initial _____

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

Initial _____

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.

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Principle 8: Preventing Harm

Initial _____

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

Initial _____

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 ascendancy 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 _____

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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: _____

Alcoholism & Drug Abuse 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

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PROFESSIONAL AFFILIATE RECOMMENDATION

Applicant Name: _____ is applying for CDC II certification in Alaska. I have known the applicant since _____.

A. Knowledge and Skills	Developing	Proficient	Exemplary
1. Understanding Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Treatment Knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Application to Practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Professional Readiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Clinical Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Screening/Intake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Treatment Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Referral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Service Coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Implementing Treatment Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Consulting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Continuing Care (Assessment & Treatment Planning)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Individual Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Group Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Family & Couple Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Client, Family and Community Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 and character. I hereby certify that the information provided is true and complete to the best of my knowledge.

Signature _____ Date _____
(Form not complete without signature)

Printed Name: _____ Title _____

Agency _____

Address _____ Phone _____

City/State/Zip _____ E-Mail _____

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

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

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Alaska Commission for Behavioral Health Certification Application for CDC II Certification

PROFESSIONAL AFFILIATE RECOMMENDATION

Applicant Name: _____ is applying for CDC II certification in Alaska. I have known the applicant since _____.

A. Knowledge and Skills	Developing	Proficient	Exemplary
1. Understanding Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Treatment Knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Application to Practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Professional Readiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Clinical Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Screening/Intake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Treatment Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Referral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Service Coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Implementing Treatment Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Consulting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Continuing Care (Assessment & Treatment Planning)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Individual Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Group Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Family & Couple Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Client, Family and Community Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 and character. I hereby certify that the information provided is true and complete to the best of my knowledge.

Signature _____ Date _____
(Form not complete without signature)

Printed Name: _____ Title _____

Agency _____

Address _____ Phone _____

City/State/Zip _____ E-Mail _____

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

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

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SUPERVISOR RECOMMENDATION FORM

Applicant Name: _____

I, _____ have known the candidate for _____ years/months,
and attest to the following:

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 Chemical Dependency Counselor II

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.

Supervisor Signature, Title Date

Printed Name 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**

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EMPLOYER VERIFICATION OF EXPERIENCE FORM

Applicant's Name: _____

The applicant is applying to the Alaska Commission for Behavioral Health Certification for certification as a Chemical Dependency Counselor II. 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 Chemical Dependency Counselor, attach an official organizational job description to this Verification of Employment/Volunteer Experience. Average percentage of the duties that were chemical dependency related (Supervision, 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 CDC II Certification

Chemical Dependency Counselor II Competency Practicum Form

Evaluation of Supervision, Knowledge, Skills and Attitudes

Applicant's Name _____
 Practicum Site _____
 Dates of fieldwork: from _____ to _____
(month/day/year) (month/day/year)

This section is two pages long

		Rating		
		Developing	Proficient	Exemplary
<u>Trans-disciplinary Foundations</u> – considered to be prerequisite to the development of discipline specific skills				
1. <u>Understanding Addiction</u> – basic knowledge of substance use disorders				
2. <u>Treatment Knowledge</u> – treatment and recovery models, to include knowledge of Alaska Native traditional health & healing when appropriate				
3. <u>Application to Practice</u> - how to apply treatment knowledge to practice				
4. <u>Professional Readiness</u> – issues related to self-awareness, appreciation of diversity, ethics, and continuing education				
<u>Professional Practice Dimensions</u> – Specific skill areas needed for the provision of effective treatment services for individuals, families, and significant others				
	Supervised Hours	Developing	Proficient	Exemplary
1. Clinical Evaluation				
1a. <u>Screening</u> – the counselor, client, and available significant others, determining the most appropriate initial course of action, given the client’s needs, characteristics, and available resources within the community				
1b. <u>Assessment</u> - the process through which the counselor collaborates with the client and others, to gather and interpret information necessary for planning treatment and evaluating client progress				
1c. <u>Treatment Planning</u> - the collaborative process through which the counselor and client develop desired treatment outcomes and identify strategies to achieve them				
1d. <u>Referral</u> - the process of facilitating the client’s utilization of available support systems and community resources to meet needs identified in clinical evaluation and/or treatment planning				
2. Service Coordination				
2a. <u>Implementation of Treatment Plan</u> - all elements of treatment plan implementation				
2b. <u>Consulting</u> - all elements of the consultation process				
2c. <u>Continuing Care</u> - all elements of the continuing care process				

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Alaska Commission for Behavioral Health Certification

Application for CDC II Certification

Applicant Name:	Hours	Developing	Proficient	Exemplary
3. Counseling				
3a. Individual - demonstrates high level of competence, knowledge and skill in counseling, using methods that are sensitive to client characteristics, and to the influence of significant others, as well as the client's cultural and social context				
3b. Group - demonstrates high level of competence, knowledge and skill in group counseling				
3c. Families & Significant Others - demonstrates high level of competence, knowledge and skill regarding the methods of family, couple and significant other counseling				
4. Client, Family & Community Education - demonstrates high level of competence, knowledge and skill in the process of providing client, families, significant others and community groups with information on risks related to psychoactive substance use as well as available prevention, treatment and recovery resources				
5. Documentation - demonstrates high level of competence, knowledge and skill in the recording of screening and intake process, assessment, treatment plan, clinical reports, clinical progress notes, discharge summaries, and other client-related data				
6. Professional & Ethical Responsibilities - demonstrates high level of competence, knowledge and skill in the practice of adhering to accepted ethical and behavioral standards of conduct and continuing professional development				
OVERALL RATING				
Total Practicum Hours (At least 100 Hours)				

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 _____

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