

Addiction Certification Preparation Program Application

Date of Application: _____

Applicant's Name: _____ Position: _____

Phone #: _____ Fax #: _____

Email Address: _____

Facility Name: _____

Supervisor's Name: _____ Phone #: _____

Location Address: _____

Mailing Address: _____

APPLICANT SECTION

Education:

(Please provide a copy of an **unofficial transcript** from each college/university.)

College/University	Type of Degree (Associate's, Bachelor's, Master's, etc.)	Major
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

GDC Counseling Training:

(Examples: Initial Correctional Counselor Training, Motivational Interviewing, M4C, MRT, Matrix, T4C, Anger Management, Problem Solving Skills in Action, etc.) Attach additional page if necessary.

Training	Provider	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Professional Conferences /Workshops:

Title of Workshop	Provider	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Professional Certifications/Licensures:

Type	Awarded By	Date	Current Yes/No
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been denied a certification or licensure? If so, what type of certification or licensure, when, and why?

Are you currently working toward a certification or licensure? What? What are your remaining requirements?

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Work History:

All:

Please list any employers, **including your current employer**, for whom you have worked where you provided direct services to an identified substance abusing population. **If you have worked at multiple GDC facilities, please list each facility separately.** Please indicate below if you received Clinical Supervision while you were there.

Employer	Date of Services	# Hours per week of Direct S.A. Services
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hrs. of Clinical Supervision

Supervisor's Name

Current:

Please list current job responsibilities that you perform directly to a substance abusing population who has been identified by a formal assessment and/or an official override.

Responsibility	# of Hrs Weekly
_____	_____
_____	_____
_____	_____
_____	_____

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Please initial next to each of the following statements indicating your commitment:

_____ I must obtain 4,000 hours (approximately two (2) years of working 40 hours per week) of experience with an identified substance abusing population.

_____ I must attend the year-long training, in which sessions occur once a month, until I meet the required 300 hours of training in all Twelve (12) Core Functions (Screening, Intake, Orientation, Assessment, Treatment Planning, Counseling, Case Management, Crisis Intervention, Client Education, Referral, Reports and Record Keeping, and Consultation). I also know other training may be involved.

_____ I must obtain 300 hours of Clinical Supervision with a minimum of 10 hours in each of the 12 Core Functions. A supervisor should have a good clinical background in substance abuse, chemical dependencies, and co-occurring disorders. Acceptable credentials for clinical supervisors are CCS, CADCI, CCDP, CCDP-D, CAADC, CACII, MAC, or any licensed behavioral health professional, such as LPC, LCSW, LMFT, RN, PsyD, or psychiatrists who have a minimum of five (5) hours of Co-Occurring or Addiction specific continuing education hours per year; certification of attendance/completion may be requested.

_____ I must apply to the certification board and take a computerized test in order to become certified.

I plan to obtain Clinical Supervision from _____

Do you have any questions regarding the program requirements?

Applicant's Signature: _____ Date: _____

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LEADERSHIP SECTION (WARDEN, DEPUTY WARDEN OF CARE AND TREATMENT, SUPERINTENDENT, ASSISTANT SUPERINTENDENT)

This section must be completed by one of the staff listed above.

- Yes No In your opinion, is this Applicant sufficiently motivated to complete this lengthy and demanding program?
- Yes No Is this Applicant adequately performing his/her assigned duties on the job?
- Yes No Is it feasible for this applicant to attend training every month for at least 3 consecutive days, as well as possible other trainings as needed, to complete the 300 hours of training required to obtain certification?
- Yes No Will this Applicant be able to provide 4,000 hours (approximately 2 years) of specific Direct Services (screening, intake, orientation, assessment, case management, crisis intervention, counseling, consultation, client education, treatment planning, referral, reports and record keeping) to a substance abusing population that has been identified through a formal assessment and/or an official override?
- Yes No Will this Applicant be able to receive the required minimum of 10 hours of Clinical Supervision in each of the 12 Core Functions as part of the 300 hours needed to obtain certification?
- Yes No Does this Applicant have your endorsement to participate in this program?

Leader's Signature: _____ Date: _____

**Please contact the Risk Reduction Services Substance Abuse Unit for further clarification of the Addiction Certification Preparation Program (ACPP) requirements.*