

**ALASKA COMMISSION FOR BEHAVIORAL HEALTH CERTIFICATION
APPLICATION PROCEDURE**

The general procedure for applying for certification is as follows:

1. Complete application - Only submit the originals, no copied or faxed applications. **(ACBHC only holds application for certification for 6 months. Your application must be complete and ready for review by the Commission within 6 months of receipt to the ACBHC office. Your incomplete file will be destroyed after 1 year.)**
2. Send copies of successfully completed trainings and/or **original** college transcripts. Make certain that (each) training is listed on the “Training Hours Tally Sheet” including the syllabi and course descriptions.
3. Use the forms provided for the reference letters, which must be mailed directly to ACBHC by the person submitting the reference.
 - Applications for CT, CDC I, and CDC II must have one reference form from their current or most recent supervisor, attesting to competency as a CD counselor. The other two should be from professional affiliates who can attest to your character.
 - Applicants for CDCS will need to provide three (3) additional reference forms specifically addressing Clinical Supervision Competencies.
 - **References that are faxed, e-mailed or submitted in an unsealed envelope will NOT be accepted.**
4. Include the percentage of time spent performing chemical dependency-specific work in the verification of employment.

5. The certification and re-certification fees are as follows:

Certification Level	Fee for initial Certification	Fee for Re-Certification	Certification Period
Traditional Counselor (TC)	\$150.00	Lifetime	
Counselor Technician (CT)	\$165.00	\$150.00	(every 2 years)
Counselor I (CDC I)	\$180.00	\$165.00	(every 2 years)
Counselor II (CDC II)	\$195.00	\$180.00	(every 2 years)
Clinical Supervisor (CDCS)	\$215.00	\$200.00	(every 2 years)
Administrator (ADM)	\$230.00	\$215.00	(every 2 years)

APPLICATION CHECK LIST FOR COUNSELOR I (CDC I)

All applications must include the following:

- General Application Information Form
- Demographic Information Form
- Training Tally Sheet

PLEASE INCLUDE ALL RELEVANT TRAININGS IN CHRONO-LOGICAL ORDER, DOCUMENTING DATES, TITLES, AND HOURS COMPLETED. INCOMPLETE TALLY SHEETS WILL BE RETURNED TO THE APPLICANT FOR PROPER COMPLETION

- Background Disclosure Form
- State of Alaska Background Check
Contact the Department of Public Safety Building in Anchorage at 907-269-5767.
Physical location: Anchorage DPS - R&I, 5700 E. Tudor Road, Anchorage, AK 99507.
Hours of Operation: Monday-Friday, 8:15 am - 4:00 pm. Or got to:
<http://www.dps.state.ak.us/Statewide/background/walkin.asp> for more resources.
- Signed Code of Ethics
- Data Collection and National Registers Form
- Two (2) Professional Affiliates Reference Forms
- Supervisor Reference Form
- Verification of Employment (required 2 years experience/ 4,000 hours)
- _____ BS/BA (may count in lieu 1 year of employment)
- 150 Hour Practicum (Supervisor Signature and Evaluation Form)
- A minimum of 118 (of the 270 required) contact training hours addressing the following competencies:
 - Ethics - 4 hours
 - Confidentiality - 4 hours
 - Documentation - 8 hours
 - Infectious diseases and HIV/AIDS - 8 hours
 - CPR/First Aid - 8 hours
 - Introduction to Addictive Behaviors – 8 hours
 - Introduction to Counseling - 16 hours
 - Cross Cultural Diversity - 16 hours
 - Crisis Intervention - 8 hours
 - Introduction to Community Resources - 8 hours
 - Recovery, Health, Wellness & Self-Care - 8 hours
 - Alaska History of Chemical Dependency – 6 hours
 - Co-Occurring Disorders – 16 hours
- Current Resume
- Copy of State ID
- Check # _____ Amount \$ _____
(\$180.00 initial fee & \$165.00 for Re-certification)

REQUIREMENTS FOR CHEMICAL DEPENDENCY COUNSELOR I (CDC I)

Experience:

Two (2) years full time work experience with increasingly specialized experience in chemical dependency treatment. A Bachelor's degree in a relevant field (BS/BA, BSW, social sciences, nursing, psychology, sociology, etc) may be submitted for consideration as a substitute for one (1) year of the two (2) years of required experience.

Requirements:

A minimum of 270 approved contact training hours addressing knowledge and skills listed in the counselor competency **(OR)** a combination of trainings and educational credits addressing the counselor competency requirement which can be evaluated for approval by the Commission.

Clinical Evaluation	Treatment Planning
Referral	Service Coordination
Counseling	Client, Family and Community Education
Documentation	Understanding Addiction
Treatment Knowledge	Professional Readiness
Application to Practice	Confidentiality and Ethical Responsibilities

Specific Training Requirements:

Ethics and Confidentiality **MUST** be completed within 2 years of the current application.

Practicum/Internship:

Completion of a 150 hour supervised practicum by a certified chemical dependency counselor (with certification at a level higher than that of applicant), with a minimum of 15 hours in each of the following professional practice dimensions:

Screening/Intake/Orientation	Assessment
Treatment Planning	Counseling & Intervention Counseling
Case Management/Service Coordination	Crisis Intervention
Client, Family & Community Education	Information & Referral/Community References
Documentation (Case Reports)	Clinical Consultation

**APPLICATION FOR CERTIFICATION
GENERAL INFORMATION
(PLEASE PRINT)**

Name: _____

Mailing Address: _____

Home Phone: _____ Business Phone: _____

E-Mail: _____

Employer: _____

Address: _____

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.

Date _____ Signature _____

(ACBHC only holds application for certification for 6 months. Your application must be complete and ready for review by the Commission within 6 months of receipt to the ACBHC office. Your incomplete file will be destroyed after 1 year.)

Mail the application to: ACBHC
207 E. Northern Lights Blvd., Suite 212
Anchorage, AK 99503

Phone 907/332-4333, Fax 907/332-4334
E-mail: certadmn@gci.net Website: www.akcertification.org

DEMOGRAPHIC INFORMATION

This anonymous “no-name” questionnaire is required by the Division of Behavioral Health and is utilized for statistical purposes by the State of Alaska.

1. Gender: Male Female

2. Ethnicity: White – Not of Hispanic Origin Black – Not of Hispanic Origin
 Tlingit Haida Tsimshian
 Athabascan Inupiat Yupik
 Other Alaskan Native American Indian Aleut
 Asian or Pacific Islander Hispanic Other

3. Education: Partial High School High School Graduate / GED
 A.A. Degree Bachelor’s Degree
 Master’s Degree Doctoral Degree
 Some Graduate Classes Post Graduate Classes
 Post Doctoral Classes

4. If employed in a chemical dependency related job, percentage of time spent, type of service, and location: _____

- _____ % Education/Prevention
- _____ % Training others
- _____ % Assessment/Treatment
- _____ % Administration
- _____ % Home-based
- _____ % Outpatient
- _____ % Residential
- _____ % Other _____

5. Employed in field: Full Time Part Time No

6. Volunteer in the field: Yes No _____ number of hours per week

7. I attend school Full Time Part Time No

8. Community, population under 5000
 Community, population under 30,000
 Community, population under 100,000
 Community, population over 100,000

9. I belong to the Alaska Chemical Dependency Counselor Association Yes No

10. Do you have any National Certifications Yes No
 If yes, Organization and Certification Level _____

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, 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, parole, furlough, SIS or deferred sentence).

Only ORIGINALS of this document will be accepted and ALL errors must be initialed.

ETHICAL STANDARDS ADOPTED BY ACBHC 09/05

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.

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.

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- 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.

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- 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.

Principle 8: Preventing Harm

I understand that every decision and action has 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

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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 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.

Signature

Date

Printed Name

Only originals will be accepted and all errors must be initialed

**THIS FORM MUST BE INCLUDED WITH THE APPLICATION AND MAILED TO
ACBHC
207 E. Northern Lights Blvd., Suite 212
Anchorage, AK 99503**

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: _____

**AUTHORIZATION FOR RELEASE TO STATE
AND / OR NATIONAL REGISTERS**

Name of Counselor: _____

Name & Address of Employer: _____

Business Telephone: _____

Alcoholism & Drug Abuse Counselor Level/Dates: _____

Highest Academic Degree: _____

Home Address: _____

Home Telephone: _____

Signature: _____ Date: _____

PROFESSIONAL AFFILIATE RECOMMENDATION

APPLICANT: _____
 is applying for a 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 _____

Printed Name: _____ Title _____

Agency _____

Address _____ Phone _____

City/State/Zip _____ E-Mail _____

Mail the application to: ACBHC
 207 E. Northern Lights Blvd., Suite 212
 Anchorage, AK 99503

PROFESSIONAL AFFILIATE RECOMMENDATION

APPLICANT: _____
 is applying for a 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 _____

Printed Name: _____ Title _____

Agency _____

Address _____ Phone _____

City/State/Zip _____ E-Mail _____

Mail the application to: ACBHC
 207 E. Northern Lights Blvd., Suite 212
 Anchorage, AK 99503

SUPERVISOR RECOMMENDATION FORM

For Applicant: _____

I, _____ have known the candidate for _____

Years/months and can attest to the following qualifications for certified chemical dependency professional.

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

Yes No Explain: _____

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

Reference Signature

Relationship to Applicant

Printed Name

Title

Name of Agency

Address

City/State/Zip

E-mail

Telephone

THIS FORM MUST BE MAILED DIRECTLY to ACBHC, 207 E. Northern Lights Blvd., Suite 212, Anchorage, AK 99503

EMPLOYER VERIFICATION OF EXPERIENCE FORM

Applicant's Name: _____

I am applying to the Alaska Commission for Behavioral Health Certification for certification as an alcohol and drug abuse counselor. Please fill out this form to document my employment in your agency and return it directly to ACBHC. **This information must be on file before my application can be processed.** Your cooperation will be very much appreciated.

EMPLOYER: 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 (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: _____

Address: _____

Only originals will be accepted and all errors must be initialed
THIS FORM MUST BE MAILED BY THE SUPERVISOR DIRECTLY TO
ACBHC, 207 E. Northern Lights Blvd., Suite 212, Anchorage, AK 99503

Addiction Counselor Competency Practicum Evaluation Form

Evaluation of Knowledge, Skills and Attitudes

Check the level that applies: Counselor I [] Counselor II []

PLEASE PRINT

Applicant's Name _____

Practicum Site _____

Dates of fieldwork: (from) _____ (To) _____
 (Month/day/year) (Month/day/year)

Addiction Counselor Competency Competency Area	# Hours Supervised	Rating		
		Developing	Proficient	Exemplary
Transdisciplinary Foundations				
1. Understanding Addiction				
2. Treatment Knowledge				
3. Application to Practice				
4. Professional Readiness				
Professional Practice Dimensions				
1. Clinical Evaluation (overall)				
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 (overall)				
5a. Individual				
5b. Group				
5c. Families & Significant Others				
6. Client, Family, & Community Education				
7. Documentation				

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8. Professional & Ethical Responsibilities				
OVERALL RATING				
Total Practicum Hours		min.150 for CDC I and 300 for CDC II		

Comments: (please be specific regarding competencies)

Supervisor Signature _____ Date _____

Certification Title: _____ Number: _____

Print the following: _____

Supervisor Name: _____ Title _____

Name of Agency _____

Street or Mailing Address _____

City/State/Zip Code _____

Telephone _____ Fax _____ E-mail _____

Only originals will be accepted and all errors must be initialed

**THIS FORM MUST BE MAILED BY THE SUPERVISOR DIRECTLY TO
ACBHC, 207 E. Northern Lights Blvd., Suite 212, Anchorage, AK 99503**