

Dear Certification Applicant:

Thank you for your interest in becoming a Certified Alcohol and Drug Abuse Counselor!

It is important that your application is submitted all at once, fully complete and organized in the order indicated. Extraneous material and information are not needed. Should the Board need any other material or information to approve your application, you will be notified.

Please consult our website, www.vtcertificationboard.org, for assistance in completing the forms. Should you need further assistance, please call Nan Kolok, Board Administrator, at 802-878-7776.

Thank you for your cooperation and good luck!

Type of Application: ____ Apprenticed Substance Abuse Counselor (ASAC)
 ____ Certified Alcohol and Drug Abuse Counselor (CADAC)
 ____ Certified Clinical Supervisor (CCS)
 ____ Student Assistance Professional Counselor (SAP)

BIOGRAPHICAL DATA

Name (last, first, middle initial)			
Home Address (street & no., city, state, zip)		Phone	
		Home:	
		Work:	
		Cell:	
Date of Birth (month, day, year)			
Male _____		Female _____	
E-mail address			
Home:			
Work:			
Schools Attended	Location	Dates Attended	Degree

Have you been convicted of a crime other than a minor traffic violation? ____Yes ____No

List any other states in which you are certified:

Has certification been denied or revoked in another state? ____ Yes ____No

If yes to any of the above, you must explain on a separate sheet.

I hereby certify that all information I have provided in this application is true and accurate to the best of my knowledge. Should I furnish any false information on this application, I hereby understand that such an act shall constitute cause for denial of my application for licensure / certification as an alcohol and drug abuse counselor.

Signature

Date

The Alcohol and Drug Abuse Counselor Licensing Rules meant to implement the provisions of Title 33, chapter 8 of the Vermont Statutes Annotated (VSA), #5, Ethical Standards, state that "Vermont alcohol and drug abuse counselors must comply with the conduct standards listed at 3 VSA 129a and 33 VSA 810. Attachment B of this Rule is designed to further describe specific principles of moral fitness and behavioral standards under 33 VSA 810 (3)."

STATEMENT OF PROFESSIONAL FITNESS

I hereby certify to the following:

I am medically and psychologically fit to practice alcohol and drug abuse counseling. I do not have a physiological, mental, or psychological condition or disorder which in any way impairs my ability to practice with reasonable skill and safety.

Signature _____

Date _____

Clinical Supervisor Statement

The following must be completed by a Certified or Licensed Alcohol and Drug Abuse Counselor or a Board-approved supervisor:

To the best of my knowledge and experience, _____
(candidate's name)
does not have a physiological, mental, or psychological condition or disorder which in any way impairs or limits his/her ability to practice with reasonable skill and safety.

Supervisor's Name _____
(printed) (signature)

LADC or CADC #: _____

Date _____

ETHICAL STANDARDS OF ALCOHOL AND DRUG ABUSE COUNSELORS

Alcoholism and drug abuse counselors hold a position of trust and responsibility in the community. They must be aware, at all times, of ethical guidelines imposed as a result of their special position. The addiction counselor must insure that all people are treated with dignity, honor, and respect and always in an ethical manner. The counselor should, thereby, provide the highest quality care, act in the best interest of those individuals who seek their professional services, and assist these individuals to help themselves.

The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs has adopted the NAADAC Counselors Ethical Standards of Alcoholism and Drug Abuse to guide counselors in maintaining a high level of ethical conduct. All counselors must subscribe to these ethical standards in their application for certification and apply them in the practice of their profession. All credentialed counselors (certified and apprenticed) in the State of Vermont are subject to these standards, and any counselor failing to meet these ethical standards will be subject to disciplinary actions. These ethical standards can be found in VSA 33, Chapter 810, Unprofessional Conduct.

I understand and will adhere to these ethical and legal principles and the responsibilities of my profession.

Signature: _____

Date: _____

SUPERVISOR INFORMATION

(to be completed by applicant's clinical supervisor. Please print.)

Name of CADC applicant: _____

Name of Supervisor: _____

Place of Employment: _____

Title: _____

Credential: Please check all that apply.

____ CADC

____ LADC

____ CCS

____ Certification Board-approved supervisor

____ CADC/LADC in another state (enclose copy of certificate/license)

(supervisor's signature)

(date)

Note: If you are not a CADC or LADC, you must be a Board-approved supervisor. Please refer to the requirements noted on the website and/or contact Nan Kolok, the Certification Board administrator.

**DOCUMENTATION OF SUPERVISION IN
THE TWELVE CORE FUNCTIONS**

Supervisor's statement:

I, _____ certify that _____
(supervisor name; please print) (applicant name; please print)

has received supervision in the Twelve Core Functions and is competent.

(supervisor's signature)

(date)

Applicant's statement:

I, _____ certify that I have received supervision in the
(applicant name; please print)

Twelve Core Functions, and I am competent.

(applicant's signature)

(date)

SUPERVISION IN THE IC&RC / AODA 12 CORE FUNCTIONS

Listed below are the 12 core functions. You should have a minimum of 20 hours of clinical supervision in each function, with a total of 300 hours.

Name of Applicant: _____

Name of Applicant's Clinical Supervisor: _____

CORE FUNCTION	NO. OF HOURS	AGENCY
Screening		
Intake		
Orientation		
Assessment		
Treatment Planning		
Counseling		
Case Management		
Crisis Intervention		
Client Education		
Referral		
Reports & Recordkeeping		
Consultation with Other Professionals		
TOTAL NO. OF HOURS:		

Signature of Applicant's Supervisor: _____

ALCOHOL / DRUG RELEVANT PAID WORK EXPERIENCE (most recent first)

Employer:		Dates: From	To	Total Hrs _____ Hours worked in 12 core functions (Multiply total hrs. X % listed)
Address:		Phone No.		
Your Title:	Treatment Services Supervisor:			
Percent of time providing alcohol/drug services as per 12 core functions: _____ %				
Duties as they relate to 12 core functions:				
Clinical Supervisor's name: (if different from above)		Address:		
Telephone No.:				

Employer:		Dates: From	To	Total Hrs _____ Hours worked in 12 core functions (Multiply total hrs. X % listed)
Address:		Phone No.		
Your Title:	Treatment Services Supervisor:			
Percent of time providing alcohol/drug services as per 12 core functions: _____ %				
Duties as they relate to 12 core functions:				
Clinical Supervisor's name: (if different from above)		Address:		
Telephone No.:				

ALCOHOL / DRUG RELEVANT INTERNSHIP OR PRACTICUM EXPERIENCE
Educationally Related Work Experience – List most recent first

Employer:		Dates: From	To	Total Hrs _____ Hours worked in 12 core functions (Multiply total hrs. X % listed)
Address:		Phone No.		
Your Title:	Treatment Services Supervisor:			
Percent of time providing alcohol/drug services as per 12 core functions: _____ %				
Duties as they relate to 12 core functions:				
Clinical Supervisor's name: (if different from above)		Address:		
Telephone No.:				

Employer:		Dates: From	To	Total Hrs _____ Hours worked in 12 core functions (Multiply total hrs. X % listed)
Address:		Phone No.		
Your Title:	Treatment Services Supervisor:			
Percent of time providing alcohol/drug services as per 12 core functions: _____ %				
Duties as they relate to 12 core functions:				
Clinical Supervisor's name: (if different from above)		Address:		
Telephone No.:				

ALCOHOL / DRUG RELEVANT VOLUNTEER WORK EXPERIENCE (most recent first)

Employer:		Dates: From	To	Total Hrs _____ Hours worked in 12 core functions (Multiply total hrs. X % listed)
Address:		Phone No.		
Your Title:	Treatment Services Supervisor:			
Percent of time providing alcohol/drug services as per 12 core functions: _____ %				
Duties as they relate to 12 core functions:				
Clinical Supervisor's name: (if different from above)		Address:		
Telephone No.:				

Employer:		Dates: From	To	Total Hrs _____ Hours worked in 12 core functions (Multiply total hrs. X % listed)
Address:		Phone No.		
Your Title:	Treatment Services Supervisor:			
Percent of time providing alcohol/drug services as per 12 core functions: _____ %				
Duties as they relate to 12 core functions:				
Clinical Supervisor's name: (if different from above)		Address:		
Telephone No.:				

