MASSACHUSETTS BOARD OF SUBSTANCE ABUSE COUNSELOR CERTIFICATION, INC.

MBSACC

CADC CERTIFICATION APPLICATION FORM

_____

APPLICANT'S NAME (Please Print)

_____

HOME E-MAIL ADDRESS

_____

WORK E-MAIL ADDRESS

FOR OFFICE USE ONLY – DO NOT WRITE IN AREA BELOW

DATE REC'D. _____ *TO REVIEW* _____ *LEVEL APPV'D.* _____

CHECK # _____ *CHECK AMNT.* _____ *CHECK DATE* _____

GRP. # _____ *APPV'D.:* Y / N / H *NOTICE SENT* _____

COMMENTS: _____

APPLICANT INFORMATION

Information in the following sections is mandatory except where specifically indicated

(Please Print Legibly)

NAME: _____
Last *First* *Middle Initial*

ADDRESS: _____
Number & Street or P.O. Box

_____
City *State* *Zip*

S.S. #: ____-____-____ *DOB:* ____/____/____ *GENDER:* *M* *F*
For Identification Purposes Only *(Must Be 18 Or Older To Apply)* *(Please Circle Gender)*

AGENCY: _____

_____

AGENCY ADDRESS: _____
Number & Street or P.O. Box

_____
City *State* *Zip*

CONTACT NUMBERS

HOME: (____) _____ *CELL:* (____) _____ *WORK:* (____) _____
Area Code *Area Code* *Area Code*

EXAM INFORMATION

I WISH TO TAKE THE WRITTEN CERTIFICATION EXAM IN: ❑ *ENGLISH* ❑ *SPANISH*

DUE TO PHYSICAL LIMITATIONS, SPECIAL ACCOMMODATIONS WILL BE REQUIRED IN ORDER FOR ME TO TAKE THE WRITTEN EXAM: ❑ *YES* ❑ *NO*

NOTE *IF YOU CHECK "YES," AN* ***EXAMINEE REQUEST FOR REASONABLE ACCOMMODATIONS FORM*** *WILL BE SENT TO YOU. THIS FORM MUST BE COMPLETED AND RETURNED TO THE CERTIFICATION OFFICE A MINIMUM OF 90 DAYS PRIOR TO THE EXAM.*

APPLICANT INFORMATION

EDUCATION

I have earned my: ❑ *High School Diploma or* ❑ *GED (Proof may be required)*

List below all ***completed*** *formal education for which you have received a Degree –*

NAME & LOCATION (CITY & ST) OF COLLEGE/UNIVERSITY	***DATES ATTENDED***	***DATE GRADUATED***	***DEGREE EARNED***

Have you ever been convicted of a felony? ❑ *Yes* ❑ *No*

(If you checked "Yes," you must give a brief explanation of the nature of the felony and the results thereof on a separate sheet of paper and attach it to the application. This is ***not*** *an optional step.)*

NOTE: *You are not required to furnish information for any offense committed prior to your 17th birthday or for a first conviction for any of the following misdemeanors: drunkenness, simple assault, speeding, minor traffic violations, affray or disturbance of the peace; or for a conviction of a misdemeanor where the date of such conviction or the completion of any period of incarceration resulting therefrom (whichever is later) occurred five or more years prior to the date of application, unless you have been convicted of any other offense within five years immediately preceding the date of this application.*

The information requested in this box is supplied voluntarily and does not affect eligibility; it is used for demographic purposes only and will not be revealed to any outside agent/agency for any reason without your expressed written permission. This demographic information is important to us, however, and we appreciate your cooperation in providing it to us.

Are you now, or have you ever been, in recovery for alcohol and/or other drug abuse? ❑ *Yes* ❑ *No*

Please check the box that best describes your ethnic background:

❑ African American/Black ❑ Hispanic/Latino

❑ Asian ❑ Native American

❑ Caucasian ❑ Other _____ (Pease specify)

The Clinical Supervisor Evaluation Forms will be completed by the following individuals:

NAME OF SUPERVISOR *AGENCY* *SUPERVISOR'S JOB TITLE*

NAME OF SUPERVISOR *AGENCY* *SUPERVISOR'S JOB TITLE*

NAME OF SUPERVISOR *AGENCY* *SUPERVISOR'S JOB TITLE*

AUTHORIZATION & RELEASE FORM

I understand that Certification through MBSACC is an entirely voluntary process, and I agree to abide by its policies and procedures for as long as I hold Certification.

I hereby authorize MBSACC, its committees, and staff to make inquiry of any agency, facility, organization, or individual for any additional information that might be necessary to fully and properly evaluate my application for Certification and to investigate my background as it relates to statements contained in the application for counselor Certification.

I hereby authorize MBSACC, its committees, and staff to contact any of the supervisors listed in my application, and request that each of the contacted supervisors fully and frankly respond to all inquiries made by MBSACC regarding my application. I understand that evaluations of me which are submitted by supervisors and/or colleagues are confidential, and I hereby relinquish my right to view these evaluations.

I hereby release, and hold harmless, MBSACC, its Board of Directors, Officers, employees and examiners from any and all manner of suits, actions, claims, and judgments which might arise from such efforts to further document the statements and claims I have made in this application or in the processing or consideration of same.

I further agree to hold free/harmless MBSACC, its Board of Directors, Officers, employees and examiners from any civil liability for damages or complaints by reason of any action that is within the scope of the performance of their duties which they take in connection with this application and subsequent examinations and/or the failure of MBSACC to issue Certification to me
.
I acknowledge, understand, and agree that any falsification or misrepresentation of information by myself or others regarding my experience and/or qualifications will be sufficient reason for disapproval of my application or revocation of my Certification (if granted) at a later date.

Upon submittal of my application, I give permission to MBSACC, its committees, or representatives to contact and question, as necessary, any person, institution, or organization for any ethics or appeals investigation.

You must sign this form in the presence of a witness who is willing to attest to the fact that you signed in his/her presence. The witness must sign where designated. The witness may be anyone who is familiar with your signature.

_____	_____
APPLICANT NAME (Please print)	*WITNESS NAME (Please print)*
_____	_____
APPLICANT SIGNATURE	*WITNESS SIGNATURE*
_____	_____
DATE	*DATE*

PROFESSIONAL CODE OF ETHICS

The Professional Code of Ethics applies equally to all certified counselors regardless of whether or not there is a previous history of personal use of alcohol or other drugs. The Massachusetts Board of Substance Abuse Counselor Certification believes that all people have rights and responsibilities through every stage of human development. The goal is for counselors to treat individuals with the dignity, honor, respect, and reverence entitled to them as human beings. We also believe that each client has the right to receive services which meet the highest professional standards and entitle human beings to the physical, social, psychological, spiritual, and emotional care to meet their human needs.

PROFESSIONAL CODE OF CONDUCT

A. *The counselor is dedicated to the concept that substance abuse is treatable and that all efforts with the substance abusing client should be directed toward the recovery of the client, as well as others who may be affected.*

B. *The counselor respects the client by maintaining an objective, non-possessive relationship at all times.*

C. *The counselor does not discriminate among clients, colleagues, or other professionals on the basis of race, religion, age, sex, sexual orientation, or national background; or engage in sexual harassment in any form.*

D. *The counselor respects the confidentiality of the clients. No records, materials, or communications concerning the client is released without an approved release of information signed by the client.*

E. *The counselor shall strive to improve institutional policies and management functions while, at the same time, respecting these existing policies.*

F. *The counselor assesses personal and vocational strengths and limitations, biases, and effectiveness and is willing to recognize when it is in the client's best interest to release the client to other professionals in the community.*

G. *The counselor does not work in isolation, but maintains inter-professional associations and develops inter-professional relationships for the purpose of clinical consultations and referrals.*

H. *The counselor is always cognizant of the mental and medical needs of the client served and refers to other specialized health care services for evaluations and treatment as necessary.*

I. *The counselor has affiliations with professional and inter-professional groups and organizations in the community.*

J. *The counselor does not offer specialized counseling services to an individual who is receiving counseling or therapy from another professional person, except by agreement with the other professional or after termination of the client's relationship with the other professional.*

K. *The counselor is careful in all publicity, public pronouncement, or publication to distinguish and differentiate between his/her private opinions and professional opinions.*

L. *The counselor takes responsibility for his/her continued professional growth through further education and training. He/she shall maintain a high level of physical, mental, and emotional well-being, including the responsible, appropriate, and legal use of alcohol and other drugs.*

I have read and subscribe to the MBSACC Professional Code of Ethics/Conduct.

_____

NAME (Please Print)

_____

SIGNATURE *DATE*

I agree to surrender my Certification, if required, for any violation of the Professional Code of Ethics/Conduct.

_____

NAME (Please Print)

_____

SIGNATURE *DATE*

WORK EXPERIENCE

NOTE: *In this section, list* ***only*** *work experience related to substance abuse counseling. An official job description for this position must be attached. The job description must be signed and dated by both you and the supervisor of record. For any employment that you list, if that facility is not licensed as an alcohol/drug abuse facility, an agency brochure for that facility must be provided with this application.*

AGENCY: _____

TYPE OF AGENCY/FACILITY: _____

AGENCY ADDRESS: _____

_____
CITY *STATE* *ZIP*

AGENCY PHONE: ( ) _____ *APPLICANT'S JOB TITLE:* _____
AREA CODE *EXT.*

SUPERVISOR'S NAME: _____ *SUPERVISOR'S TITLE:* _____

NUMBER OF FULL-TIME WORK HOURS WEEKLY: _____

DATES OF EMPLOYMENT:

FROM: _____ *TO:* _____
MM/YY *MM/YY*

NUMBER OF PART-TIME WORK HOURS WEEKLY: _____

DATES OF EMPLOYMENT:

FROM: _____ *TO:* _____
MM/YY *MM/YY*

NUMBER OF SUBSTANCE ABUSE COUNSELING HOURS PER WEEK SPENT IN THE FOLLOWING AREAS:

Do ***not*** *include hours that are not specifically spent in counseling (i.e., staff meetings, report/record keeping, trainings, etc.) in the hours you list below*

INDIVIDUAL COUNSELING _____ *GROUP COUNSELING* _____ *FAMILY/SIGNIFICANT OTHER COUNSELING* _____

TOTAL NUMBER OF HOURS WORKED IN THIS POSITION: (From start date to present) _____

PERCENTAGE OF TIME SPENT IN THE FOLLOWING CASELOAD AREAS:

PRIMARY DIAGNOSIS OF ALCOHOLISM/DRUG ABUSE _____*%*

PRIMARY DIAGNOSIS OF OTHER _____*%* *(PLEASE SPECIFY)* _____

SECONDARY DIAGNOSIS OF ALCOHOLISM/DRUG ABUSE _____*%*

In this space, please provide a description of your primary responsibilities as an alcohol/drug abuse counselor at the time of reported employment:

WORK EXPERIENCE

(THIS SECTION MAY BE PHOTOCOPIED IF ADDITIONAL ENTRY SPACE IS REQUIRED)

AGENCY: _____

TYPE OF AGENCY/FACILITY: _____

AGENCY ADDRESS: _____

_____
CITY *STATE* *ZIP*

AGENCY PHONE: (_____) _____
AREA CODE *EXT.*

APPLICANT'S JOB TITLE: _____

SUPERVISOR'S NAME: _____

SUPERVISOR'S TITLE: _____

NUMBER OF FULL-TIME WORK HOURS WEEKLY: _____

DATES OF EMPLOYMENT:

FROM: _____ *TO:* _____
MM/YY *MM/YY*

NUMBER OF PART-TIME WORK HOURS WEEKLY: _____

DATES OF EMPLOYMENT:

FROM: _____ *TO:* _____
MM/YY *MM/YY*

NUMBER OF SUBSTANCE ABUSE COUNSELING HOURS PER WEEK SPENT IN THE FOLLOWING AREAS:

*Do **not** include hours that are not specifically spent in counseling (i.e., staff meetings, report/record keeping, trainings, etc.) in the hours you list below*

INDIVIDUAL COUNSELING _____ *GROUP COUNSELING* _____ *FAMILY/SIGNIFICANT OTHER COUNSELING* _____

TOTAL NUMBER OF HOURS WORKED IN THIS POSITION: (From start date to present) _____

PERCENTAGE OF TIME SPENT IN THE FOLLOWING CASELOAD AREAS:

PRIMARY DIAGNOSIS OF ALCOHOLISM/DRUG ABUSE _____%

PRIMARY DIAGNOSIS OF OTHER _____% *(PLEASE SPECIFY)* _____

SECONDARY DIAGNOSIS OF ALCOHOLISM/DRUG ABUSE _____%

In this space, please provide a brief description of your primary responsibilities as an alcohol/drug abuse counselor at the time of reported employment.

EDUCATION RESUME

(THIS SECTION MAY BE PHOTOCOPIED IF ADDITIONAL ENTRY SPACE IS REQUIRED.)

Each training event listed must be accompanied by appropriate documentation (i.e., transcript, Certificate of Attendance, etc.).

Please refer to the Information Packet under the level of Certification for which you are applying to obtain the number of hours required for that level in each of the categories listed below.

CATEGORY I - *Alcohol/Drug Specific Studies (AD)*
CATEGORY II - *Counseling Techniques (CT)*
CATEGORY III - *Behavioral Sciences (BS)*
CATEGORY IV - *Ethics Training (ET)*

TITLE OF COURSE OR PROGRAM	DATE	INSTITUTION OR INDIVIDUAL OFFERING THE TRAINING	NUMBER OF TRAINING HOURS (OR CREDITS)	CATEGORY HOURS
				Category I ____hrs. Category II ____ hrs. Category III ____hrs. Category IV ____hrs.

Briefly describe the objectives and content of this training -

TITLE OF COURSE OR PROGRAM	DATE	INSTITUTION OR INDIVIDUAL OFFERING THE TRAINING	NUMBER OF TRAINING HOURS (OR CREDITS)	CATEGORY HOURS
				Category I ____hrs. Category II ____ hrs. Category III ____hrs. Category IV ____hrs.

Briefly describe the objectives and content of this training –

TITLE OF COURSE OR PROGRAM	DATE	INSTITUTION OR INDIVIDUAL OFFERING THE TRAINING	NUMBER OF TRAINING HOURS (OR CREDITS)	CATEGORY HOURS
				Category I _____hrs. Category II ____ hrs. Category III _____hrs. Category IV _____hrs.

Briefly describe the objectives and content of this training –

TITLE OF COURSE OR PROGRAM	DATE	INSTITUTION OR INDIVIDUAL OFFERING THE TRAINING	NUMBER OF TRAINING HOURS (OR CREDITS)	CATEGORY HOURS
				Category I _____hrs. Category II ____ hrs. Category III _____hrs. Category IV _____hrs.

Briefly describe the objectives and content of this training –

TITLE OF COURSE OR PROGRAM	DATE	INSTITUTION OR INDIVIDUAL OFFERING THE TRAINING	NUMBER OF TRAINING HOURS (OR CREDITS)	CATEGORY HOURS
				Category I _____hrs. Category II ____ hrs. Category III _____hrs. Category IV _____hrs.

Briefly describe the objectives and content of this training –

SUPERVISION

APPLICANT'S NAME *(Please Print)*

SUPERVISOR'S NAME *(Please Print)*

Supervisor Directions –

Please complete this form indicating the applicant's on-the-job supervision in the Performance Domains. This form is not intended to document the total number of hours that the applicant has worked but rather the number of hours of on-the-job supervision that you have provided to the applicant. MBSACC considers supervision to be a formal, systematic process that focuses on skill development and integration of knowledge. The supervision must take place in a setting where substance abuse counseling is being provided. The supervision may be completed under more than one supervisor in the facility.

By signing your name on this form (below), you are verifying that you have provided to the applicant the supervision hours that you have listed next to each Performance Domain.

NOTE: A minimum of ten hours is required in each Performance Domain (#1 - #4) below.

The supervision required will be tiered based on the applicant's highest level of education as follows:

300 hours of supervision with a high school diploma or GED

250 hours of supervision with an Associate's Degree in the Behavioral Sciences Field

200 hours of supervision with a Bachelor's Degree in the Behavioral Sciences Field

100 hours of supervision with a Master's (or higher) Degree in Counseling (or a closely related field)

PERFORMANCE DOMAINS	# HOURS PROVIDED IN EACH DOMAIN
1. Screening, Assessment, and Engagement	
2. Treatment Planning, Collaboration, and Referral	
3. Counseling	
4. Professional and Ethical Responsibilities	

TOTAL # OF HOURS _____

NAME OF AGENCY WHERE SUPERVISION TOOK PLACE _____

I attest that the reported information above is, to the best of my knowledge, an accurate accounting of the supervision I have provided to this applicant.

SUPERVISOR'S NAME (Please PRINT)

DATE

SUPERVISOR'S SIGNATURE