THE MASSACHUSETTS BOARD OF SUBSTANCE ABUSE COUNSELOR CERTIFICATION, INC.

MBSACC

CERTIFIED CLINICAL SUPERVISOR

CCS

APPLICATION FORM

_____

APPLICANT'S NAME (PLEASE PRINT)

THIS APPLICATION MUST BE LEGIBLY HAND-PRINTED

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 (DO NOT OMIT ZIP)*

S.S.#: ____/____/____ ***D.O.B.:*** ____/____/____ ***GENDER:*** ***M*** ***F***
Identification Purposes Only *Must Be 18 Yrs. or Older to Apply* *(Circle Gender)*

AGENCY: _____

_____

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

_____
City *State* *Zip (DO NOT OMIT ZIP)*

CONTACT NUMBERS

(DO NOT OMIT AREA CODES)

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

EMAIL ADDRESS: _____
Home *Work*

SPECIAL ACCOMMODATIONS FOR TESTING

Due to physical limitations, special accommodations will be required in order for me to take the Certified Clinical Supervisor written exam: ❑ **YES** ❑ **NO**

NOTE: *IF YOU CHECK YES, A REQUEST FOR REASONABLE ACCOMMODATIONS FORM WILL BE SENT TO YOU. THIS FORM MUST BE COMPLETED BY A PHYSICIAN OR OTHER MEDICAL PROFESSIONAL WHO CAN VERIFY YOUR NEED FOR SPECIAL ACCOMMODATIONS. THE FORM MUST BE RETURNED TO THE CERTIFICATION OFFICE A MINIUM OF 90 DAYS PRIOR TO THE EXAM FOR WHICH YOU SUBMITTED AN APPLICATION.*

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 clinical supervisor 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 so 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***

EDUCATION RÉSUMÉ

PHOTOCOPY THIS PAGE WHILE IT IS BLANK IF YOU WILL REQUIRE ADDITIONAL ENTRY SPACE

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

REQUIRED: *30 hours of education specific to the first five IC&RC clinical supervision domains with a minimum of 4 (four) hours in each domain.*

Domain #1: *Counselor Development*
Domain #2: *Professional & Ethical Standards*
Domain #3: *Program Development & Quality Assurance*
Domain #4: *Performance Evaluation*
Domain #5: *Administration*
Domain #6: *Treatment Knowledge*

TITLE OF COURSE OR PROGRAM	***DATE***	***INSTITUTION OR INDIVIDUAL OFFERING COURSE***	***NUMBER OF TRAINING HOURS***	***INDICATE DOMAIN OF TRAINING***
				Domain # _____

Briefly describe the objectives and content of this training.

TITLE OF COURSE OR PROGRAM	***DATE***	***INSTITUTION OR INDIVIDUAL OFFERING COURSE***	***NUMBER OF TRAINING HOURS***	***INDICATE DOMAIN OF TRAINING***
				Domain # _____

Briefly describe the objectives and content of this training.

PROFESSIONAL WORK EXPERIENCE RÉSUMÉ

COMPLETE A SEPARATE PAGE FOR EACH POSITION AND/OR JOB HELD

PHOTOCOPY THIS BLANK SHEET AS MANY TIMES AS NEEDED

IN THIS SECTION, LIST WORK EXPERIENCE IN THE SUBSTANCE ABUSE FIELD ONLY
(LIST MOST RECENT FIRST)

*Name & Address of Employer:*_____

*Applicant's Job Title:*_____

*Supervisor's Name:*_____

*Work Phone:(_____)*_____
Area Code *EXT.*

*Term of Employment - FROM:*_____ *TO:*_____
MM/YY *MM/YY*

*Number of full-time hours per week*_____ *Number of part-time hours per week:*_____

*Number of other hours (if any) per week:*_____ *(Please Specify):*_____

*Total number of hours in this position:*_____ *Total years in this position:*_____

*Total of months in this position (if less than 1 yr.):*_____

*Briefly describe duties/responsibilities:*_____

_____

_____

_____

_____

_____

_____

_____

*What percentage of your time in this position involved direct counseling with substance abuse clients?*_____%

*In this position, how many hours were spent providing face-to-face clinical supervision?*_____

PROFESSIONAL CODE OF ETHICS

The Professional Code of Ethics applies equally to all certified clinical supervisors 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 clinical supervisors 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 clinical supervisor 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 clinical supervisor respects the client by maintaining an objective, non-possessive relationship at all times.*

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

F. *The clinical supervisor 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 clinical supervisor 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 clinical supervisor 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 clinical supervisor has affiliations with professional and inter-professional groups and organizations in the community.*

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

L. *The clinical supervisor 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*