



Southwest Certification Board

RE-CERTIFICATION CHECKLIST

for

Certified Alcohol & Drug Abuse Counselor (CADC I, II, III)

Certified Criminal Justice Professional (CCJP)

Certified Prevention Specialist (CPS)

Please include this Checklist with your renewal packet.

PLEASE PROVIDE THE FOLLOWING:

- _____ Complete Recertification Application Form
- _____ Applicable Box Checked (CADC I, II, III, CCJP or CPS)
- _____ Current Job Description
- _____ Supporting Documentation of Continuing Education (i.e. college transcripts, training certificates, in-service training documentation, etc.)
- _____ Current Supervisor's Evaluation Form (from your current employment, only if employment has changed in the past two years)
- _____ Applicable Code of Ethics – Signed & Dated
- _____ IC&RC Renewal Form (if applicable)

REQUIRED FEESTHE FOLLOWING:

- _____ \$150 per certification (money order or agency check) – Non-Refundable
- _____ \$ 24 per IC&RC renewal

Your application will not be processed until all of the above items have been received by the Southwest Certification Board.

It is recommended that all application materials be sent in one mailing to SCB.

COMPLETED BY

DATE

**Southwest Certification
c/o Native American Connections
4520 N. Central Avenue, Ste. 600
Phoenix, Arizona 85012
602 254-3247
Fax: 602 256-7356**

MAKE CHECKS PAYABLE TO: Southwest Certification Board



Southwest Certification Board

APPLICATION FOR RECERTIFICATION

FOR OFFICE USE ONLY

<input type="radio"/> APPROVED	EXPIRATION DATE:
<input type="radio"/> NOT APPROVED	<input type="radio"/> INCOMPLETE
COMMENTS:	
SIGNATURE:	DATE:

PART I. PERSONAL INFORMATION

Social Security Number:	Applying For:		
	<input type="radio"/> CADC Level I	<input type="radio"/> CADC Level II	<input type="radio"/> CADC Level III
	<input type="radio"/> CCJP	<input type="radio"/> CPS	
Date of Birth:	Gender:		
	<input type="radio"/> Male	<input type="radio"/> Female	
First Name:	Middle Name:	Last Name:	
Home Address:			
City:	State:	Zip:	
Home Phone:		Business Phone:	
Current Position:		E-Mail Address:	
Nationality:	Tribal Affiliation:		
<input type="radio"/> Native American			
<input type="radio"/> Caucasian	<input type="radio"/> African-American	<input type="radio"/> Mexican-American	<input type="radio"/> Asian-American
<input type="radio"/> Other:			

You must provide your supervisor's name and phone number if you are certified as a CACII.

SUPERVISOR'S NAME

WORK PHONE

Please note that if you provide only a home address and phone number, then the home address and phone number becomes the certification address. Otherwise, the business address and phone number are the certification address. You must notify the Board in writing within 30 days of any change of address or name change. Such changes must be reported on a form available from the Board by calling 602/254-3247 or email swcert@nativeconnections.org and requesting a Name/Address Change Form.



Southwest Certification Board

EMPLOYMENT VERIFICATION FORM

II. CURRENT EMPLOYMENT

APPLICANT:			JOB TITLE:		
AGENCY:					
ADDRESS:				PHONE:	
CITY:	STATE:	ZIP:	PHONE:		
NAME OF SUPERVISOR:					
CONTACT INFORMATION FOR SUPERVISOR:					
MAJOR DUTIES:					
VERIFICATION OF EMPLOYMENT:					
FROM:			TO:		
PERCENTAGE OF TIME SPENT IN ACTIVIES RELATED TO COUNSLING INDIVIDUALS AND THEIR FAMILIES WHO EXPERIENCE ALCOHOL/DRIG PROBLEMS.					
Percentage of time:			# of Hours:		
VERIFY YEARS OF SOBRIETY/DRUG FREE:					

III. BACKGROUND INFORMATION

Please read the following questions carefully. You must answer every question. If any questions are answered YES, please attach a separate sheet with a thorough explanation and include appropriate documentation such as related court orders and treatment and/or rehabilitation plans. Include your name and social security number on each page.

YES NO (a) Have you ever applied for and been denied a license, certificate, registration or membership by any state regulatory board, any professional or occupational credentialing authority or any professional association in Arizona or any other state or country?

YES NO (b) Have you ever been or are you currently the subject of any complaint, investigation or disciplinary action against your license, certificate, registration or membership by any state regulatory board, any professional or occupational credentialing authority or any professional association in Arizona or any other state or country? If yes, please provide copies of the complaint and all final actions. *You must identify all complaints ever filed against you, pending or completed, other than those filed by this Board, and attach an explanation. For example, even if a complaint against you was dismissed, you must answer “yes” and include an explanation.*

YES NO (c) To your knowledge, have any unresolved or pending complaints been filed against you by any state regulatory board, any professional or occupational credentialing authority or any professional association in Arizona or any other state or country?

YES NO (d) Have you ever had any disciplinary action or sanctions of any kind taken against you by any state or federally licensed facility or employer in Arizona or any other state or country?



Southwest Certification Board

YES NO (e) Have you ever voluntarily surrendered, allowed to lapse, canceled or resigned your license, certificate, registration or membership in lieu of disciplinary proceedings or sanctions of any kind by any state regulatory board, any professional or occupational credentialing authority or any professional association in Arizona or any other state or country?

YES NO (f) Have you ever had a limited license, certificate, or registration issued by any state regulatory board, any professional or occupational credentialing authority or any professional association in Arizona or any other state or country?

YES NO (g) Have you ever been convicted of or pled nolo contendere to a criminal offense, other than a minor traffic violation, in any state or in federal court? If yes, please provide copies of the court documents such as the complaint, the pleadings and final order(s). **You must answer "yes" even if you received a pardon, the conviction was set aside, the records were expunged, your civil rights were restored and whether or not sentence was imposed or suspended.**

YES NO (h) Have you ever entered into any type of pretrial diversion agreement with a state or federal government? If yes, please provide a copy of your pretrial diversion agreement.

YES NO (i) Have you ever been or are you currently a defendant in any type of civil or criminal action related to any professional services (i.e., malpractice)? If so, indicate whether you entered into a settlement agreement or were ordered to pay damages and whether such a suit is currently pending. Provide copies of the original complaint and response, any judgment entered and any settlement agreements.

YES NO (j) Have you ever been involuntarily terminated from any behavioral health position or related employment? If yes, please provide the name, address and telephone number of the employer, the name of your immediate supervisor and a description of the cause for the termination.

YES NO (k) Are you currently engaged in the illegal use of any controlled substance, habit-forming drug or prescription medication?

YES NO (l) If you consume intoxicating beverages, has your consumption impaired or limited in any way your present ability to competently and safely perform the essential functions of your profession?

YES NO (m) Are you now or have you in the last 5 years been actively addicted to any chemical substance including alcohol (excluding tobacco and caffeine)?

YES NO (n) Are you now being treated or have you in the last 5 years been treated for a drug or alcohol addiction or participated in a rehabilitation program?

YES NO (o) Do you have or have you had within the last 5 years any disease or medical condition that in any way impairs or limits your ability to competently and safely perform the essential functions of your profession? "Medical condition" includes physiological, mental or psychological conditions or disorders such as, but not limited to, physical impairments, emotional or mental diseases or conditions or alcohol or other substance abuse.

NAME

SOCIAL SECURITY NUMBER



Southwest Certification Board

IV. NOTARIZED AFFIDAVIT

I certify under penalty of perjury that all information contained in this renewal application, including all supporting documents, is true and correct to the best of my knowledge and belief with full knowledge that all statements made in this renewal application may be grounds for refusal or subsequent revocation or suspension of my certification(s). I authorize the Southwest Certification Board to obtain any relevant information regarding my renewal application. I further authorize any entity holding relevant information to release said information to the Board.

I affirm that I have completed the required 40 hours of continuing education within the preceding two years of the expiration date of my current license. (Please fill out the attached form listing the 40 hours of continuing education.)

I will obtain signed provider verification or other documentation of continuing education activities used for license renewal and retain these documents for a minimum of 48 months from the date of renewal of my certification. These verification documents will be made available to the Board upon request.

This affidavit must be signed in front of a notary. The dates of signature for the professional and the notary must match or the renewal application will be returned.

APPLICANT SIGNATURE

DATE

Subscribed and sworn before me this _____ Day of _____, 20_____

In the State of: _____, County of: _____ (Seal)

Notary Public Signature: _____

My Commission Expires: _____



Southwest Certification Board

CONTINUING EDUCATION ACTIVITIES - INSTRUCTION SHEET

You must document 40 clock hours of continuing education for each renewal submitted on a Continuing Education Activities form (form may be copied) and submit this form with your renewal application

CONTINUING EDUCATION ACTIVITIES: Only activities with dates between your last renewal or initial certification and the expiration of the current certification may be included.

ACTIVITY TYPE: Indicate if the event was a college course, workshop, conference, seminar, in-service training, first time presentation you gave, publication of a paper, report or book or attendance at a Board or credentialing committee meeting.

NAME OF ACTIVITY: Give the workshop name, course title or subject covered if no name is available.

SPONSORING INDIVIDUAL OR ORGANIZATION: Name of the professional organization, agency or school sponsoring the activity.

DESCRIPTION OF CONTENT: Give a brief description of the specific areas covered in the activity. You may wish to provide a separate more detailed description if the relevance of the activity is questionable.

DATES ATTENDED: Give the date(s) attended.

HOURS: List the number of hours attended (i.e., 2 hours, 3.5 hours). One semester-credit hour is equivalent to 15 clock hours of continuing education and one quarter-credit hour is equivalent to 10 clock hours of continuing education.

CONTINUING ACTIVITIES LISTING FORMS *MUST* BE LEGIBLE OR THEY WILL BE RETURNED TO YOU.

RENEWAL AND CONTINUING EDUCATION

Continuing Education

1. A professional who maintains more than one certification may apply the same continuing education hours for each renewal if the content of the continuing education relates to the scope of practice of each specific certification.
2. For each renewal period, a certified professional may report a maximum of 10 clock hours of continuing education from the first-time presentations by the certified professional that deal with current developments, skills, procedures or treatments related to the practice of behavioral health. The professional may claim one clock hour for each hour spent preparing, writing, and presenting information.
3. For each renewal period, a certified professional other than a Board member may report a maximum of six clock hours of continuing education for attendance at a Board meeting.
4. For each renewal period, a certified professional may report a maximum of 10 clock hours of continuing education for service as a Board member.
5. Continuing education activities shall relate to the scope of practice of the specific credential held. The Board shall determine if continuing education submitted by a certified professional is appropriate for the purpose of maintaining or improving the skills and competency of a certified professional.



Southwest Certification Board

Appropriate continuing education activities include:

1. Activities sponsored or approved by national, regional, or state professional associations or organizations in the specialties of marriage and family therapy, professional counseling, social work, substance abuse counseling, or in the allied professions of psychiatry, psychiatric nursing, psychology, or pastoral counseling;
2. Programs in the behavioral health field sponsored or approved by a regionally accredited college or university;
3. In-service training, courses, or workshops in the behavioral health field sponsored by federal, state, or local social service agencies, public school systems, or licensed health facilities and hospitals;
4. Graduate-level or undergraduate course work in the behavioral health field offered by accredited colleges or universities. One semester-credit hour is equivalent to 15 clock hours of continuing education and 1 quarter-credit hour is equivalent to 10 clock hours of continuing education. Audited courses shall have hours in attendance documented;
5. A licensee's first-time presentation of an academic course, in-service training workshop, or seminar;
6. Publishing a paper, report or book that deals with current developments, skills, procedures or treatments related to the practice of behavioral health. The certified professional may claim one clock hour for each hour spent preparing and writing materials. Publications can only be claimed after the date of actual publication;
7. Attendance at a Board meeting where the certified professional does not address the Board or with regard to any matter on the agenda; and
8. Service as a Board member.

Continuing Education Documentation:

1. A certified professional shall maintain documentation of continuing education activities for **48 months following the date of the renewal**.
2. The certified professional shall retain the following documentation as evidence of participation in continuing education activities:
 - a. For conferences, seminars, workshops, and in-service training presentations, a signed certificate of attendance or a statement from the provider verifying the certified professional's participation in the activity, including the title of the program, name, address, and phone number of the sponsoring organization, names of presenters, date of the program, and clock hours involved;
 - b. For first-time presentations by a certified professional, the title of the program, name, address, and telephone number of the sponsoring organization, date of the program, syllabus, and clock hours required to prepare and make the presentation;
 - c. For a graduate or undergraduate course, an official transcript;
 - d. For an audited graduate or undergraduate course: an official transcript; and
 - e. For attendance at a Board meeting, a signed certificate of attendance prepared by the Agency.



Southwest Certification Board

V. CONTINUING EDUCATION ACTIVITIES LISTING (40 HOURS REQUIRED with at least 6 hours of Ethics)

ACTIVITY TYPE *	NAME OF ACTIVITY	SPONSORING INDIVIDUAL OR ORGANIZATION	DESCRIPTION OF CONTENT	DATES ATTENDED	HOURS	Office Use Only **

*college course, workshop, conference, seminar, in-service you gave.
** A=approved; OT=not in 24 months prior to renewal; NR=needs committee review; E=exceeds maximum hours allowed; D=denied, not w/in rule definition



Southwest Certification Board

CONTINUING EDUCATION ACTIVITIES LISTING (40 HOURS REQUIRED with at least 6 hours of Ethics)

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Southwest Certification Board

PART VI: SUPERVISOR’S EVALUATION FORM (Complete only if you have changed jobs in the last 2 years)

NAME OF APPLICANT: _____

Completion of this form represents your personal appraisal of the applicant’s skill level in the areas of competency necessary to be a professional Certified Alcohol & Drug Counselor (CADC). The applicant has the right to inspect this evaluation and/or any other communication between you and SCB. Please fill out this form and return to the applicant in a sealed envelope. Applicant must then submit completed application with all form attached.

LENGTH OF TIME YOU HAVE KNOWN THE APPLICANT: _____

IMPORTANT: PLEASE RESPOND TO ALL QUESTIONS

	WEAK	ADEQUATE	SUPERIOR
COMMUNICATIONS			
1. Oral.....	1 2 3	4 5 6 7	8 9 10
2. Written.....	1 2 3	4 5 6 7	8 9 10
KNOWLEDGE OF ALCOHOL/ALCOHOLISM & DRUG ABUSE			
3. Physiological.....	1 2 3	4 5 6 7	8 9 10
4. Psychological.....	1 2 3	4 5 6 7	8 9 10
5. Socio-cultural.....	1 2 3	4 5 6 7	8 9 10
EVALUATION AND CLIENT ASSESSMENT			
6. Human growth and development.....	1 2 3	4 5 6 7	8 9 10
7. Signs & symptoms indicating referral for medical, psychological or other assessment....	1 2 3	4 5 6 7	8 9 10
8. Signs and symptoms of alcoholism & drug abuse..	1 2 3	4 5 6 7	8 9 10
9. Assessing stages of alcoholism/drug abuse.....	1 2 3	4 5 6 7	8 9 10
10. Ability to take a case history.....	1 2 3	4 5 6 7	8 9 10
11. Evaluation of client progress.....	1 2 3	4 5 6 7	8 9 10
12. Goal setting contracting, problem solving....	1 2 3	4 5 6 7	8 9 10
13. Individual treatment planning.....	1 2 3	4 5 6 7	8 9 10
14. Informing client of legal rights...	1 2 3	4 5 6 7	8 9 10



Southwest Certification Board

	WEAK	ADEQUATE	SUPERIOR
15. Mobilizing community resources	1 2 3	4 5 6 7	8 9 10
16. Knowledge of eligibility requirements.....	1 2 3	4 5 6 7	8 9 10
17. Knowledge of treatment philosophies....	1 2 3	4 5 6 7	8 9 10
18. Selecting proper referral....	1 2 3	4 5 6 7	8 9 10
19. Follow-up to insure client gets service from other providers....	1 2 3	4 5 6 7	8 9 10
20. Establishing a trust relationship with client...	1 2 3	4 5 6 7	8 9 10
21. Elicit feelings.....	1 2 3	4 5 6 7	8 9 10
22. Motivate the client.....	1 2 3	4 5 6 7	8 9 10
23. One-to-one counseling...	1 2 3	4 5 6 7	8 9 10
24. Group counseling....	1 2 3	4 5 6 7	8 9 10
25. Counseling with spouse and family....	1 2 3	4 5 6 7	8 9 10
26. Coordinate client's continuum of treatment...	1 2 3	4 5 6 7	8 9 10
27. Understand steps, traditions & philosophy of NA, AA, Al-Anon, Ala-Teen.....	1 2 3	4 5 6 7	8 9 10
28. Encourage client's participation in N.A., A.A., Al-Anon, Ala-Teen....	1 2 3	4 5 6 7	8 9 10
29. Ability to utilize Indian culture values and traditions in treatment....	1 2 3	4 5 6 7	8 9 10
30. Ability to assist clients in establishing new social activities and relationships....	1 2 3	4 5 6 7	8 9 10

COMMENTS: (Do your responses need to be qualified in any way? Are there aspects of the Applicant's competence that deserve special attention?) _____

NAME OF SUPERVISOR: _____

ADDRESS: _____ CITY _____ ST _____ ZIP _____

TELEPHONE: _____

SIGNATURE: _____ DATE _____



Southwest Certification Board

ASSURANCES

I certify that I voluntarily made this application, and freely submit myself to the evaluation of the Southwest Certification Board. I will accept the decision of the Board and do accept full responsibility for any and all consequences of the process of seeking certification.

I certify that I have no history of alcohol or other substance misuse for a minimum period of one year immediately prior to making this application.

To the best of my knowledge, the information contained herein is true and correct.

I authorize members or representatives of the Southwest Certification Board to contact and obtain information from any references, employers or educational institutions deemed necessary in the evaluation of this application.

I understand that I have the right to inspect the results of any such inquiries made to references, employers, or education institutions. I understand that I have the right to inspect any letters of endorsement or personal reference. I understand that I have the right to inspect the record of deliberation of the Board in considering this application.

SIGNATURE

DATE



Southwest Certification Board

CHANGE OF NAME/ADDRESS REQUEST:

Please complete all parts even if "not new" information. Please print.

PLEASE NOTE: If you provide only a home address and phone number, then the home address and phone number become the certification record. Otherwise, the business address and phone number are certification record.

NAME	SOCIAL SECURITY NUMBER
CERTIFICATION NUMBER(S)	

HOME ADDRESS CHANGE

STREET ADDRESS)		
CITY	STATE	ZIP
HOME PHONE		

WORK ADDRESS CHANGE

AGENCY		
STREET ADDRESS)		
CITY	STATE	ZIP
WORK PHONE	FAX NUMBER	

NAME CHANGE

PREVIOUS NAME
NEW NAME

Name change request must include supporting legal documents such as a copy of your marriage certificate or court order granting the name change.

SIGNATURE	DATE
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