SOUTHWEST CERTIFICATION BOARD

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

Checklist

This form is provided to help you keep track of the necessary steps and forms required for certification

PLEASE PROVIDE THE FOLLOWING:

_____Completed Application Form

_____Applicable Box Checked (CADC I, II) **(PART I: Personal Information,)**

_____Current Copy of Job Description **(PART VI: Job Description)**

_____Transcripts, Certificates of Training, Documentation of Training **(PART VIII – Training Verification)**

_____ Letter of Personal Reference **(PART X: Personal Letter of Reference)**

_____Three (3) Letters of Professional Endorsement **(PART XI: Letter of Professional Endorsement)**

_____Past Employment Verification **(PART XII: Supervisor's Evaluation Form)**

_____Current Supervisor's Evaluation Form **(PART XIII: Supervised Field Work Practicum Log)**

_____CADC Code of Ethics – Signed & Dated

REQUIRED FEES:

_____$150.00 check, money order, or agency check for application process (non-refundable)

_____$25.00 per IC&RC Certification (Does not pertain to CADC Level I)

Counselors now have two options to obtain their IC&RC Credential, see below:

- Option 1: SCB will renew your IC&RC certification upon request; submit your IC&RC application to SCB.
- Option 2: Submit your IC&RC certificate order form directly from ICRC, at http://internationalcredentialing.org/credentials or contact ICRC directly at 717-540-4457.

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

You are only officially certified when you have passed the IC&RC International Written ADC Examination (CADC Level II) or the IC&RC International Written AADC Examination and have met approval by the Southwest Certification Board.

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

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FOR OFFICE USE ONLY

○ **APPROVED**	**EXPIRATION DATE:**
○ **NOT APPROVED** ○ **INCOMPLETE**	**COMMENTS:**
SIGNATURE:	

PART I: PERSONAL INFORMATION

Social Security Number:	**Applying For:** ○ CADC Level I ○ CADC Level II	
Date of Birth:	**Gender:** ○ Male ○ Female	
First Name:	**Middle Name:**	**Last Name:**
Home Address:		
City:	**State:**	**Zip:**
Home Phone:	**Business Phone:**	
Current Position:	**E-Mail Address:**	
Nationality: ○ Native American	Tribal Affiliation:	
○ Caucasian ○ African-American ○ Mexican-American ○ Asian-American ○ Other:		

PART II: EDUCATION

Name of School	**Degree**	**Major**

PART III: ADDITIONAL INFORMATION

Certification/Professional Licenses	**Organization**

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PART IV: EMPLOYMENT HISTORY

Please list full-time, paid positions beginning with your current position and going back consecutively for at least five positions and/or five years.

EMPLOYER:		**SUPERVISOR:**	
POSITION HELD:		**DATES:** FROM:	TO:
MAJOR DUTIES:			
BUSINESS ADDRESS:			
CITY:	**STATE:**	**ZIP:**	**PHONE:**

EMPLOYER:		**SUPERVISOR:**	
POSITION HELD:		**DATES:** FROM:	TO:
MAJOR DUTIES:			
BUSINESS ADDRESS:			
CITY:	**STATE:**	**ZIP:**	**PHONE:**

EMPLOYER:		**SUPERVISOR:**	
POSITION HELD:		**DATES:** FROM:	TO:
MAJOR DUTIES:			
BUSINESS ADDRESS:			
CITY:	**STATE:**	**ZIP:**	**PHONE:**

EMPLOYER:		**SUPERVISOR:**	
POSITION HELD:		**DATES:** FROM:	TO:
MAJOR DUTIES:			
BUSINESS ADDRESS:			
CITY:	**STATE:**	**ZIP:**	**PHONE:**

EMPLOYER:		**SUPERVISOR:**	
POSITION HELD:		**DATES:** FROM:	TO:
MAJOR DUTIES:			
BUSINESS ADDRESS:			
CITY:	**STATE:**	**ZIP:**	**PHONE:**

SIGNATURE: ____________________ **DATE** ____________

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PART V: EMPLOYMENT VERFICATION FORM

The following information is offered in fulfillment of the requirement of at least one year for CADC I, two years for CADC II, of continuous employment utilizing alcoholism and/or drug counseling skills in a facility approved by the State of Arizona or Indian Health Services, immediately prior to submission of this application.

APPLICANT:			**SSN:**
AGENCY:			
ADDRESS:			**PHONE:**
CITY:	**STATE:**	**ZIP:**	**PHONE:**
NAME OF SUPERVISOR:			
POSITION OF APPLICANT:			
MAJOR DUTIES:			
VERFICATION 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:			

PART VI: 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?

☐ 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**

Part VII: JOB DESCRIPTION

Please provide a copy of your current job description along with your application.

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PART VIII: TRAINING/EDUCATION VERFICATION (Insert additional pages if needed)
Verification of applicant's substance abuse training. Please list training in chronological order & provide copies of training certification, college transcripts, and in-service documentation.

AGENCY	TITLE OF TRAINING	CREDITS	DATES

_____ _____

SUPERVISOR'S SIGNATURE: **DATE**

_____ _____

APPLICANT SIGNATURE: **DATE**

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PART IX: 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 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: _____

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PART X: PERSONAL LETTER OF REFERENCE
One letter required by someone who has known the applicant for more than three years.

NAME OF APPLICANT: _____

The above applicant has applied for certification as a Certified Alcohol and Drug Counselor (CADC) with the Southwest Certification Board (SCB). To assist SCB with its evaluation of the applicant, please complete the following information and return to the applicant in a sealed envelope. All information is conficential andonly the applicant has the right to inspect this letter.

LENGTH OF TIME YOU HAVE KNOWN THE APPLICANT: _____
(Must have known the Applicant for more than three years.)

RELATIONSHIP TO THE APPLICANT: O Friend O Co-Worker O Supervisor
O Other: _____

Please comment on the following characteristics regarding the applicant.

1. Ethical issues in counseling:

2. Personal history of alcohol or other substance misuse (length of non-use):

3. Volunteer activities:

4. Non-alcohol/drug-related activities:

5. Family relationships

_____
NAME OF ENDORSOR:

_____ _____ _____ _____
ADDRESS: **CITY** **ST** **ZIP CODE**

_____
TELEPHONE:

_____ _____
SIGNATURE: **DATE**

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PART X1: LETTER OF PROFESSIONAL ENDORSEMENT
Three letters required by someone who can attest to your competence as an addictions professional)

NAME OF APPLICANT: _____

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LENGTH OF TIME YOU HAVE KNOWN THE APPLICANT: _____
(Must have known the Applicant for more than three years.)

RELATIONSHIP TO THE APPLICANT: O Friend O Co-Worker O Supervisor
O Other: _____

Please comment on the following characteristics regarding the applicant.

1. Professionalism:

2. Commitment to helping Indian alcohol/drug user:

3. Skill and Knowledge Level:
    a. Oral communication skills:

    b. Written communication skills:

    c. Understanding of human growth and development:

    d. Ability to use Indian values and culture in treatment:

    e. Ability to facilitate groups:

    f. Ability to use other community resources:

    g. Ability to develop trust in relationship with clients:

h. Ability to communicate about alcoholism and drug abuse:

i. Ability to work as a team leader:

j. Personal history of alcohol or other substance abuse.

k. Other remarks:

_____

NAME OF ENDORSOR:

_____ _____ _____ _____

ADDRESS: **CITY** **ST** **ZIP CODE**

_____

TELEPHONE:

_____ _____

SIGNATURE: **DATE**

SOUTHWEST CERTIFICATION BOARD

PART XI: LETTER OF PROFESSIONAL ENDORSEMENT
Three letters required by someone who can attest to your competence as an addictions professional)

NAME OF APPLICANT: _____

The above applicant has applied for certification as a Certified Alcohol and Drug Counselor (CADC) with the Southwest Certification Board (SCB). To assist SCB with its evaluation of the applicant, please complete the following information and return to the applicant in a sealed envelope. All information is conficential andonly the applicant has the right to inspect this letter.

LENGTH OF TIME YOU HAVE KNOWN THE APPLICANT:_____
(Must have known the Applicant for more than three years.)

RELATIONSHIP TO THE APPLICANT: O Friend O Co-Worker O Supervisor
O Other: _____

Please comment on the following characteristics regarding the applicant.

4. Professionalism:

5. Commitment to helping Indian alcohol/drug user:

6. Skill and Knowledge Level:
    a. Oral communication skills:

    b. Written communication skills:

    c. Understanding of human growth and development:

    d. Ability to use Indian values and culture in treatment:

    e. Ability to facilitate groups:

    f. Ability to use other community resources:

    g. Ability to develop trust in relationship with clients:

h. Ability to communicate about alcoholism and drug abuse:

i. Ability to work as a team leader:

j. Personal history of alcohol or other substance abuse.

k. Other remarks:

_____

NAME OF ENDORSOR:

_____ _____ _____ _____

ADDRESS: **CITY** **ST** **ZIP CODE**

_____

TELEPHONE:

_____ _____

SIGNATURE: **DATE**

SOUTHWEST CERTIFICATION BOARD

PART XI: LETTER OF PROFESSIONAL ENDORSEMENT
Three letters required by someone who can attest to your competence as an addictions professional)

NAME OF APPLICANT: _____

The above applicant has applied for certification as a Certified Alcohol and Drug Counselor (CADC) with the Southwest Certification Board (SCB). To assist SCB with its evaluation of the applicant, please complete the following information and return to the applicant in a sealed envelope. All information is conficential andonly the applicant has the right to inspect this letter.

LENGTH OF TIME YOU HAVE KNOWN THE APPLICANT: _____
(Must have known the Applicant for more than three years.)

RELATIONSHIP TO THE APPLICANT: O Friend O Co-Worker O Supervisor
O Other: _____

Please comment on the following characteristics regarding the applicant.

7. Professionalism:

8. Commitment to helping Indian alcohol/drug user:

9. Skill and Knowledge Level:
    a. Oral communication skills:
    b. Written communication skills:
    c. Understanding of human growth and development:
    d. Ability to use Indian values and culture in treatment:
    e. Ability to facilitate groups:
    f. Ability to use other community resources:

g. Ability to develop trust in relationship with clients:

h. Ability to communicate about alcoholism and drug abuse:

i. Ability to work as a team leader:

j. Personal history of alcohol or other substance abuse.

k. Other remarks:

_____

NAME OF ENDORSOR:

_____ _____ _____ _____

ADDRESS: **CITY** **ST** **ZIP CODE**

_____

TELEPHONE:

_____ _____

SIGNATURE: **DATE**

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PART XII: SUPERVISOR'S EVALUATION FORM

NAME OF APPLICANT: _____

Completion of this form represents your personal appraisal of the applicant's skill level in the areas of competency necessar 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
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

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	WEAK			ADEQUATE				SUPERIOR		
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	1

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 ENDORSOR:

_____ _____ _____ _____

ADDRESS: **CITY** **ST** **ZIP CODE**

_____

TELEPHONE:

_____ _____

SIGNATURE: **DATE**

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PART XIII: SUPERVISED FIELD WORK PRACTICUM LOG

APPLICANT: Log the number of hours you have completed in each of the 12 core domains with the dates completed. Your supervisor must sign to verify completion of each domain. Twenty hours are required for each core function.

SUPERVISOR'S DIRECTIONS: By signing your name, you are attesting that the applicant's core functions were met. This will verify that the 20 required experiential hours in the specific core function indicated have been completed. It is your responsibility to verify by log, or calendar, or another mechanism that the function was indeed adequately and successfully completed.

NOTE:

Field Work represents supervised clinical work in the addiction-counseling field. Classroom experience is not applicable.

1. **Core Function of SCREENING**:

From _____/_____/____, _____ hours were completed in the **SCREENING** process.

Supervisor's signature_____ Date _____

2. **Core Function of INTAKE:**

From _____/_____/____, _____ hours were completed in the **INTAKE** process.

Supervisor's signature_____ Date _____

3. Core Function of ORIENTATION:

From _____/_____/____, _____ hours were completed in the **ORIENTATION** process.

Supervisor's signature_____ Date _____

4. **Core Function of ASSESSMENT:**

From _____/_____/____, _____ hours were completed in the **ASSESSMENT** process.

Supervisor's signature_____ Date _____

5. **Core Function of TREATMENT PLANNING:**

From _____/_____/____, _____ hours were completed in the **TREATMENT PLANNING** process.

Supervisor's signature_____ Date _____

6. **Core Function of COUNSELING:**

From _____/_____/____, _____ hours were completed in the **COUNSELING** process.

Supervisor's signature_____ Date _____

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7. **Core Function of CASE MANAGEMENT:**

From _____/_____/____, _____ hours were completed in the **CASE MANAGEMENT** process.

Supervisor's signature_____ Date _____

8. **Core Function of CRISIS INTERVENTION:**

From _____/_____/____, _____ hours were completed in the **CRISIS INTERVENTION** process.

Supervisor's signature_____ Date _____

9. **Core Function of CLIENT EDUCATION:**

From _____/_____/____, _____ hours were completed in the **CLIENT EDUCATION** process.

Supervisor's signature_____ Date _____

10. **Core Function of REFERRAL:**

From _____/_____/____, _____ hours were completed in the **REFERRAL** process.

Supervisor's signature_____ Date _____

11. **Core Function of REPORTS AND RECORDKEEPING:**

From _____/_____/____, _____ hours were completed in the **REPORTS & RECORDKEEPING** process.

Supervisor's signature_____ Date _____

12. **Core Function of CONSULTATION:**

From _____/_____/____, _____ hours were completed in the **CONSULTATION** process.

Supervisor's signature_____ Date _____

INFORMATION ABOUT SUPERVISOR:

_____

NAME OF SUPERVISOR: **DATE**

_____ _____

POSITION TITLE: **AGENCY OR FACILITY:**

_____

TELEPHONE:

SOUTHWEST CERTIFICATION BOARD

PART XIV. COUNSELOR EVALUATION FORM (CONFIDENTIAL)

(Must be verified from previous supervisors within the last five years)

CLINICAL SUPERVISOR:
The employee listed on this form is applying to the Southwest Certification Board (SCB) for counselor certification. The information requested here is an essential part of the Board's evaluation process to determine knowledge and competency of the applicant and must be included to meet Board requirements.

Your evaluation from direct observation and supervision of the applicant's work, in addition to other references, will determine the applicant's eligibility for certification. We require careful and truthful reporting. Please fill out this form and return to applicant in sealed envelope. Applicant must then submit completed application with all forms attached.

EVALUATOR HISTORY:

How long have you been employed by this program/agency? _____

Where did you receive your Counseling training? _____

Professional certificates or licenses you hold? _____

_____

Are you involved in the administration/management of the program at which you are employed?

Check one:
_____ a) No.
_____ b) Yes, limited to clinical aspects (i.e., supervision of counselors).
_____ c) Yes, limited to administrative responsibilities such as budgeting.
_____ d) Yes, both clinically and administratively.

EVALUATOR STATEMENT:
How long have you supervised this applicant?_____

Dates From: _____ To: _____

What is/was the size of the counselor's caseload? _____

Average number of hours/week counselor worked in individual counseling? _____

Average number of hours/week worked in group counseling? _____

Any special skills of the counselor? Please describe._____

_____

_____

For what period of time, while under your supervision, was counseling the major part of this applicant's responsibility?

Dates from: _____ To: _____

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Comments and/or additional information you feel may be pertinent: _____

_____

_____

I HEREBY CERTIFY THAT I HAVE BEEN IN A POSITION TO OBSERVE AND HAVE FIRST-HAND

KNOWLEDGE OF _____'S WORK AT _____
(Applicant) (Program/Agency)

Check One:

_____ I recommend this applicant for certification as an alcoholism counselor and/or drug abuse counselor.

_____ I have some reservations in recommending this applicant.

_____ I do not recommend this applicant as an alcoholism counselor &/or drug abuse counselor

I HEREBY CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE:

_____ _____
CLINICAL SUPERVISOR/EVALUATOR SIGNATURE **DATE**