CERTIFIED ASSOCIATE COUNSELOR - ALCOHOL AND DRUG

APPLICATION INSTRUCTIONS

**** IMPORTANT ****

<u>BEFORE</u> submitting your application, please:

- □ Retain a copy of all documents for your records. Documents <u>will not</u> be returned once received by the Board.
- All forms must be legible, complete, signed, and dated (where applicable) or processing may be delayed.
- □ Include a check or money order in the amount of \$150.00 payable to: Board of Professional Counselors and Therapists. Fees are <u>non-refundable</u> and <u>non-transferable.</u>
- □ Applications <u>may not</u> be submitted via fax or email. Please mail to:

Board of Professional Counselors and Therapists Attn: Janice Isaac, Alcohol and Drug Counselor Licensing Coordinator 4201 Patterson Avenue, Suite 316 Baltimore, MD 21215

NEW Submit a copy of the receipt from your criminal history record check (CHRC) with your application. The form for the CHRC is included in the application. Reports are sent directly to the Board by CJIS.

ELIGIBLITY/REQUIREMENTS: The following is a summary only. For complete requirements and definitions, see Md. Code Ann. Health Occ. II, §17-101, et. seq. and COMAR 10.58 which may be found on the Board's website, www.dh.maryland.gov/bopc.

Education: Applicant shall at a minimum:

1) Hold a bachelor's degree or higher from a regionally accredited educational institution approved by the Board in a *health and human services counseling field*; <u>OR</u>

2) Hold a bachelor's degree from a regionally accredited educational institution approved by the board in a program of studies judged by the board to be substantially equivalent in subject matter under COMAR 10.58.07.06A(3)(a); <u>AND</u>

3) Complete a minimum of 33 semester credit hours or 50 quarter credit hours in alcohol and drug counselor training from a regionally accredited institution of higher education approved by the Board including:

(i) A 3-semester credit hour or 5 quarter credit hour course taken at a regionally accredited educational institution **in each** of the following courses:

1. Medical aspects of chemical dependency;

2. Addictions treatment delivery;

- 3. Group counseling;
- 4. Individual counseling;

5. Ethics that includes alcohol and drug counseling issues; and

6. Abnormal psychology; and

(ii) *Any three* of the following 3 semester credit hour or 5 quarter credit hour courses taken at a regionally accredited educational institution:

- 1. Family counseling;
- 2. Theories of counseling;
- 3. Human development;
- 4. Topics in substance related and addictive disorders; and
- 5. Treatment of co-occurring disorders; and

4) Complete an internship in alcohol and drug counseling that totals 6 semester credit hours or 10 quarter credit hours;

5) Complete not less than 1 year with a minimum of 2,000 hours of supervised clinical experience in alcohol and drug counseling under the supervision of a Board-approved alcohol and drug supervisor; and

Examinations: Upon determination of eligibility by the Board, an applicant must pass the following:

- 1) The NCAC Level II exam; and
- 2) The Maryland law exam.

Both examinations are administered by testing services at several locations within the State. The date and time of examinations is determined on an individual basis after the applicant has been notified by the Board that he/she may sit for the exam(s).

□ A **Criminal History Records Check** (CHRC) (form included with application). Applicant must include a copy of the receipt from the CHRC with this application. This allows the Board to access the report online from CJIS.

CERTIFIED ASSOICATE COUNSELOR - ALCOHOL AND DRUG

APPLICATION

Please type or print all information.

I. VETERANS AND SPOUSAL PREFERENCE

Are you an active service member or the spouse of any active service member? \Box Yes \Box No

Are you a veteran or the spouse of a veteran who was discharged from active duty under circumstances other than dishonorable within one year of filing this \Box Yes \Box No application?

II. DEMOGRAPHIC INFORMATION

Name:					
Last			First	MI	Maiden
SSN:	Date	of Birth: _		Place of Birth:	
Home Phone:	Work:		Cell:	Email:	
Home Address:					
		Street	City	State	Zip
Prior address:					
(If less than 3 years at current	address)	Street	City	State	Zip
Mailing Address:					
(If different than above)		Street	City	State	Zip
Business:					
Name		Street	City	State	Zip

Gender and Ethnicity: *This information is optional and may be used for statistical purposes by authorized personnel.*

Gender:	□ Male	□ Female		
Ethnicity:	Are you of His	panic or Latino origin?	□ Yes	□ No
	Check all that	apply:		
	American In	dian or Alaska Native	\Box Asian	□ White
	□ Black or Afr	ican American	□ Native Hawa	aiian or Pacific Islander

III. INFORMATION REGARDING BACKGROUND

Please answer Yes or No to each question.

YES NO 1. Has any state licensing or disciplinary board ever taken any disciplinary action against П your license or certification, including, but not limited to, charges, admonishment, reprimand, revocation, or suspension? If yes, attach a separate page with a complete explanation of each occurrence (include date, time, location, disposition, etc.) and a copy of the disciplinary/court document from the issuing agency, if applicable. 2. Have you pled guilty, nolo contender (no contest), or been convicted of, received probation before judgment or had a conviction set aside for any criminal act (excluding traffic violations)? If yes, attach a separate page with a complete explanation of each occurrence (include date, time, location, disposition, etc.) and a copy of the disciplinary/court document from the issuing agency, if applicable. The failure to include this information will result in processing delays. 3. Were you ever granted "Alcohol and Drug Trainee Status" prior to this application? If yes, when does/did it expire? ____/____. 4. Are you currently (or have you ever been) licensed or certified as a: *Check all that apply.* \Box CSC-AD □ CPC-AD □ LCADC \Box CAC-AD \square LGADC \Box LCPC \Box LGPC □ LCMFT □ LBMFT □ LCPAT \Box LGPAT \square None of the above. 5. Are you currently licensed or certified by another *Maryland* board in mental health counseling or other health occupation? If so, specify license/certificate (Ex: LCSW-C, Psychologist, Registered Nurse, etc.) 6. Are you currently licensed or certified by a mental health or addictions counseling board outside of Maryland? If yes, please complete the "Out of State" application for certification in Alcohol and Drug Counseling which can be found on the Board's website:

www.health.maryland.gov/bopc.

IV. EDUCATION: List colleges or universities attended to satisfy academic requirements for licensure or certification. Do not list degrees unrelated to counseling. Please list the most recent colleges/universities first and provide **official** transcripts. Attach additional sheets, if necessary.

Name of School	City		State
Dates attended: From (mo./yr.)		To (mo./yr.)	
Degree awarded:		Date awarded:	
Major field of study:			
Name of Cohool	Cite		State
<i>Name of School</i> Dates attended: From (mo./yr.)	City	T_{0} (mo /vr)	
Degree awarded:		To (mo./yr.) Date awarded:	
Major field of study:		Date awarded.	
Name of School	City		State
Dates attended: From (mo./yr.)		To (mo./yr.)	
Degree awarded:		Date awarded:	
Major field of study:			
Name of School	City		State
Dates attended: From (mo./yr.)	•	To (mo./yr.)	
		•	
Degree awarded:		Date awarded:	

V. QUALIFICATIONS: *Complete the chart below. If the title of your course differs from those listed, you must include a catalog course description or syllabus for each course. A course applied to one topic area <u>may not</u> be used to fulfill another topic area. * Official transcript(s) must be attached to this application. Do not include continuing education courses/workshops.

Topic Area	Course Title and Number (Must appear on transcript)	Credits Earned	College/Univ.	Date	Grade
Medical Aspects of Chemical Dependency					
Indiv. Counseling					
Group Counseling					
Abnormal Psychology					
Addictions Treatment Delivery					

Electives: At least 3 from the		
courses below:		

Total Credits Earned: _____

VI. SUPERVISED EXPERIENCE: Applicant must complete not less than 1 year with a minimum of 2,000 hours of supervised clinical experience in alcohol and drug counseling under the supervision of a Board-approved alcohol and drug supervisor. Attach additional sheets, if necessary.

Dates To/From:	Agency/ Employer	Applicant's Job Title and Job Description	Hours of supervised experience completed	Was Applicant's practice satisfactory?	Supervisor's Name (print) Approved Supervisor Ref. #

** Supervisor's signature above constitutes verification that he/she is a board-approved supervisor and that the supervised experience hours listed are true and accurate.

VII. EXAMINATIONS: Applicant must pass the NCAC Level II exam and the Maryland law exam. In order to sit for the required exams, applicant must meet the educational requirements and obtain authorization from the Board to register for the exams.

Have you passed the NCAC Level II exam?	□ No	□ Yes (include copy of official exam score).
Have you passed the Maryland law exam?	□ No	□ Yes (include copy of official exam score).

VII. AFFIDAVIT

In making this application to the Maryland Board of Professional Counselors and Therapists (the "Board") for the issuance of a Certified Associate Counselor - Alcohol and Drug credential:

- □ I agree to abide by the rules and regulations of the Board and to take all examinations necessary for the processing of my application;
- Upon issuance of certification, I agree to abide by the Code of Ethics as set forth in COMAR;
- □ I understand that the fee submitted with this application is **NON-REFUNDABLE**;
- □ I agree to hold the Board, its members, officers, agents, and examiners free from any damage or claim of damage or complaint by reason of any action taken in connection with this application, the attendant examination, the grades with respect to any examination, and/or the failure or refusal of the Board to issue me a license or certificate.
- I grant permission to the Board to seek any information or references it deems appropriate or necessary in verifying my credentials as it pertains to this application.
- □ I understand, by law, it is my responsibility to notify the Board, in writing, of any change of address.

I do hereby affirm that all of the statements made herein are true and correct to the best of my knowledge and belief. I voluntarily consent to a thorough review of the information in this application and other activities for the purpose of verifying my qualifications for certification

Applicant's SignatureDate		
		ATTACH APPLICANT
		РНОТО
NOTARY REQUIRED		
State of		(Recent 2"x2")
City/County of		, , ,
I HEREBY CERTIFY that on this da	y of,	
before me, a Notary Public of the		
State and City/County aforesaid, personally ap	peared	
and	l	
made oath in due form that the contents of the	foregoing Affidavit are true.	
Notary Public	Commission Expires	



Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

CAC-AD - SUPERVISION VERIFICATION

I,, certi Supervisor's Name (printed)		rtify that I supervis	tify that I supervised	
Supervisor's Num	e (prinied)		Applicant's Name	
u	ntil	at		•
Month/Year	Month/Year	Name o	f Facility and Location	
	·	_ hours of experie	nce under my supervision	n as a
Applicant's Job Title				
The Applicant's	job duties consisted	of:		

The Applicant's practice was \Box Satisfactory \Box Unsatisfactory.

 \square

 \square

 \square

 \square

 \square

Please place a check mark in the box and indicate the number of hours this applicant performed one or more of the following duties under your supervision:

Group Counseling	 hours
Individual Counseling	 hours
Family Counseling	 hours
Screening	 hours
Intake	 hours
Orientation	 hours
Case Management	 hours
Crisis Intervention	 hours
Education & Prevention	 hours
Referral	 hours
Consultation	 hours
Reports and Record Keeping	 hours
Assess and diagnosis (Diagnostic impression)	 hours

Treatment Planning	5	hours
Meeting with super	visor	hours
Total Hours	out of 2000 hours	

I certify that I am an approved alcohol and drug supervisor as specified in COMAR 10.58.07.02(2).

I further certify that I provided the supervision described above, and that it is a true and accurate representation.

Supervisor's Signature Date

 \square

License/Certificate/Approved Supervisor Number & Expiration date

Supervisor Phone Number

Email

PROFESSIONAL REFERENCE ASSESSMENT for CAC-AD

Applicant's Name:

The person named above has applied to the Maryland Board of Professional Counselors and Therapists to become a Certified Associate Counselor – Alcohol and Drug. Your assessment of the applicant's characteristics will enable the Board to evaluate whether the applicant meets the Board's standards for certification. Please answer each question to the best of your ability.

Reference's Name: _____ Credentials: _____

Place of Employment: _____

Relationship to Applicant: _____

How long have you known the Applicant? From ______ to ______ to ______.

Please rate the Applicant compared to other counselors you know on the following characteristics:

(Counselor educators should be evaluated on their ability to train students in counseling skill areas).

Skill	Outstanding	Above Avg.	Average	Below Avg.	Poor	Cannot Evaluate
Individual						L'unuate
counseling						
Making						
appropriate						
Referrals						
Group						
counseling						
Personal						
Integrity						
Consulting						
Insight into						
client's						
problems						
Ability to						
relate to co-						
workers						
Ability to be						
objective						
Ethical						
conduct						
Concern for						
welfare of						
clients						
Sense of						
responsibility						
Recognition of						
own limits						
Supervisory						
abilities						
Ability to						
keep material						
confidential						

I recommend the Applicant for certification as a Certified Associate Counselor – Alcohol and Drug (CAC-AD). \Box Yes \Box No

This recommendation is based upon my best judgment. I am willing to answer additional questions concerning this evaluation should the Board deem it necessary.

Signature of Reference

Date

After completing this form, please place in a sealed envelope, sign the sealed flap, and return to Applicant.



Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

NOTICE OF CRIMINAL HISTORY RECORDS CHECK

Effective January 1, 2014, the Maryland Board of Professional Counselors and Therapists (the "Board") requires that all applicants for licensure, certification, and trainee status complete a criminal history records check in accordance with §§17-501 and 17-501.1 of the Health Occupations Article, Annotated Code of Maryland.

A Criminal History Records Check includes a national and state criminal history background search. The criminal history records check requires you to be fingerprinted. In order to be fingerprinted, you will need to complete and present the LiveScan Pre-Registration Form. (Attached).

You must present this form to the fingerprinting site because it provides the Criminal Justice Information System (CJIS) authorization number **#1300005490** and the FBI ORI number **#MD920512Z** assigned specifically to the Board.

This allows the information to be forwarded directly to the Board. For additional information contact CJIS at 410-764-4501. For current listings of fingerprinting providers please go to <u>http://www.dpscs.maryland.gov/publicservs/fingerprint.shtml.</u>

FOR FAST AND ACCURATE SERVICE

- 1. When requesting a criminal history records check for licensing purposes you must have an agency name and authorization number (Listed above).
- 2. Your background check is being sent to the Board.
- 3. You must bring a valid form of government identification. (Examples: driver's license, Certificate of Naturalization, passport, Alien Registration Card, or Military Identification).
- 4. Complete the LiveScan Pre-registration Application and bring it to any fingerprinting center/provider.
- 5. Bring payment as indicated above. The Board will receive the results from the criminal history records check directly from CJIS within 5-7 business days. The Board will contact you if it has any questions regarding the report. Please do not contact the Board to check if the report has been received.
- 6. Please do not send the LiveScan Pre-registration Application to the Board. You must present it at the fingerprint center/provider location.