

Michigan Certification Board for Addiction Professionals

APPLICATION FORMS

For

**Certified Prevention Consultant - R
(IC&RC reciprocal)**

CPC-R

Certified Prevention Consultant (CPC- R) Directions for Submitting Application

Completion of this packet of forms and submission of supporting documentation constitutes your Certification Application. Please note that this is not a career portfolio. You are only required to submit material sufficient to meet the requirements of the certification for which you are applying. All information must be typed or printed legibly.

This packet of forms is intended to help make your application compilation as easy as possible, within the constraints of the requirements of the level of certification you are seeking. The bottom of each form will summarize the requirements and give brief instructions on how to complete the form. If you have any questions, please refer to the appropriate sections in the full application manual. If you still have questions, please call the Michigan Certification Board office at (517) 347-0891.

Submit your application forms in the following order with supporting documents.

1. Application - (Submit copy of any name change legal documents) (Form #1).
2. Application Check List (Form #2)
3. Experience - Documentation of Experience form(s) (Form #3).
4. Supervised Practical Training - Supervised Practical Training form (Form #4).
5. Education - Documentation of Education form (Forms # 5 to 5C).
6. Testing and Review - Documentation of Passed Examination (Form #6)
7. Code of Ethics - Read, Sign and Return Code of Ethics (Form #7).
8. Fees & mailing Instructions – Submit all forms, documentation and \$150.00 (check or money order) non-refundable two-year certification fee payable to MCBAP.

Mail to:

**MCBAP
6639 Centurion Drive
Suite 170
Lansing, MI 48917**

Certified Prevention Consultant (CPC- R)

APPLICATION
(all information must be typed or printed)

I - Personal Information

Name _____
(as you want it to appear on your certificate)

Address _____
Street Apt.

_____ City State County Zip Code

Email Address _____ Highest Level of Education _____

Program/Business Name _____

Program/Business Address _____
Street Suite

_____ City State Zip Code

Home Telephone _____ Business Telephone _____ Soc.Sec.Number
(Last 4 digits only)

II - Signature Requirement

I hereby certify that all of the information being submitted in this application is true and accurate and that I have read, signed, and ascribe to the attached Code of Ethics.

Applicant's Signature _____ Date _____

The certification fee is \$150.00 for two-years. Please attach a check or money order made payable to MCBAP. This is a non-refundable application fee. Please mail to: MCBAP, 6639 Centurion Drive, Suite 170, Lansing, MI 48917

**Certified Prevention Consultant
(CPC- R)**

DOCUMENTATION OF EXPERIENCE

Section I - Applicant Information *(All information must be typed or printed.)*

Name _____

Section II - Program Information

Program Name _____

Program Address _____
Street

City _____ State _____ Zip Code _____

Daytime Phone Number _____ MDCH License _____

Section III - Documentation of Experience (attach a copy of the applicant's formal job description).

Applicant's position _____

Beginning date _____ Ending date _____

Write below the average number of direct and indirect hours per week the applicant spent in the ATOD prevention activities of planning and evaluation, education and skill development, community organization, public and organization policy, professional growth and responsibility. (Full time ATOD Prevention Consultants may enter 40 hours) _____

Section IV

By signing below, I attest that the applicant named in Section I worked as a Prevention professional at this program providing prevention services.

 Supervisor or Program Director PRINT and SIGN Date

Certified Prevention Consultants are required to have 8,000 hours of ATOD-related Prevention experience. Certain educational degrees can be substituted for some experience hours (see the experience section of manual). This form should be completed by the program director or supervisor of the program in which the experience was gained. If the experience was in several programs, each of them should complete copies of this form.

Certified Prevention Consultant (CPC- R)

SUPERVISED PRACTICAL TRAINING

Section I - Applicant Information (All information must be typed or printed.)

Name _____

Section II - Program Information

Program Name _____

Program Address _____
Street
City
State
Zip Code

Daytime Phone Number _____ MDCH License # _____

Section III - Documentation of Supervised Practical Training Experience

**Supervisors must be a CPS-M / CPS-R or CPC-M / CPC-R or work in collaboration with a MCBAP Certified Prevention Specialist/Consultant.*

<u>Domain</u>	<u>Hours</u>	<u>Professional Providing Supervision & Certification Number</u>
Planning and Evaluation	_____	_____
Prevention Education and Service Delivery	_____	_____
Communication	_____	_____
Community Organization	_____	_____
Public Policy and Environmental Change	_____	_____
Professional Growth and Responsibility	_____	_____

Certified Prevention Consultants must have 240 hours of Supervised Practical Training in the Prevention Performance Domains, with at least 10 hours in each of the listed Performance Domains. This form or forms should be completed by the person or persons supervising the applicant.

By signing below, I attest that the applicant (name) _____ received supervised practical training experience in the Performance Domains as listed above.

 Supervisor or Program Director PRINT and SIGN Date

Certified Prevention Consultant (CPC- R)

DOCUMENTATION OF EDUCATION ATOD Prevention Specific

Document each training course, seminar, workshop, etc., date(s) and contact hours using this format. **This form should reflect only workshops that were ATOD Prevention Specific.** Attach certificates of completion or other documentation verifying attendance at the below listed educational events. (this form may be duplicated)

Name _____

_____ **48 Contact Hours were ATOD Prevention Specific**

<u>Title and sponsor or provider of training course, workshop, seminar, etc.</u>	<u>Date(s)</u>	<u>Contact Hours</u>

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**DOCUMENTATION OF EDUCATION
ATOD Prevention Related**

Document each training course, seminar, workshop, etc., date(s) and contact hours using this format. **This form should reflect only workshops that were ATOD Prevention Related.** Attach certificates of completion or other documentation verifying attendance at the below listed educational events. (This form may be duplicated)

Name _____

_____ **192 Contact Hours were in ATOD Prevention Related**

<u>Title and sponsor of training course, workshop, seminar, etc.</u>	<u>Date(s)</u>	<u>Contact Hours</u>

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EDUCATION FORM FOR UNDOCUMENTED EVENTS

This form is to be used to verify undocumented education. If you don't have certificates of completion for any trainings or workshops, you must fill out this sheet and have your supervisor or program director sign the bottom to verify that you have attended these trainings. **Listing trainings on this form should be the exception in your documentation.** You should make every effort to locate missing verification of educational hours before using this form. This form can also be used to document in-service trainings. Indicate which type of education the entry applies to by listing the appropriate form number at the end of the line.

Name _____

<u>Title and sponsor of training</u>	<u>Date(s)</u>	<u>Contact Hours</u>	<u>Applies to (5, 5B)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

By signing this form, I attest that the above applicant has attended the trainings listed on pages 5A-E, and that the trainings are relevant to the suggested area.

Supervisor/Program Director PRINT and SIGN _____ Date _____

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**PROFESSIONAL ETHICS TRAINING,
TESTING and ACADEMIC EQUIVALENTS Documentation**

I. Professional Ethics Training – enter title of ethics training taken to meet the requirement of six (6) hours of face-to-face, MCBAP approved prevention ethics and submit documentation verifying completion of the training.

Date _____ **Contact Hours** _____

Sponsor _____

Trainer _____

II. IC&RC Prevention Specialist exam - enter date in space provided and submit a copy of verifying document for the exam

IC&RC Prevention Specialist exam passed on _____

III. Academic Degree Equivalents for Experience - to use an academic degree for part of the experience requirement, please complete the following and attach documentation verifying highest degree obtained.

Degree _____ **Date Earned** _____

College/University _____

Major/Minor Course of Study _____

Bachelors experience equivalent: 2000 hours _____

OR

Masters experience equivalent: 4000 hours _____

- Ethics training required for the CPC-R
 - Testing required for the CPC-R
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**Certified Prevention Consultant
(CPC- R)**

CODE OF ETHICS AGREEMENT AND ASSURANCES

I, the undersigned individual, agree to adhere to the Code of Ethical Standards for Certified Prevention Professionals and understand that violation of the Ethical Standards for Certified Prevention Professionals may result in loss of certification.

Applicant Signature

Date

Please Print or Type Your Name

I, the undersigned individual, assure that all information provided in this CPC-R application is truthful and accurate to my knowledge. I agree to provide updated or corrected information to MCBAP if so requested, or when necessary in the future. I understand that once this initial CPC-R credential application is approved, I will be responsible for meeting all renewal/recertification requirements, including required continuing education hours and timely renewal/recertification applications. I also understand that the \$150 application fee being submitted with this application is non-refundable once MCBAP has received and begun review of this application, even if I later withdraw or fail to complete application requirements.

Applicant Signature

Date

Please type or print name

Certified Addictions Counselor (CPC-R) Data Collection Form

This data is important in identifying the on-going status of substance abuse workforce in the state of Michigan. The information will assist with identification of future needs, e.g. competency standard, credentialing, training, education, future funding and other planning activities. The aggregate data will be shared with groups such as providers, Prepaid Inpatient Health Plans, Office of Drug Control Policy, elected officials and other interested parties.

Type of service in which you spend the majority of your time

- | | |
|--|---|
| <input type="checkbox"/> Prevention | <input type="checkbox"/> Detoxification |
| <input type="checkbox"/> Residential | <input type="checkbox"/> Intensive Outpatient |
| <input type="checkbox"/> Outpatient | <input type="checkbox"/> Methadone |
| <input type="checkbox"/> Supervision/Management/Administration | |

Typical hours worked per week in substance abuse treatment or prevention work

_____ Hours

Primary role/responsibility function

- | | |
|--|--|
| <input type="checkbox"/> Primary Therapist | <input type="checkbox"/> Didactics |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> AAR Screener/Assessor |
| <input type="checkbox"/> Clinical Supervisor | <input type="checkbox"/> Medical/Psychiatric |
| <input type="checkbox"/> Administrator | <input type="checkbox"/> Residential Aid/Milieu Technician |
| <input type="checkbox"/> Other _____ | |

Annual salary from treatment or prevention work (optional)

- | | | |
|--|--|---|
| <input type="checkbox"/> \$ 0 - \$10,000 | <input type="checkbox"/> \$31,000 - \$40,000 | <input type="checkbox"/> \$61,000 - \$70,000 |
| <input type="checkbox"/> \$11,000 - \$20,000 | <input type="checkbox"/> \$41,000 - \$50,000 | <input type="checkbox"/> \$71,000 - \$80,000 |
| <input type="checkbox"/> \$21,000 - \$30,000 | <input type="checkbox"/> \$51,000 - \$60,000 | <input type="checkbox"/> \$81,000 - \$90,000 plus |

Gender (optional) Female Male

Primary Race/Ethnic Group (optional)

- | | |
|--|---|
| <input type="checkbox"/> White/Caucasian (non-Hispanic) | <input type="checkbox"/> Asian American |
| <input type="checkbox"/> Black/African American (non-Hispanic) | <input type="checkbox"/> Native American/Indian |
| <input type="checkbox"/> Native Hawaiian/Pacific Islander | <input type="checkbox"/> Alaska Native |
| <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Arab/Chaldean |
| <input type="checkbox"/> Other (please specify) _____ | |

Certification(s)/Licensure(s) (identify ALL and if temporary status)
