

Michigan Certification Board for Addiction Professionals

APPLICATION FORMS

for

**Certified Advanced Alcohol and Drug
Counselor
(IC&RC reciprocal)**

CAADC

Certified Advanced Alcohol and Drug Counselor (CAADC) 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. If you have any questions, please refer to the appropriate sections in the full application manual. If you still have questions, please call the MCBAP 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. Experience – Documentation of Experience Form(s) (Form #2).
3. Supervision- Supervision Form (Form #3).
4. Education – Documentation of Education Forms (Form #4). And Education Form for Undocumented Events (Form #5).
5. Review –Testing, Academic Equivalents, and Ethics Training Form (Form #6).
6. Code of Ethics – Sign Code of Ethics (Form #7).
7. 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

Checklist for the CAADC Application



Please do not include this checklist with your application submission, this is for personal use only.

This checklist is not intended to cover all instructions for the CAADC application, you must read the full set of Application Instructions.

<u>Required</u>	✓
Form 1 – all sections complete	
Form 2 – all sections complete	
An official job description matching the employment from Form 2	
Form 3 – all sections complete	
Form(s) 4 – title, source, date, hours of education (totaling 180 hours). This education can only be categorized as SPECIFIC to substance use disorder, not related.	
50 hours of education (included in the 180) in person, not online or via home-study	
Copies of certificates for each training listed on Form(s) 4 (totaling 180) hours	
Form 6 – all sections complete	
A copy of your IC&RC exam official passing score	
Form 7 – all sections signed	
Copy of certificate of education for clinical ethics course (6 hours)	
Original official graduate level transcript – must be mailed or sent by Parchment directly from the college/university to MCBAP	
\$150 check or money order OR receipt of payment made online	
<u>Optional</u>	
Form 5	
Other original official college transcripts if using education – must be mailed or sent by Parchment directly from the college/university to MCBAP	
Name Change documentation if any item contains a different name. Must be legal court documentation.	

**Certified Advanced Alcohol and Drug Counselor
(CAADC)
Application**
(Please type or print legibly)

I - Personal Information

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

Address _____
Street Apt. #

City County State Zip Code

Email Address Highest Level of Education

Date of Birth _____

Business Address _____
Street Suite #

City County State Zip Code

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

II - Signature Requirement

I hereby certify that all the above information is true and accurate and that I have read, signed, and ascribe to the attached Code of Ethics. In signing, I am applying for the Certified Advanced Alcohol and Drug Counselor credential.

Applicant's Signature _____ Date _____

III - Fees and 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 Advanced Alcohol and Drug Counselor
(CAADC)
Documentation of Experience**
(Please type or print legibly)

Applicable to this experience is any time spent providing services substance abuse disorder and/or co-occurring mental health services within the IC&RC/AADC Domains including screening, assessment, engagement, treatment planning, therapeutic counseling, patient and family education, collaboration, referral, care coordination, and professional and ethical responsibility in regard to client treatment/service. Section II and III should be completed by the applicant's supervisor, program director or personnel office. Include a copy of the applicant's formal job description.

Section I - Applicant Information – *To be completed by the applicant.*

Name _____

Address _____ Apt. _____

City _____ State _____ Zip Code _____

Section II - Program Information - *To be completed by the applicant's supervisor, program director or personnel office.*

Program name _____

Program address _____

MI LARA Program license number _____ Telephone # _____

Section III - Documentation of Experience - *To be completed by the applicant's supervisor or program director or personnel office.*

Applicant's Position _____

Beginning Date _____ Ending Date _____

Full Time - Total years experience _____ or Part Time total hours experience _____

Please attach a copy of the applicant's formal job description for the position held.

By signing below, I attest that the applicant (named in Section I) performed adequately at the program (named in Section II) providing supervised counseling services to SUD clients.

Supervisor's Signature _____ Date _____

Supervisor: Print Name and Title _____

Certified Advanced Alcohol and Drug Counselor (CAADC) Supervision

(Please type or print legibly)

Section I - Applicant Information

Name _____

Section II - Program Information

Program Name _____

Program Address _____
Street
City
State
Zip

Section III - Documentation of Supervision

Write below the total number of hours of supervised practical experience for each of the Domains. A *total of 100 hours POST GRADUATE DEGREE* must be documented for certification, with a minimum of 25 hours in each Domain listed.

DOMAIN	Number of Supervision Hours
Screening, Assessment, and Engagement	_____
Treatment Planning, Collaboration, and Referral	_____
Counseling and Education	_____
Professional and Ethical Responsibilities	_____
TOTAL HOURS	_____

Beginning Date _____ Ending Date _____

By signing below, I attest that the applicant received supervised practical training as listed above.

 Signature of Supervisor or Program Director Print Name Date

**Certified Advanced Alcohol and Drug Counselor
(CAADC)
Documentation of Education**
(Please type or print legibly)

Document each training course, seminar, workshop, etc., date(s), contact hours, substance abuse **specific** using this format. Attach certificates of completion or other documentation verifying attendance at the below listed educational events. This Form May Be Duplicated.

Applicant Name

Title training course	Date(s)	Contact Hours	Source
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Title training course	Date(s)	Contact Hours	Source
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Title training course	Date(s)	Contact Hours	Source
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Title training course	Date(s)	Contact Hours	Source
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Title training course	Date(s)	Contact Hours	Source
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Title training course	Date(s)	Contact Hours	Source
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Title training course	Date(s)	Contact Hours	Source
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Title training course	Date(s)	Contact Hours	Source
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Title training course	Date(s)	Contact Hours	Source
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Title training course	Date(s)	Contact Hours	Source
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Title training course	Date(s)	Contact Hours	Source
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**Certified Advanced Alcohol and Drug Counselor
(CAADC)
Education Form For Undocumented Events
(Please type or print legibly)**

This form is to be used to verify undocumented education and in-service trainings. If you don't have certificates of completion for specific 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. This Form May Be Duplicated.

Applicant Name

Title training course	Date(s)	Contact Hours	Source
-----------------------	---------	---------------	--------

Title training course	Date(s)	Contact Hours	Source
-----------------------	---------	---------------	--------

Title training course	Date(s)	Contact Hours	Source
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Title training course	Date(s)	Contact Hours	Source
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Title training course	Date(s)	Contact Hours	Source
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Title training course	Date(s)	Contact Hours	Source
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Title training course	Date(s)	Contact Hours	Source
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Title training course	Date(s)	Contact Hours	Source
-----------------------	---------	---------------	--------

By signing this form, I attest that the above applicant has attended the trainings and in-services listed on this page.

Signature of Supervisor or Program Director

Print Name

Date

**Certified Advanced Alcohol and Drug Counselor
(CAADC)
Academic Degree, Testing, and Ethics Training**
(Please type or print legibly)

I – Testing – enter date in space provided and submit a copy of verifying document for the exam

IC&RC/AADC examination passed on _____

II - Academic Degree (Master's or advanced) - complete the following and attach documentation verifying highest degree obtained.

_____	_____
Degree	Date Earned

College or University	

Major/Minor Course of Study	

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

_____	_____
Date	Contact Hours

Sponsor

Trainer

**Certified Advanced Alcohol and Drug Counselor
(CAADC)
Code Of Ethics Agreement and Assurances
(Please type or print legibly)**

I, the undersigned individual, agree to adhere to the Code of Ethical Standards for Certified Addiction Counselors (see appendix B) and understand that violation of the Ethical Standards for Certified Addiction Counselors may result in sanctions including loss of the CAADC credential.

Applicant Signature Date

Please type or print name

I, the undersigned individual, assure that all information provided in this CAADC 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 CAADC 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 Advanced Alcohol and Drug Counselor (CAADC) 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)
