Michigan Certification Board for Addiction Professionals

APPLICATION FORMS

for

Certified Alcohol and Drug Counselor
(IC&RC reciprocal)

CADC

Certified Alcohol and Drug Counselor
(CADC)
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 Form (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

Form #1

Certified Alcohol and Drug Counselor (CADC) Application

(Please type or print legibly)

I - Personal Information

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_____

Program/Business Name _____

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 Addictions 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

Form #2

Certified Alcohol and Drug Counselor (CADC) 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/ADC Domains. See list of domains on Form 3. 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

Form #3

Certified Alcohol and Drug Counselor (CADC) 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 300 (200 for individuals holding a Bachelor's Degree in a related field or higher level) must be documented for certification, with a minimum of 50 hours in each Domain listed.*

DOMAIN	**Number of Supervision Hours**
Screening, Assessment, and Engagement	_____
Treatment Planning, Collaboration and Referral	_____
Counseling	_____
Professional and Ethical Responsibility	_____
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

Form #4

Certified Alcohol and Drug Counselor (CADC) Documentation of Education

(Please type or print legibly)

Document each training course, seminar, workshop, etc., date(s), contact hours, substance abuse specific or related 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	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related

Form #5

Certified Alcohol and Drug Counselor (CADC) 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	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related
Title training course	Date(s)	Contact Hours	Specific/Related

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

Form #6

Certified Alcohol and Drug Counselor (CADC) Testing, Academic Equivalents and Ethics

(Please type or print legibly)

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

IC&RC/ADC examination passed on _____

II - Academic Degree - 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

Form #7

Certified Alcohol and Drug Counselor (CADC) 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 Alcohol and Drug Counselors (see appendix B) and understand that violation of the Ethical Standards for Certified Alcohol and Drug Counselors may result in sanctions including loss of the CADC credential.

_____

Applicant Signature Date

_____

Please type or print name

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

_____ Prevention
_____Residential
_____Outpatient
_____Supervision/Management/Administration
_____Detoxification
_____Intensive Outpatient
_____Methadone

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

_____Hours

Primary role/responsibility function

_____Primary Therapist
_____Case Management
_____Clinical Supervisor
_____Administrator
_____Other _____
_____Didactics
_____AAR Screener/Assessor
_____Medical/Psychiatric
_____Residential Aid/Milieu Technician

Annual salary from treatment or prevention work (optional)

_____$ 0 - $10,000
_____$11,000 - $20,000
_____$21,000 - $30,000
_____$31,000 - $40,000
_____$41,000 - $50,000
_____$51,000 - $60,000
_____$61,000 - $70,000
_____$71,000 - $80,000
_____$81,000 – $90,000 plus

Gender (optional) _____ Female _____Male

Primary Race/Ethnic Group (optional)

_____White/Caucasian (non-Hispanic)
_____Black/African American (non-Hispanic)
_____Native Hawaiian/Pacific Islander
_____Hispanic/Latino
_____Other (please specify) _____
_____Asian American
_____Native American/Indian
_____Alaska Native
_____Arab/Chaldean

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

_____

_____