Michigan Certification Board for Addiction Professionals

APPLICATION FORMS

for

Certified Clinical Supervisor
(IC&RC reciprocal)

CCS

Certified Clinical Supervisor
(CCS)
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.

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 Code of Ethics (Form #6).

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 Clinical Supervisor (CCS)
APPLICATION

(All information must be typed or legibly printed)

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

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 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 Clinical Supervisor credential.

_____
Applicants 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 Clinical Supervisor
(CCS)
DOCUMENTATION OF EXPERIENCE

(All information must be typed or legibly printed)

Applicable to this experience is any time spent providing services substance abuse disorder and/or co-occurring mental health services within the IC&RC/CS 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/director/administrator, 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 _____

Counseling - SUD counseling work experience (minimum of 10,000 hours) _____

Clinical Supervision – SUD supervisor work experience (minimum of 4,000 hours) _____

Section IV – By signing below, I attest the applicant (Section I), performed adequately at the program (Section II), providing SUD counseling and SUD Clinical Supervision.

_____

Supervisor, Program Director, or Personnel Manager PRINT name and SIGN Date

Form 3

Certified Clinical Supervisor (CCS)

SUPERVISION

(All information must be typed or legibly printed)

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 200 hours must be documented for certification, with a minimum of 10 hours in each Domain listed.*

DOMAIN	**Number of Supervision Hours**
Counselor Development	_____
Professional and Ethical Standards	_____
Program Development and Quality Assurance	_____
Performance Evaluation	_____
Administration	_____
Treatment Knowledge	_____
TOTAL HOURS	_____

Beginning Date _____ Ending Date _____

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

_____

Supervisor, Program Director, or Personnel Manager PRINT name and SIGN Date

Form 4

Certified Clinical Supervisor (CCS)

DOCUMENTATION OF EDUCATION

(All information must be typed or legibly printed)

Thirty- (30) contact hours of didactic training in clinical supervision is required; this must include a minimum of four (4) hours of training in each of the following performance domains: counselor development, professional and ethical standards, program development and quality assurance, performance evaluation, administration, treatment knowledge. Document each training course, seminar, workshop, etc., date(s) and contact hours using this format. Attach certificates of completion or other documentation verifying attendance at the below listed educational events. **(Make copies of this form if additional space is required.)**

_____

Applicant Name

Title training course, seminar, workshop, etc.	Date(s)	Contact Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact Hours
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Title training course, seminar, workshop, etc.	Date(s)	Contact Hours

Certified Clinical Supervisor (CCS)

EDUCATION Form for Undocumented Events

(All information must be typed or legibly printed)

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, seminar, workshop, etc.	Date(s)	Contact Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact Hours

Signature Requirement:

I hereby certify that all the above information is true and accurate.

Supervisor, Program Director, or Personnel Manager PRINT NAME, SIGN BELOW	Date

Form 6

Certified Clinical Supervisor
(CCS)
Testing, Academic Degree and Code of Ethics Agreement

(Please type or print legibly)

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

IC&RC/Clinical Supervisor examination passed on _____

II - 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.

Associate's degree equivalent: _____ **1,000 hours**

Bachelor's degree equivalent: _____ **2,000 hours**

Master's degree equivalent: _____**4,000 hours**

_____

Degree Date Earned

_____

College or University

_____

Major/Minor Course of Study

III – Code of Ethics Agreement

I, the undersigned individual, agree to adhere to the Code of Ethical Standards for Certified Clinical Supervisors (see appendix B) and understand that violation of the Ethical Standards for Certified Clinical Supervisors may result in suspension, sanctions or revocation of certification.

Applicant Signature Date

Certified Clinical Supervisor
(CCS)
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)

_____