Michigan Certification Board for Addiction Professionals

APPLICATION FORMS

For

Certified Prevention Specialist
(IC&RC reciprocal)

CPS

© 2008 MCBAP – All Rights Reserved

Certified Prevention Specialist
(CPS)
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. Experience - Documentation of Experience form(s) (Form #2).

3. Supervised Practical Training - Supervised Practical Training form (Form #3).

4. Education - Documentation of Education form (Forms #4A to 4C).

5. Ethics Training and Testing - Documentation Required (Form #5)

6. Code of Ethics - Read, Sign and Return 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

© 2008 MCBAP – All Rights Reserved

Form # 1

Certified Prevention Specialist
(CPS)

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 <u>non-refundable</u> application fee. Please mail to: MCBAP, 6639 Centurion Drive, Suite 170, Lansing, MI 48917

© 2008 MCBAP – All Rights Reserved

Form #2

Certified Prevention Specialist (CPS)

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, prevention education and service delivery, communication, community organization, public policy and enviornmental change, professional growth and responsibility. (Full time ATOD Prevention Specialists 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 Specialists are required to have 2,000 hours of ATOD-related Prevention experience. 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.

© 2008 MCBAP – All Rights Reserved

Form # 3

Certified Prevention Specialist (CPS)

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.

Domain	Hours	Professional Providing Supervision & Certification Number
Planning and Evaluation	_______	____
Prevention Education Service Delivery	_______	____
Communication	_______	____
Community Organization	_______	____
Public Policy Enviornmental Change	_______	____
Professional Growth and Responsibility	_______	____

Certified Prevention Specialists must have 120 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

© 2008 MCBAP – All Rights Reserved

Form # 4-A

Certified Prevention Specialist (CPS)

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. (only document the minimum standard)

Name ____

___________ **24 Contact Hours were ATOD Prevention Specific**

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

© 2008 MCBAP – All Rights Reserved

Form 4-B

Certified Prevention Specialist (CPS)

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. (only document the minimum standard)

Name____

______**96 Contact Hours were ATOD Prevention Related**

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

© 2008 MCBAP – All Rights Reserved

Form 4-C

Certified Prevention Specialist
(CPS)

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____

Title and sponsor of training	Date(s)	Contact Hours

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

____

Supervisor/Program Director PRINT and SIGN   Date

© 2008 MCBAP – All Rights Reserved

Certified Prevention Specialist (CPS)

PROFESSIONAL ETHICS TRAINING and TEST Documentation

I. **Professional Ethics Training** – enter title of the 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 ____

© 2008 MCBAP – All Rights Reserved

Form # 6

Certified Prevention Specialist
(CPS)

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 CPS 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 CPS 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

© 2008 MCBAP – All Rights Reserved

© 2008 MCBAP – All Rights Reserved

Certified Addictions Counselor
(CPS)
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)

____

____

© 2008 MCBAP – All Rights Reserved