

WEST VIRGINIA CERTIFICATION BOARD
FOR ADDICTION AND PREVENTION PROFESSIONALS
1400A OHIO AVENUE
DUNBAR, WV 25064
(304) 768-2942
(304) 768-1562 FAX

APPLICATION FOR ADDICTION COUNSELOR CERTIFICATION
THE ENTIRE APPLICATION MUST BE TYPED

Guidelines and Procedures for Completing
The Certification Process

Please read the enclosed materials carefully **BEFORE** you complete any portion of the application. It is the responsibility of the applicant to meet all deadlines and be aware of all test dates, etc. If a deadline for submission of documentation is missed, a late fee will be assessed. If documentation is submitted so late that the Board does not have time to consider the material, testing may be deferred to the next testing cycle, generally one year later in the case of the written test. Therefore, **TIMELY SUBMISSION OF ALL FEES AND MATERIALS** is of utmost importance. Fees are non-refundable.

Payment of fees is best made by Postal Money Orders or Cashier's Checks, since personal checks that are returned for insufficient funds will cause you to be assessed a penalty fee of \$20 beyond the bank charge for such, and can cause your application to be too late to process.

THIS APPLICATION PACKET CONTAINS:

1. Certification Procedures and Guidelines (Page 2)
2. Application (Pages 5 - 20)
3. Demographic Data Form (Page 4)
Some individuals find questions of age or race to be offensive. This information is requested so that the Board can respond to national surveys by NAADAC and ICRC/AODA. Leave blank race or age questions which offend you. Complete all other demographic data questions.
4. Fee Schedule (Page 3)
5. WVCBAPP Code of Ethics (Located in Appendix B of the Certification Manual)

**WEST VIRGINIA CERTIFICATION BOARD
FOR ADDICTION AND PREVENTION PROFESSIONALS**

CERTIFICATION PROCEDURES AND GUIDELINES

1. Application/portfolio must be received and complete 60 days before scheduled test date.

The application and accompanying documentation must be received 60 days before the next scheduled test date in order to test. Otherwise, it will be held for the following test time.

2. Notification of the Results of the Application/Portfolio Review

Applicants will be notified by the WVCBAPP regarding the status of the application, missing or deficient items, and approval to sit for the written test, etc., in a timely manner. The application packet and documentation of qualification must be complete in order for the applicant to be eligible to take the written test.

3. Written Test – March, June, September, December

The written test date is set by the International Certification Reciprocity Consortium/Alcohol and Other Drugs of Abuse (ICRC/AODA). Their schedule is the second weekend in March, June, September, and December.

WEST VIRGINIA CERTIFICATION BOARD
FOR ADDICTION AND PREVENTION PROFESSIONALS
APPLICATION FOR ADDICTION COUNSELOR CERTIFICATION

THE ENTIRE APPLICATION MUST BE TYPED

A. FEES:

I understand that the application process requires pre-payment of the **NON-REFUNDABLE** application fee. I have enclosed a check, postal money order or cashier's check. I wish to be considered as an applicant for certification as:

- () Certified Clinical Addiction Counselor (CCAC) \$75.00
(Requires a Masters Degree)
(IC&RC/AODA Reciprocal Credential)

- () Certified Addiction Counselor (CAC) \$75.00
(IC&RC/AODA Reciprocal Credential)

- () I am a CIS and wish to become a CAC \$25.00
(PLEASE RE-OPEN MY APPLICATION PACKET)
(Indicate your Certificate Number below)

- () I am a CAC and wish to become a CCAC \$25.00
(PLEASE RE-OPEN MY APPLICATION PACKET)
(Indicate your Certificate Number below)

MY CERTIFICATE NUMBER: _____

SIGNATURE

DATE

SOCIAL SECURITY NUMBER

PRINT YOUR NAME HERE

WEST VIRGINIA CERTIFICATION BOARD
FOR ADDICTION AND PREVENTION PROFESSIONALS
APPLICATION FOR ADDICTION COUNSELOR CERTIFICATION

B. DEMOGRAPHIC DATA

DATE: _____ SOCIAL SECURITY NUMBER: _____

NAME: _____
 LAST MIDDLE FIRST Maiden or Nickname

PREFERRED ADDRESS: _____
 STREET, P.O. BOX APT. NUMBER/SUITE

 CITY STATE ZIP CODE

ALTERNATE ADDRESS: _____
 STREET, P.O. BOX APT. NUMBER/SUITE

 CITY STATE ZIP CODE

WORK PHONE: _____ HOME PHONE: _____

FAX NUMBER: _____ E-MAIL ADDRESS: _____

BUSINESS NAME OR AGENCY: _____

GENDER: () FEMALE () MALE BIRTH DATE: _____

RACE: _____
(OPTIONAL. USED FOR STATISTICAL PURPOSES ONLY)

ARE YOU IN PRIVATE PRACTICE? () YES () NO

HIGHEST ACADEMIC DEGREE: _____ FIELD OF STUDY: _____

LICENSES: () SOCIAL WORK () COUNSELING () MEDICINE
 () PSYCHOLOGY () NURSING
 () OTHER _____

FIRST YEAR OF EMPLOYMENT IN THE ADDICTION FIELD: _____

ARE YOU CREDENTIALLED AS A CIS? ____ Yes ____ No CAC ____ Yes ____ No

If yes, what is your certificate number? _____

WEST VIRGINIA CERTIFICATION BOARD
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APPLICATION FOR ADDICTION COUNSELOR CERTIFICATION

C. QUALIFYING EXPERIENCE

Please refer to the Certification Manual for specific criteria for each level of certification and definition of terms. The point of this portion of the application is to provide accurate information regarding your qualifying work experience.

List your most recent employment first. Then, from your past employment, select **ONLY** those work experiences which you feel **BEST** fit the description of **QUALIFYING WORK EXPERIENCE** as defined in the Certification Manual. "Full-time Equivalent Work" means that you spent at least 35 hours per week in work-related activities. One **MAY NOT** earn more than one year's experience in one year.

1. WORK EXPERIENCE SPECIFIC TO ADDICTION:

If addiction counseling experience represents only a portion or percentage of a full-time job, report **ONLY** the addiction-related work in this category. You may report the remaining portion under general work experience (later in the application) if applicable. Example: You have a full-time job that is 20% administrative, 20% addiction counseling, and 60% counseling other populations. **Only the addiction counseling should be reported here.** The other 80% can be reported under "General Work Experience". Please read the Certification Manual definition carefully before filling out this part.

EMPLOYER/AGENCY: _____
YOUR JOB TITLE

ADDRESS: _____

SUPERVISOR: _____ PHONE: _____
() Paid Position () Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES: _____

DATES: Beginning ____/____/____ Ending ____/____/____ (a) Total Number of Months: _____
Month day year month day year

What percentage of full time equivalent was this job? (b) ____%
Multiply the total number of months (a) by that percentage (b) = (c) _____ actual months worked

What percentage of your work time was dedicated to addiction? (d) _____%
Multiply actual number of months worked © by the percentage of work time dedicated to substance abuse (d). Eg.: a half time job that lasted six months and was spent on addiction specific work 25% of the time: 6 months(a) X 50%(b) = 3 months(c). 3 months© X 25 % (d) = .75 month.

Enter that number: _____ months of addiction specific work

C. QUALIFYING EXPERIENCE, Contd.

EMPLOYER/AGENCY: _____
YOUR JOB TITLE

ADDRESS: _____

SUPERVISOR: _____ PHONE: _____
() Paid Position () Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES: _____

DATES: Beginning ____/____/____ Ending ____/____/____ Total Number of Months: _____
month day year month day year

What percentage of full time equivalent was this job? (b) ____%
Multiply the total number of months (a) by that percentage (b) = (c) _____ actual months worked

What percentage of your work time was dedicated to addiction? (d) _____%
Multiply actual number of months worked © by the percentage of work time dedicated to addiction (d). (e.g.: a half time job that lasted six months and was spent on addiction specific work 25% of the time: 6 months(a) X 50%(b) = 3 months(c). 3 months© X 25 % (d) = .75 month.

Enter that number: _____ months of addiction specific work

EMPLOYER/AGENCY: _____
YOUR JOB TITLE

ADDRESS: _____

SUPERVISOR: _____ PHONE: _____
() Paid Position () Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES: _____

DATES: Beginning ____/____/____ Ending ____/____/____ Total Number of Months: _____
month day year month day year

What percentage of full time equivalent was this job? (b) ____%
Multiply the total number of months (a) by that percentage (b) = (c) _____ actual months worked

What percentage of your work time was dedicated to addiction? (d) _____%
Multiply actual number of months worked © by the percentage of work time dedicated to addiction (e.g.: a half time job that lasted six months and was spent on addiction specific work 25% of the time: 6 months(a) X 50%(b) = 3 months(c). 3 months© X 25 % (d) = .75 month.

Enter that number: _____ months of addiction specific work

FOR BOARD USE ONLY:
WORK EXP SPECIFIC TO ADDICTION: _____ MONTHS TOTAL

2. POST GRADUATE WORK EXPERIENCE (for CCAC)

This phrase is used to mean responsible supervised employment or supervised volunteer work providing counseling services to persons with the primary problem of alcoholism/drug addiction/dependency. This experience must begin after attaining the Master's Degree.

EMPLOYER/AGENCY: _____
YOUR JOB TITLE

ADDRESS: _____

SUPERVISOR: _____ PHONE: _____
() Paid Position () Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES: _____

DATES: Beginning ____/____/____ Ending ____/____/____ Total Number of Months: _____
Month day year month day year

What percentage of full time was this job? (b) _____ %
Multiply the total number of months (a) by that percentage (b) = (c) _____ actual months worked.

What percentage of your work time was dedicated to addiction: (d) _____ %
Multiply actual number of months worked (c) by the percentage of work time dedicated to addiction (d). (e.g.: a half time job that lasted six months and was spent on addiction specific work 25% of the time: 6 months (a) X 50% (b) = 3 months (c). 3 months (c) X 25% (d) = .75 month.)

Enter that number: _____ months of addiction specific work.

Photocopy this page if needed to document additional post-graduate work experience.

FOR BOARD USE ONLY:
WORK EXPERIENCE SPECIFIC TO ADDICTION POST-GRADUATE: _____ Months total

3. GENERAL WORK EXPERIENCE

This phrase is used to mean responsible employment or supervised volunteer work which demonstrates the ability to work with people within a therapeutic framework. Other types of work which involve person to person contact may be considered.

EMPLOYER/AGENCY: _____

YOUR JOB TITLE

ADDRESS: _____

SUPERVISOR: _____ PHONE: _____

() Paid Position () Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES: _____

DATES: Beginning ____/____/____ Ending ____/____/____ Total Number of Months: _____
month day year month day year

What percentage of full time was this job? _____%

Multiply total number of months by the percentage of full time equivalency.

Enter that number: _____ months of general work experience

EMPLOYER/AGENCY: _____

YOUR JOB TITLE

ADDRESS: _____

SUPERVISOR: _____ PHONE: _____

() Paid Position () Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES: _____

DATES: Beginning ____/____/____ Ending ____/____/____ Total Number of Months: _____
month day year month day year

What percentage of full time was this job? _____%

Multiply total number of months by the percentage of full time equivalency.

Enter that number: _____ months of general work experience

C. QUALIFYING EXPERIENCE, Contd.

ATTACH ADDITIONAL SHEETS IF NECESSARY

See Counselor Certification Manual for Definitions

EMPLOYER/AGENCY: _____
YOUR JOB TITLE

ADDRESS: _____

SUPERVISOR: _____ PHONE: _____
() Paid Position () Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES: _____

DATES: Beginning ____/____/____ Ending ____/____/____ Total Number of Months: _____
month day year month day year

What percentage of full time was this job? _____%

Multiply total number of months by the percentage of full time equivalency.

Enter that number: _____ months of general work experience

EMPLOYER/AGENCY: _____
YOUR JOB TITLE

ADDRESS: _____

SUPERVISOR: _____ PHONE: _____
() Paid Position () Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES: _____

DATES: Beginning ____/____/____ Ending ____/____/____ Total Number of Months: _____
month day year month day year

What percentage of full time was this job? _____%

Multiply total number of months by the percentage of full time equivalency.

Enter that number: _____ months of general work experience

FOR BOARD USE ONLY:

GENERAL WORK EXPERIENCE: _____ MONTHS TOTAL

D. SUPERVISED PRACTICAL EXPERIENCE

(A college practicum/internship may be used but is not required - see Certification Manual)

The SUPERVISED PRACTICAL EXPERIENCE consists of three hundred hours of work during which the applicant receives regular supervision from a *Certified Addiction Counselor (CAC)*. It is not the intent that the individual receive three hundred hours of supervision.

YOU MUST DOCUMENT THE FOLLOWING:

1. Beginning and ending dates of the work experience
2. Number of hours completed.
3. Defined Learning Goals.

Those goals must give evidence that the practicum covered at least ten (10) hours of experience in each of the twelve (12) core functions. The goals must be specific to the knowledge areas of addiction, listed under “performance domains: tasks and knowledge” in the Certification Manual. The intent of this section of the application is that you communicate what you were learning during the SPE. These learning goals may be developed by the applicant alone, or with the help of the supervisor. The form must be signed by both. Letters of reference from the work supervisor do not replace the documentation of the Supervised Practical Experience, which must be presented according to the format on the forms provided.

4. Methods (specific things you did) during the practicum in each Core Function:

You must document **TASKS AND BEHAVIORS THAT YOU PERFORMED**. Do not indicate topics that you and your supervisor discussed, books you read or classes you took. The intent of this section of the application is that you communicate the professional behaviors and activities that you performed during your SPE.

THE ATTACHED FORM MUST BE USED AS AN OUTLINE FOR THE SUPERVISED PRACTICAL EXPERIENCE DOCUMENTATION

YOU MAY LIST AS MANY GOALS AND METHODS AS YOU WISH,
BUT AT A MINIMUM LIST TWO GOALS FOR EACH CORE FUNCTION
AND TWO METHODS FOR EACH GOAL.

YOU MAY PHOTOCOPY THE ATTACHED FORMS OR RE-TYPE THEM TO ACCOMMODATE YOUR NEEDS FOR DOCUMENTING YOUR SUPERVISED PRACTICAL EXPERIENCE.

PLEASE NOTE: There are **THREE** ways of completing and documenting a supervised practical experience:

- 1. **PROSPECTIVE**
Before actually beginning the SPE, you meet with your clinical supervisor and write up the SPE outline, specifying what your goals are for each Core Function, and what you will do (Methods) to achieve these goals. Then you do your 300 hour Supervised Practical Experience, completing the tasks (methods) for each Core Function.
- 2. **CONTEMPORANEOUS**
You may already be working under supervision and may have completed some of your SPE, but perhaps have not written out the outline yet. Complete the Goals portion of the SPE outline and then document professional activities you have already completed, and additional activities that you will complete, that fit with those goals,

in the Methods section of the outline.

D. SUPERVISED PRACTICAL EXPERIENCE, contd.

- **3. RETROSPECTIVE**

In the past you worked under supervision and completed a variety of tasks in all of the twelve Core Functions, but are no longer at that agency or in that job. Complete the outline by writing up goals (that detail the things you learned to do) and describing those professional activities (Methods) you completed in order to meet those goals. If you use the “retrospective” method of completing your SPE, you must have it signed **by the individual who supervised you at the time of that employment.** Your present clinical supervisor can only sign off on this if he/she had direct knowledge of your work during the time that you did it.

SUPERVISED PRACTICAL EXPERIENCE DOCUMENTATION FORM

NAME: _____ SUPERVISOR: _____

(Must be a CAC-S, CCAC, CCAC-S)

LOCATION/AGENCY: _____

DATES OF SUPERVISED PRACTICAL EXPERIENCE: FROM ____/____/____ TO ____/____/____

TOTAL NUMBER OF HOURS WORKED DURING THE SUPERVISED PRACTICAL EXPERIENCE AT THE TIME OF SIGNING OF THIS FORM: _____

<u>CORE FUNCTION</u>	<u>LEARNING GOALS</u>	<u>METHODS</u>
SCREENING	1.	A. B.
	2.	A. B.
	3.	A. B.
INTAKE	1.	A. B.
	2.	A. B.
	3.	A. B.
ORIENTATION	1.	A. B.
	2.	A. B.
	3.	A. B.
ASSESSMENT	1.	A. B.
	2.	A. B.
	3.	A. B.

<u>CORE FUNCTION</u>		<u>LEARNING GOALS</u>	<u>METHODS</u>
TREATMENT PLANNING	1.		A. B.
	2.		A. B.
	3.		A. B.
COUNSELING	1.		A. B.
	2.		A. B.
	3.		A. B.
CASE MANAGEMENT	1.		A. B.
	2.		A. B.
	3.		A. B.
CRISIS INTERVENTION	1.		A. B.
	2.		A. B.
	3.		A. B.
CLIENT EDUCATION	1.		A. B.
	2.		A. B.
	3.		A. B.

<u>CORE FUNCTION</u>	<u>LEARNING GOALS</u>	<u>METHODS</u>
REFERRAL	1.	A. B.
	2.	A. B.
	3.	A. B.
REPORTS AND RECORD-KEEPING	1.	A. B.
	2.	A. B.
	3.	A. B.
CONSULTATION	1.	A. B.
	2.	A. B.
	3.	A. B.

FOR SUPERVISOR TO COMPLETE:

Did the applicant have at least 10 hours in each of the twelve core functions? () Yes () No

PERFORMANCE EVALUATION, COMMENTS AND RECOMMENDATIONS: _____

CLINICAL SUPERVISOR SIGN HERE

APPLICANT SIGN HERE

CLINICAL SUPERVISOR PRINT NAME HERE

DATE

**WEST VIRGINIA CERTIFICATION BOARD
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See the Certification Manual for definitions.

Attach additional pages if necessary

3. ACCREDITED DEGREE WORK:

Attach transcripts for all degree work listed.

You may only list hours for which you received a passing grade.

College/University Name and Address	Degree	Date	Hours Earned
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TOTAL # SEMESTER HOURS EARNED: _____

FOR CERTIFICATION BOARD USE ONLY:

TOTAL # ADDICTION HOURS: _____

TOTAL # HOURS GENERAL TRAINING: _____

MINIMUM 6 HOURS TRAINING IN ADDICTION ETHICS: () YES () NO

F. RESUME

Please attach a complete, typewritten resume.

WVCBAPP
1400A OHIO AVENUE
DUNBAR, WV 25064

EDUCATION TRAINING DESCRIPTION

NAME OF SESSION _____

DATE(S) OF SESSION _____

OBJECTIVES FOR SESSION _____

INSTRUCTORS CREDENTIALS including licenses, certifications and academic degrees (please attach resume)

OTHER INFORMATION USEFUL IN EVALUATING TRAINING FOR THE PURPOSE OF WVCBAPP
CERTIFICATION BOARD ENDORSEMENT:

NUMBER OF CONTACT HOURS FOR THIS SESSION

* ONE CONTACT HOUR EQUALS 50 MINUTES OF CONTINUED STRUCTURED LEARNING
EXPERIENCE.

ATTACH WORKSHOP OR CONFERENCE BROCHURE TO THIS APPLICATION

Please check mark all which will be addressed
by the training

12 CORE FUNCTIONS OF ADDICTION COUNSELING

- () **SCREENING:** The process by which a client is determined appropriate and eligible for admission to a particular program.
- () **INTAKE:** The administrative and initial assessment procedures for admission to a program.
- () **ORIENTATION:** Describing to the client the following: general nature and goals of the program; rules governing client conduct and infractions that can lead to disciplinary action or discharge from the program; in a non-residential program, the hours during which services are available; treatment costs to be borne by the client, if any; and client's rights.
- () **ASSESSMENT:** Those procedures by which a counselor/program identifies and evaluates an individual's strengths, weaknesses, problems and needs for the development of a treatment plan.
- () **TREATMENT PLANNING:** Process by which the counselor and the client identify and rank problems needing resolution; establish agreed upon immediate and long-term goals; and decide upon a treatment process and the resources to be utilized.
- () **COUNSELING** (Individual, Group and Significant Others): The utilization of special skills to assist individuals, families or groups in achieving objectives through exploration of a problem and its ramifications; examination of attitudes and feelings; consideration of alternative solutions; and decision-making.
- () **CASE MANAGEMENT:** Activities which bring services, agencies, resources or people together within a planned framework of action toward the achievement of established goals. It may involve liaison activities and collateral contacts.
- () **CRISIS INTERVENTION:** Those services which respond to an alcohol and/or other drug abuser's needs during acute emotional and/or physical distress.
- () **CLIENT EDUCATION:** Provision of information to individuals and groups concerning alcohol and other drugs abuse and the available services and resources.
- () **REFERRAL:** Identifying the needs of a client that cannot be met by the counselor or agency and assisting the client to utilize the support systems and community resources available.
- () **REPORTS AND RECORD KEEPING:** Charting the results of the assessment and treatment plan, writing reports, progress notes, discharge summaries and other client-related data.
- () **CONSULTATION WITH OTHER PROFESSIONALS IN REGARD TO CLIENT TREATMENT/SERVICES:** Relating with in-house staff or outside professionals to assure comprehensive, quality care for the client.

Please check mark all which will be addressed
by the training

SKILLS AND KNOWLEDGE AREAS OF ADDICTION COUNSELING

(Please see the Counselor Certification Manual for a Complete List)

- () Human Behavior
 - () Signs and Symptoms of Alcohol and Other Drug Abuse (including pharmacological factors)
 - () Behavioral Addictions (including gambling, eating disorders, sexual addiction)
 - () Counseling Approaches, Modalities, Philosophies, Techniques, Methods and Objectives
 - () Working Therapeutically With Individuals, Groups and Families
 - () Communication Skills
 - () Establishing Rapport
 - () Continuum of Care (including Case Management)
 - () DUI Safety and Treatment
 - () Federal, State and Local Statutes, Administrative Rules and Regulations
 - () Ethics
 - () Chemical Dependency Resources at the Federal, State and Local Level
(including agencies, organizations, facilities)
 - () How to Refer to and utilize 12 Step and Other Support Groups (Attendance at 12 Step meetings is not
included)
 - () Clinical Supervision
 - () Other (please describe and be specific) _____
-
-

**WEST VIRGINIA CERTIFICATION BOARD
FOR ADDICTION AND PREVENTION PROFESSIONALS**

G. CERTIFICATION OF TRUTH

**1. APPLICANT
MUST BE NOTARIZED**

I hereby certify that the statements contained in this application and supporting documents, given for consideration of my application for certification as a Certified Clinical Addiction Counselor, Certified Addiction Counselor or Counselor in Service are, to the best of my knowledge, true and correct. I acknowledge that fees are non-refundable.

I further certify that I have read and subscribe to and abide by the WVCBAPP Code of Ethics. I authorize the Board to conduct inquiries or interviews as they deem necessary.

Signature of Applicant

STATE OF WEST VIRGINIA,

COUNTY OF _____, TO-WIT:

Subscribed and signed this _____ day of _____.

My commission expires: _____
Notary Public

**2. SUPERVISOR
MUST BE NOTARIZED**

I hereby certify that the statements contained in this application and supporting documents, given for consideration of my supervisee's application for certification as a Certified Addiction Counselor or Counselor in Service are, to the best of my knowledge, true and correct.

Signature of Supervisor

STATE OF WEST VIRGINIA,

COUNTY OF _____, TO-WIT:

Subscribed and signed this _____ day of _____.

My commission expires: _____
Notary Public