

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



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? \_\_\_\_\_



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

C. QUALIFYING EXPERIENCE, Contd.

**ATTACH ADDITIONAL SHEETS IF NECESSARY**  
See Counselor Certification Manual for Definitions

**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:

\_\_\_\_\_



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.

CORE FUNCTION

TREATMENT PLANNING

LEARNING GOALS

METHODS

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.

1.

A.  
B.

2.

A.  
B.

3.

A.  
B.

CORE FUNCTION

REFERRAL

LEARNING GOALS

METHODS

REPORTS AND RECORD-KEEPING

- 1.
- 2.
- 3.

- A.
- B.
- A.
- B.
- A.
- B.

CONSULTATION

- 1.
- 2.
- 3.
- 1.
- 2.
- 3.

- A.
- B.
- A.
- B.
- A.
- B.
- A.
- B.
- 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  
FOR ADDICTION AND PREVENTION PROFESSIONALS**

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

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.

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

See the Certification Manual for definitions.

Attach additional pages if necessary

**4. DISTANCE LEARNING:**

Attach transcripts, certificates of attendance, brochures, etc. for all distance learning listed.

You must complete the "Application for Distance Learning Approval" form (see next 4 pages) for each course, workshop, etc., that was completed via distance learning.

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

College/Univ/Sponsor and Address	Course Name	Date	Hours Earned
-------------------------------------	-------------	------	--------------

---

---

---

---

---

---

---

---

---

---

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

**WVCBAPP**  
1400A OHIO AVENUE  
DUNBAR, WV 25064

Application Form  
Distance Learning Approval  
For Use by Individuals Applying for Initial Certification  
Part I

DATE OF APPLICATION \_\_\_\_\_

APPLICANT'S NAME \_\_\_\_\_

APPLICANT'S ADDRESS \_\_\_\_\_  
\_\_\_\_\_

APPLICANT'S PHONE NUMBER \_\_\_\_\_

COURSE/TRAINING/WORKSHOP TITLE \_\_\_\_\_

INSTITUTION SPONSORED BY: \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

Part II

EDUCATION TRAINING DESCRIPTION

Please read the enclosed "Counselor Core Functions" and "Skill and Knowledge" forms and check mark the items which will be emphasized in the training event. If you are applying for approval for an event which has several different sessions and presenters, please make multiple copies of the attached form. Complete one form per session.

When you receive the letter of approval for this training, keep it along with other documentation related to your application for initial certification. This form is not to be used for re-certification.

I hereby attest that all information provided in this application is true and valid to the best of my knowledge.

\_\_\_\_\_  
Authorizing Signature

\_\_\_\_\_  
Name Printed

\_\_\_\_\_  
Date

A COPY OF A BROCHURE, OR SCHOOL BULLETIN COURSE DESCRIPTION MUST ACCOMPANY THIS

DISTANCE LARANING, Con't

**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**