WEST VIRGINIA CERTIFICATION BOARD FOR ADDICTION AND PREVENTION PROFESSIONALS
436 12th Street, Suite C
Dunbar, WV 25064
(304) 768-2942
(304) 768-1562 FAX

APPLICATION FOR CLINICAL SUPERVISOR CERTIFICATION

THE ENTIRE APPLICATION MUST BE TYPED AND THE ORIGINAL AND ONE COPY MUST BE SUBMITTED.

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. Therefore, TIMELY SUBMISSION OF ALL FEES AND MATERIALS is of utmost importance.

Payment of fees is best made by Postal Money Order or Cashier Check, since personal checks that are returned for insufficient funds will cause you to be assessed a penalty fee of $20.00 beyond the bank charge for such, and can cause your application to be too late to process.

THIS APPLICATION PACKET CONTAINS:

1. WVCBAPP Clinical Supervisor Certification Manual

2. Clinical Supervisor Performance Domains

3. NAADAC Code of Ethics (WVCBAPP's adopted Code of Ethics)

4. Application

5. Demographic Data Form

6. Copy of current photo ID

CERTIFICATION PROCEDURES AND GUIDELINES

Completion Period: An applicant has one certification period (two years) from the date of passing the written test, to meet all other requirements for certification. If an individual does not complete all requirements, he/she must reapply to continue in the process. In addition, an applicant must retake the written test if he/she has not completed all other requirements within two years of the date that the written test was passed.

Eligibility Period for Tests: In order to be eligible to take the written test, the applicant's portfolio (application and all related materials) must be substantially complete. Incomplete applications will be returned, or the applicant will be notified of the deficiencies and will be required to submit additional documentation to correct all deficiencies. A fee will be assessed for each individual item submitted to correct deficiencies.

APPLICATION FOR CLINICAL SUPERVISOR 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 also understand that a computer based test (CBT) fee ($200) will be due later in the process for CS applicants. I have enclosed a check, postal money order or cashier's check. I wish to be considered as an applicant for certification as:

( ) Clinical Supervisor (CS) $75.00

_____ _____ _____

SIGNATURE DATE SOCIAL SECURITY NUMBER

_____

PRINT YOUR NAME HERE

WEST VIRGINIA CERTIFICATION BOARD FOR ADDICTION AND PREVENTION PROFESSIONALS

B. DEMOGRAPHIC DATA You must submit a photocopy of a government-issued photo ID with this application. This same photo ID must be brought to the testing center. You will not be admitted to test unless the name by which you were pre-registered by WVCBAPP matches the name on the ID.

DATE:_____ SOCIAL SECURITY NUMBER:_____

NAME: _____ _____
LAST MIDDLE FIRST Maiden or Nickname

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

_____
CITY STATE ZIP

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

_____
CITY STATE ZIP

WORK PHONE: _____ HOME PHONE: _____

FAX NUMBER: _____ E-MAIL : _____

BUSINESS NAME OR AGENCY: _____

COUNTY: _____

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: _____

CERTIFICATIONS: ( ) ADC ( ) AADC ( ) CCJP ( ) PS1 ( ) PS2

LICENSES: ( )SOCIAL WORK ( )COUNSELING ( )MEDICINE

( )PSYCHOLOGY ( )NURSING

( )OTHER _____

FIRST YEAR OF EMPLOYMENT IN THE ADDICTION FIELD: _____

APPLICATION FOR CLINICAL SUPERVISOR CERTIFICATION

C. QUALIFYING EXPERIENCE

List your most recent employment first. Select ONLY those work experiences which fit the description of qualifying work experience as described 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 COUNSELING**: If addiction counseling experience represents only a portion or percentage of a full-time job, report ONLY the addiction counseling work in this category. 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.

EMPLOYER/AGENCY: _____

YOUR JOB TITLE: _____

ADDRESS: _____

_____

SUPERVISOR: _____ PHONE: _____

( ) Paid Position ( ) Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES:

_____

_____

_____

DATES: Beginning ___/___/___ Ending ___/___/___
(a) Total Number of Months: _____

What percentage of full time equivalent was this job? (b) _____%

Multiply the total number of months (a) by that percentage (b) = © _____ actual months worked

What percentage of your work time was dedicated to addiction counseling? (d) _____ %

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

Enter that number: _____ months of addiction counseling specific work.

****

EMPLOYER/AGENCY: _____

YOUR JOB TITLE: _____

ADDRESS: _____

_____

SUPERVISOR: _____ PHONE: _____

( ) Paid Position ( ) Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES:

_____

_____

_____

DATES: Beginning ___/___/___ Ending ___/___/___

(a) Total Number of Months: _____

What percentage of full time equivalent was this job? (b) _____%

Multiply the total number of months (a) by that percentage (b) = © _____ actual months worked

What percentage of your work time was dedicated to addiction counseling? (d) _____ %

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

Enter that number: _____ months of addiction counseling specific work.

EMPLOYER/AGENCY: _____ _____

YOUR JOB TITLE: _____

ADDRESS: _____

SUPERVISOR: _____ PHONE: _____

( ) Paid Position ( ) Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES:

_____

_____

_____

DATES: Beginning ___/___/___ Ending ___/___/___
(a) Total Number of Months: _____

What percentage of full time equivalent was this job? (b) _____%

Multiply the total number of months (a) by that percentage (b) = © _____ actual months worked

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Enter that number: _____ months of addiction counseling specific work.

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

2. **WORK EXPERIENCE SPECIFIC TO ADDICTION CLINICAL SUPERVISION**: If clinical supervision experience represents only a portion or percentage of a full-time job, report **ONLY** the clinical supervision work in this category. Example: You have a full-time job that is 20% addiction counseling, 20% counseling other populations and 60% clinical supervision. Only the addiction clinical supervision should be reported here.

EMPLOYER/AGENCY: _____

YOUR JOB TITLE: _____

ADDRESS: _____

_____

SUPERVISOR: _____ PHONE: _____

( ) Paid Position ( ) Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES:

_____

_____

_____

DATES: Beginning ___/___/___ Ending ___/___/___

(a) Total Number of Months: _____

What percentage of full time equivalent was this job? (b) _____%

Multiply the total number of months (a) by that percentage (b) = © _____ actual months worked

What percentage of your work time was dedicated to addiction counseling? (d) _____ %

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

Enter that number: _____ months of addiction counseling specific work.

****

EMPLOYER/AGENCY: _____

YOUR JOB TITLE: _____

ADDRESS: _____

_____

SUPERVISOR: _____PHONE: _____

( ) Paid Position ( ) Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES:

_____

_____

_____

DATES: Beginning ___/___/___ Ending ___/___/___

(a) Total Number of Months: _____

What percentage of full time equivalent was this job? (b) _____%

Multiply the total number of months (a) by that percentage (b) = © _____ actual months worked

What percentage of your work time was dedicated to addiction counseling? (d) _____ %

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

Enter that number: _____ months of addiction counseling specific work.

****

EMPLOYER/AGENCY: _____

YOUR JOB TITLE: _____

ADDRESS: _____

_____

SUPERVISOR:_____PHONE: _____

( ) Paid Position ( ) Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES:

_____

_____

_____

DATES: Beginning ___/___/___ Ending ___/___/___
(a) Total Number of Months: _____

What percentage of full time equivalent was this job? (b) _____%

Multiply the total number of months (a) by that percentage (b) = © _____ actual months worked

What percentage of your work time was dedicated to addiction counseling? (d) _____ %

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

Enter that number: _____ months of addiction counseling specific work.
****
EMPLOYER/AGENCY: _____

YOUR JOB TITLE: _____

ADDRESS: _____

_____

SUPERVISOR: _____ PHONE: _____

( ) Paid Position ( ) Volunteer Position

BRIEFLY DESCRIBE JOB DUTIES:

_____

_____

_____

DATES: Beginning ___/___/___ Ending ___/___/___
(a) Total Number of Months: _____

What percentage of full time equivalent was this job? (b) _____%

Multiply the total number of months (a) by that percentage (b) = © _____ actual months worked

What percentage of your work time was dedicated to addiction counseling? (d) _____ %

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

FOR BOARD USE ONLY:
WORK EXPERIENCE SPECIFIC TO ADDICTION CLINICAL SUPERVISION:
_____ MONTHS TOTAL

D. SUPERVISION

TO SUPERVISOR: Please complete this form indicating this applicant's on the job supervision in providing clinical supervision. This form is not intended to document applicant's total number of hours worked but rather the hours of face to face supervision this applicant has provided to counselors.

Applicant's Name: _____

I hereby attest that minimum of 200 clock hours of face to face supervision in the following performance domains have been provided to counselors by the above named applicant as outlined below.

PERFORMANCE DOMAINS # HOURS PROVIDED IN EACH

1. Counselor Development_____
2. Professional and Ethical Standards_____
3. Program Development and Quality Assurance_____
4. Assessing Counselor Competencies and Performance_____
5. Treatment Knowledge_____

TOTAL MUST BE AT LEAST 200 HOURS _____

SUPERVISOR SIGNATURE

SUPERVISOR PRINT NAME

DATE

E. EDUCATION/TRAINING IN CLINICAL SUPERVISION

YOU MUST ATTACH DOCUMENTATION IN THE FORM OF OFFICIAL TRANSCRIPTS OR CERTIFICATES OF ATTENDANCE, FOR ALL HOURS LISTED. THIRTY (30) HOURS OF DIDACTIC EDUCATION/TRAINING IN CLINICAL SUPERVISION IS REQUIRED. THIS MUST INCLUDE EDUCATION/TRAINING IN EACH OF THE FIVE DOMAINS: (must be a minimum of six (6) hours in each domain). For distance learning please see subsequent pages.

At least 50% of all training must be face-to-face. Online College and University classes taken toward a degree are exempted from this rule. Webinars are also excluded from this rule. No more than 12 hours of CEUs will be awarded for any 24-hour period.

COURSE TITLE SPONSOR DATE # CONTACT HOURS

BRIEFLY DESCRIBE CONTENT OF EDUCATION:

RELEVANT TO THE FOLLOWING PERFORMANCE DOMAIN:

( ) Counselor Development **( )** Professional and Ethical Standards **( )** Treatment Knowledge

( ) Program Development & Quality Assurance **( )**Assessing Counselor Competencies & Performance

****

COURSE TITLE SPONSOR DATE # CONTACT HOURS

_____

BRIEFLY DESCRIBE CONTENT OF EDUCATION:

_____

_____

_____

RELEVANT TO THE FOLLOWING PERFORMANCE DOMAIN:

( ) Counselor Development **( )** Professional and Ethical Standards **( )** Treatment Knowledge

( ) Program Development & Quality Assurance **( )**Assessing Counselor Competencies & Performance

****

COURSE TITLE SPONSOR DATE # CONTACT HOURS

_____

BRIEFLY DESCRIBE CONTENT OF EDUCATION:

_____

_____

_____

RELEVANT TO THE FOLLOWING PERFORMANCE DOMAIN:

( ) Counselor Development **( )** Professional and Ethical Standards **( )** Treatment Knowledge

( ) Program Development & Quality Assurance **( )**Assessing Counselor Competencies &

Performance

****

COURSE TITLE SPONSOR DATE # CONTACT HOURS

_____

BRIEFLY DESCRIBE CONTENT OF EDUCATION:

_____

_____

_____

RELEVANT TO THE FOLLOWING PERFORMANCE DOMAIN:

( ) Counselor Development **( )** Professional and Ethical Standards **( )** Treatment Knowledge

( ) Program Development & Quality Assurance **( )**Assessing Counselor Competencies & Performance

****

See next 4 pages to document distance learning.

DISTANCE LEARNING

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, SCHOOL BULLETIN OR COURSE DESCRIPTION MUST ACCOMPANY THIS

DISTANCE LEARNING

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 60 MINUTES OF CONTINUED STRUCTURED LEARNING EXPERIENCE.

ATTACH WORKSHOP OR CONFERENCE BROCHURE TO THIS APPLICATION

DISTANCE LEARNING
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.

DISTANCE LEARNING
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) _____

_____

_____

FOR BOARD USE ONLY: TOTAL HOURS EDUCATION/TRAINING _____

F. RESUME - Please attach a complete, typewritten resume.

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 Clinical Supervisor are, to the best of my knowledge, true and correct.

I further certify that I have read and subscribe to and abide by the WVCBAPP Code of Ethics, based on the NAADAC 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 Clinical Supervisor 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

WVCBAPP Certification Professionals

Education &Training

1. What is the highest degree or level of education you have <u>completed</u>?

O High school or GED
O Associate's degree or trade school
O Bachelor's degree
O Master's degree
O Doctoral degree
O Prefer not to say

2. What year did you complete your highest level of education? ___ ___ ___ ___

3. In what state did you complete your highest level of education? _____

School/Program Name_____

4. Do you have a National Provider Identification (NPI) number?

O Yes (write-in number)
_____
O No
O Prefer not to say

5. Please mark any counseling certifications you currently hold:

Certification: ___ ___ ___ ___
O Certified Alcohol and Drug Counselor ___ ___ ___ ___
O Certified Advanced Alcohol and Drug Counselor ___ ___ ___ ___
O Certified Clinical Supervisor ___ ___ ___ ___
O Certified Prevention Specialist ___ ___ ___ ___
O Certified Criminal Justice Addictions Professional ___ ___ ___ ___
O National Certified Counselor ___ ___ ___ ___
O National Certified Addiction Counselor I ___ ___ ___ ___
O National Certified Addiction Counselor II
O Master Addictions Counselor
O Certified Clinical Mental Health Counselor
O National Certified School Counselor

Year obtained:

___ ___ ___ ___
___ ___ ___ ___
___ ___ ___ ___

O Other (please specify; include state-specific and non-reciprocal credentials):

6. Please mark any professional licenses you currently hold:

O Social Worker
O Psychologist
O School Psychologist
O Licensed Professional Counselor
O Marriage and Family Therapist
O Physician Assistant

O MD or DO
O Registered Nurse or APRN
O CNA or LPN
O Other_____

7. Are you a clinical supervisor?

O Yes O No

7a If yes, about how many people do you supervise currently? _____

Practice Characteristics

8. What best describes your current employment status?

O Full-time
O Part-time
O Not currently working
O Retired
O Per diem/casual
O Volunteer
O Prefer not to say

If not currently working or retired, skip to Demographics—Question 24

9. What best describes your PRIMARY employment position?

O Actively working in a substance use disorder services and/or prevention position that requires a WVCBAPP certification
O Actively working in a substance use disorder services and/or prevention position that does not require a WVCBAPP certification
O Actively working in a position other than substance use disorder services
O Prefer not to say

If working a substance use disorder services and/or prevention position, please answer questions 10 - 15 ; if NOT please skip to question 16

10. Which of the following best describes your PRIMARY position arrangement?

O Self-employed
O Salaried employment
O Hourly employment
O Temporary
O Other (specify): _____
O Prefer not to say

11. What is the address where you spend most of your time for your PRIMARY position?

_____
Number Street

_____
City State Zip Code

12. About how many people are usually on your caseload? _____

13. Which type of setting most closely describes to your PRIMARY practice location?

O Specialized substance use disorder outpatient treatment facility
O Community health center
O Mental health clinic
O Methadone clinic
O Primary or specialist medical care
O Child welfare
O Criminal justice
O Hospital Federal Government hospital
O Non-federal hospital: Inpatient
O Non-federal hospital: General Medical
O Non-federal hospital: Psychiatric
O Non-federal hospital: Other - e.g. nursing home unit
O Private practice
O Rehabilitation
O Detox
O Residential setting
O Recovery support services
O School health service
O Faith-based setting
O Other (specify):_____

14. What best describes your employment plans for the next 12 months?

O Increase hours
O Decrease hours
O Seek another position in substance use disorder
O Seek a position in another field
O Retire
O Continue as you are
O Unknown
O Prefer not to say

15. Do you ever use telehealth in your primary position? i.e. remote support of persons in recovery or prevention by means of telecommunications

O Yes O No

15a. If yes, about what percentage of your time with a client is delivered by telehealth in your primary position?

O Less than 25%
O 25%-50%
O 50%-75%
O More than 75%

15b. If yes, which best describes the population you see using telehealth in your primary position?

O All are located in West Virginia
O Most are located in West Virginia
O About half are located in West Virginia and about half are out of state
O Most are located out of the state of West Virginia
O All are located out of the state of West Virginia

*****16. Do you have a SECONDARY employment position?**

O Yes O No

***If no, please skip to Demographics—Question 24 ***

17. What best describes your SECONDARY employment position?

O Actively working in a substance use disorder services and/or prevention position that requires a WVCBAPP certification
O Actively working in a substance use disorder service and/or prevention position that does not require a WVCBAPP certification
O Actively working in a field other than substance use disorder services
O Prefer not to say

If working a substance use disorder services and/or prevention position, please answer questions 18 - 23; if NOT please skip to question 24

18. Which of the following best describes your SECONDARY position arrangement?

O Self-employed O Locum tenens / temporary
O Salaried employment O Other (specify): _____
O Hourly employment O Prefer not to say

19. What is the address where you spend most time for your SECONDARY position?

_____
Number Street

_____
City State Zip Code

20. About how many people are usually on your caseload? _____

ETHICAL CODE OF CONDUCT

It is the policy of the West Virginia Certification Board for Addiction and Prevention Professionals to promote and safeguard the quality, effectiveness and competence of professional addiction counselors through the insistence of adherence to its Code of Ethics by all WVCBAPP certified clinical supervisors.

The ethics committee recommends an ethical code of conduct for adoption by the Board of Directors. Currently, the Board has adopted the NAADAC code of ethics. The ethics committee has jurisdiction over all matters of violation and misconduct by certified clinical supervisors in the state of West Virginia. It immediately and thoroughly investigates such charges and makes recommendation to the Board of Directors for appropriate action.

NAADAC: The Association for Addiction Professionals
NCC AP: The National Certification Commission for Addiction Professionals

CODE OF ETHICS: Approved 10.09.2016 can be obtained and reviewed online at www.naadac.org or www.wvcbapp.org or in the Clinical Supervisor Manual