KENTUCKY BOARD OF ALCOHOL AND DRUG COUNSELORS

P.O. Box 1360, Frankfort, Kentucky 40602 ~ 500 Mero St., 2 SC 32, Frankfort, Kentucky 40601
Phone (502) 782-8814 ~ http://adc.ky.gov

APPLICATION FOR:

TEMPORARY REGISTRATION AS PEER SUPPORT SPECIALIST	**( )**
REGISTRATION AS PEER SUPPORT SPECIALIST	**( )**
CERTIFIED ALCOHOL AND DRUG COUNSELOR ASSOCIATE I	**( )**
CERTIFIED ALCOHOL AND DRUG COUNSELOR ASSOCIATE II	**( )**
TEMPORARY CERTIFICATION AS AN ALCOHOL AND DRUG COUNSELOR	**( )**
CERTIFICATION AS AN ALCOHOL AND DRUG COUNSELOR	**( )**
LICENSED CLINICAL ALCOHOL AND DRUG COUNSELOR ASSOCIATE	**( )**
LICENSED CLINICAL ALCOHOL AND DRUG COUNSELOR	**( )**
LICENSED ALCOHOL AND DRUG COUNSELOR	**( )**

SECTION 1 – APPLICANT INFORMATION

1. _____
Name: First Middle Last Maiden

_____-_____-_____
Social Security Number Date of Birth Home Phone Cell Phone

_____
Mailing Address: Street City State Zip Code

_____
Employer Business Phone

_____
Employer's Address: Street City State Zip Code

_____
Home Email Business Email

2. Have you had a credential in Kentucky or any other state that has ever been suspended or revoked?
☐ YES ☐ NO If yes, give details:

_____

3. Have you been convicted of a felony or plead guilty, including an Alford plea (other than minor traffic violations) under the laws of the United States in the last 5 years? ☐ YES ☐ NO If yes, what offense? _____(If yes, send supporting documentation.)

4. Are you credentialed as an Alcohol or Drug Counselor in any other state? ☐ YES ☐ NO
If yes, what state?_____Type of Credential? _____

5. Have you ever been discharged or forced to resign for misconduct or unsatisfactory service from any position from any professional training program, or from the program of any university? ☐ YES ☐ NO
(If yes, send supporting documentation.)

6. Have you ever been sanctioned by the Kentucky Board of Alcohol and Drug Counselors or by any other credentialing board or professional associations for ethical misconduct? ☐ YES ☐ NO
(If yes, send supporting documentation.)

7. Are you currently on active military duty? ☐ YES ☐ NO
8. Are you or your spouse a member of the United States military, Reserves, or National Guard, or are you or your spouse a veteran? ☐ YES ☐ NO

If yes, do you currently hold or recently held an equivalent credential issued by another state, the District of Columbia, or any possession or territory of the United States? ☐ YES ☐ NO

If yes, please answer the following questions:
Has your credential issued by another state, the District of Columbia, or any possession or territory of the United States been expired for more than two years? ☐ YES ☐ NO
Is your credential issued by another state, the District of Columbia, or any possession or territory of the United States in good standing? ☐ YES ☐ NO
Has your credential issued by another state, the District of Columbia, or any possession or territory of the United States been suspended for disciplinary reasons? ☐ YES ☐ NO

The United States military service member, Reserves or National Guard member, veteran, or spouse shall submit:

(1) Proof of issuance of a valid license, permit, certificate, or other document issued by another state, the District of Columbia, or any possession or territory of the United States that is active or has been expired for less than two (2) years;
(2) Proof that the valid license, permit, certificate, or other document issued by another state, the District of Columbia, or any possession or territory of the United States is in good standing or was upon the date of expiration; and
(3) His or her DD-214 form or other proof of active or prior military service with an honorable discharge, discharge under honorable conditions, or a general discharge under honorable conditions.

SECTION 2 – APPLICANT EDUCATION

School	Name and Location	Dates Attended	Date of Graduation	Number of Hours	Degree Obtained
High School/Equivalent					
Baccalaureate					
Master's					
Doctoral					

Submit proof of your <u>highest</u> education achieved:

- High school / equivalent - submit a copy of your diploma or certificate.
- Other higher education - submit official transcript sent from registrar of the college or university.

SECTION 3 – WORK EXPERIENCE (Attach Additional Related Experience If Needed)

Name of Employer: _____

Title or Position: _____

Employment Start Date: _____ End Date: _____

Address of Employer: _____

Clinical Supervisor: _____ Credential Number: _____

Total Number of Work Hours per Week Related to Alcohol and Drug Clients: _____

Describe Work Duties Related to Alcohol and Drug Clients: _____

_____

Name of Employer: _____

Title or Position: _____

Employment Start Date: _____ End Date: _____

Address of Employer: _____

Clinical Supervisor: _____ Credential Number: _____

Total Number of Work Hours per Week Related to Alcohol and Drug Clients: _____

Describe Work Duties Related to Alcohol and Drug Clients: _____

_____

AFFIDAVIT

I do hereby certify under penalty of law, that the information contained herein is true, correct and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose such misrepresentation or falsification, my application could be rejected or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

_____ _____

Applicant's Signature (Do not type or print) Date

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SUPERVISION EVALUATION

(Completed by each Supervisor)

This form must be entirely completed by each supervisor of qualifying experience. Please pay special attention to the number of hours of direct clinical supervision and percentage of applicant's time allotted to chemical dependency clients.

Applicant's Name: _____

Applicant's Address: _____

_____

Clinical Supervisor: _____ Credential Number: _____

Current Address: _____

Date of Issue of Certification: _____ Supervisor's Day Phone Number: ____/_____/_____

Program or agency where you supervised the applicant: _____

I have supervised the applicant's work from _____ to _____, which includes approximately _____
(Date) (Date)

hours of face to face clinical supervision per month for a total of _____ hours.

The approximate percentage of his/her time spent in delivery of services to substance abuse clients: _____%____

PERSONAL ATTRIBUTES:

Evaluate the applicant as you observe(d) him/her in the following areas of interpersonal relationship with clients:
(Please use appropriate number as indicated on scale.)

1 / Weak	2 / Fair	3 / Average	4 / Above Average	5 / Superior	6 / NA

_____ A. Respect for client.

_____ B. Care and concern for client.

_____ C. Genuineness with client.

_____ D. Empathy with client.

_____ E. Flexibility with client.

_____ F. Clinical Judgment with client.

_____ G. Spontaneity with client.

_____ H. Capacity for confrontation with client.

_____ I. Capacity for appropriate self-disclosure.

_____ J. Sense of immediacy.

_____ K. Concreteness.

Applicant's Name: _____

AREAS OF COMPETENCY

The following items are representative of the skills needed by an alcohol and drug counselor in the core functions. Evaluate the applicant as you feel he/she demonstrates his/her abilities in each area. Mark the rating most nearly descriptive of the applicant's demonstrated skills using the scales given.

_____ A. Screening assessment and engagement

_____ B. Treatment planning, collaboration, and referral

_____ C. Counseling

_____ D. Professional and ethical responsibilities

PROFESSIONAL AND ETHICAL CONDUCT:

1. Employment of fraud or deception in applying for a certificate: ☐ Yes ☐ No. If yes, please comment:
   Comment: _____

2. Practice of Alcohol and Drug Counseling under a false or assumed name or the impersonation of another counselor of a like or different name. ☐ Yes ☐ No. If yes, please comment:
   Comment: _____

3. Habitual abuse of any mood-altering chemical substance to such an extent as to interfere consistently with the competent performance of his/her duties. ☐ Yes ☐ No. If yes, please comment:
   Comment: _____

4. Misrepresentation of one's professional credentials: ☐ Yes ☐ No. If yes, please comment:
   Comment: _____

5. Failure to adhere to KRS 309.080 to 309.089: ☐ Yes ☐ No. If yes, please comment:
   Comment: _____

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CERTIFIED ALCOHOL AND DRUG COUNSELOR AND LICENSED ALCOHOL AND DRUG COUNSELOR VERIFICATION OF CLASSROOM TRAINING

In accordance with 201 KAR 35:050, Section 1(4), an applicant seeking certification as an alcohol and drug counselor and licensure as a licensed alcohol and drug counselor shall complete classroom hours which are specifically related to the knowledge and skills necessary to perform the following alcohol and drug counselor domains:

1. Screening assessment and engagement;
2. Treatment planning, collaboration, and referral;
3. Counseling; and
4. Professional and ethical responsibilities

A minimum of ten (10) hours must be accumulated in each of the four domains.

I certify, under penalty of perjury, that I have had training or education in each of the four domains related to the practice of alcohol and drugcounseling.

Signature:_____Date: _____

ETHICS TRAINING (6) – A minimum of 6 hours shall be interactive, face-to-face ethics training related to counseling. PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Applicant Name_____ **Total Number of Hours:** _____

Applicant Name _____

<u>HIV TRAINING (2)</u> – A minimum of two (2) hours of training in transmission, control, treatment and prevention of the human immunodeficiency virus. PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours: _____

<u>DOMESTIC VIOLENCE (3)</u> – A minimum of three (3) hours of training specific to domestic violence. PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours: _____

<u>ALCOHOL AND DRUG COMPETENCY TRAINING HOURS.</u> All training hours shall specifically be related to the knowledge and skills necessary to perform the four alcohol and drug counselor domains:
1. Screening assessment and engagement; 2. Treatment planning, collaboration, and referral; 3. Counseling; and 4. Professional and ethical responsibilities.

PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours: _____

Applicant Name_____

ALCOHOL AND DRUG COMPETENCY TRAINING HOURS (Make as many copies of this page as needed.Number each page.)
PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours on This Page: _____

Applicant Name_____

<u>ALCOHOL AND DRUG COMPETENCY TRAINING HOURS</u> (Make as many copies of this page as needed.Number each page.)
PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours on This Page: _____

Describe what you believe to be significant strengths and / or deficiencies of the applicant:

To be completed upon application for certification or licensure.

I recommend _____ for certification / licensure.
Applicant's Name

I do not recommend _____ for certification / licensure.
Applicant's Name

Signature: _____ Credential: _____

Current Address: _____

_____

Date Signed: _____

Supervisee's Name: _____

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VERIFICATION OF CLINICAL SUPERVISION

Highest Educational Level Achieved: _____

Documentation of direct supervision by a Board-Approved Certified Alcohol and Drug Counselor or a Licensed Clinical Alcohol and Drug Counselor must be provided. This form must be completed by the applicant and signed by the clinical supervisor.

Clinical supervision shall meet the following minimum requirements:
(a) Applicants with a high school diploma or high school equivalency diploma require 300 hours of clinical supervision with a minimum of ten (10) hours in each of the four domains;
(b) Applicants with an associate's degree in a relevant field require 250 hours of clinical supervision with a minimum of ten (10) hours in each of the four domains;
(c) Applicants with a bachelor's degree in a relevant field require 200 hours of clinical supervision with a minimum of ten (10) hours in each of the four domains; and
(d) Applicants with a master's degree or higher in a relevant field require 100 hours of clinical supervision with a minimum of ten (10) hours in each of the four domains.

In accordance with 201 KAR 35:010, Section 1 (13), "clinical supervision" means a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical, and supportive. These activities are observed/reviewed by the clinical supervisor who provides timely positive and constructive feedback to assist the counselor in the learning process. Methods of supervision include: face-to-face, interactive video, or observation. **A minimum of 10 hoursof face-to-face clinical supervision must be documented in each of the four (4) domains**.

APPLICANT/SUPERVISEE'S NAME:

APPLICANT/SUPERVISEE'S STRENGTHS: _____

_____

_____

_____

APPLICANT/SUPERVISEE'S WEAKNESSES:_____

_____

_____

_____

Supervisee's Name: _____

COMPLETE THE FOLLOWING **SUMMARY** OF CLINICAL SUPERVISION HOURS - SPECIFIC DETAILS MUST ACCOMPANY THIS PAGE. USE AS MANY PAGES AS NECESSARY TO PROVIDE DETAILS OF CLINICAL SUPERVISION. NUMBER EACH PAGE.

DOMAIN	**Number of Face-to-Face Hours**	**TOTAL NUMBER OF HOURS**
Screening assessment and engagement		
Treatment planning, collaboration, and referral		
Counseling		
Professional and ethical responsibilities		
TOTAL		

Affidavit: I verify, under the penalty of perjury, that the information documented above is true and accurate to the best of my knowledge and belief.

Applicant Signature:_____ Date: _____

Supervisee's Name: _____

DOMAIN 1: SCREENING ASSESSMENT AND ENGAGEMENT

(Methods of supervision include face-to-face, interactive video, or observation.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Screening Assessment and Engagement _____

Supervisee's Name: _____

DOMAIN 2: TREATMENT PLANNING, COLLABORATION, AND REFERRAL

(Methods of supervision include face-to-face, interactive video, or observation.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Treatment Planning, Collaboration, and Referral _____

Supervisor's Name _____

DOMAIN 3: COUNSELING

(Methods of supervision include face-to-face, interactive video, or observation.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Counseling _____

DOMAIN 4: PROFESSIONAL AND ETHICAL RESPONSIBILITIES

(Methods of supervision include face-to-face, interactive video, or observation.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Professional and Ethical Responsibilities _____