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 highest 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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ATTESTATION OF RECOVERY

TEMPORARY REGISTRATION AS PEER SUPPORT SPECIALIST ( )
REGISTRATION AS PEER SUPPORT SPECIALIST ( )

Pursuant to KRS 309.0831(7), I attest to being in recovery for a minimum of one (1) year from a substance-related disorder.

_______________________________________ _______________________________
Signature (Must not be printed or typed) Date

____
Printed Name

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PEER SUPPORT SPECIALIST
ALCOHOL / DRUG TRAINING VERIFICATION FORM

In accordance with 201 KAR 35:050, Section 1 (1), an applicant seeking registration as an alcohol and drug peer support specialist shall complete forty (40) classroom hours, which shall include:

1. Sixteen (16) hours of interactive training in ethics of which eight (8) hours shall consist of face-to-face ethics training;
2. Three (3) hours of domestic violence training;
3. Two (2) hours of training in transmission, control, treatment and prevention of the human immunodeficiency virus;
4. Ten (10) hours of advocacy training;
5. Ten (10) hours of training in mentoring and education; and
6. Ten (10) hours of training in recovery support

.

(Make as many copies of these pages as needed. Number each page.)

ETHICS TRAINING (16)

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

Total Number of Hours: _______________

HIV TRAINING (2)

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

Total Number of Hours: _______________

MENTORING AND EDUCATION TRAINING (10)

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

Total Number of Hours: ______________

RECOVERY SUPPORT TRAINING (10)

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

Total Number of Hours: ______________

ADVOCACY TRAINING (10)

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

Total Number of Hours: ______________

DOMESTIC VIOLENCE TRAINING (3)

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

Total Number of Hours: ______________

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PEER SUPPORT SPECIALIST SUPERVISORY AGREEMENT

To Be Completed By Applicant and Supervisor

INSTRUCTIONS

1. This form is to be used with Microsoft Word.
2. Press the TAB key to skip to the next field.
3. Once you have completed the form, you must print the form, and apply your handwritten signature. Forms submitted without the appropriate signatures will be returned.
4. The completed form may be submitted to the Kentucky Board of Alcohol and Drug Counselors either by mail to P.O. Box 1360, Frankfort, Kentucky 40602 or by delivery to 500 Mero Street, 2SC32, Frankfort, Kentucky 40601.

SECTION 1
APPLICANT INFORMATION

First Name	Middle Name	Last Name
/ /	( ) -	( ) -
Social Security Number	Home Telephone	Work Telephone

Email Address

Street Address

City	State	Zip Code

SECTION 2
SUPERVISOR INFORMATION

First Name	Middle Name	Last Name

Email Address

Street Address

City	State	Zip Code
( ) -		
Telephone Number	Type of License/Certification Held and Number	

/ /	/ /
Date of issue (attach a copy)	Expiration Date (Attach a copy)

Date of Board Approved Supervision Training (Attach copy of certificate of attendance)	Number of Supervisee's Currently Providing with Board Approved Supervision

SECTION 3
INFORMATION RELATED TO SUPERVISED EXPERIENCE

Applicant Name ____

Name of organization or agency where experience will be gained (complete a separate form for each setting.)

____

____
Street Address of Organization or Agency

____
City State Zip Code

Average number of hours expected to be gained per week: ______________________________

Type of Setting:
- ☐ State/Government Agency
- ☐ Non-Profit
- ☐ School
- ☐ Hospital
- ☐ DUI/Private Practice
- ☐ Rehab Center

Type of peer support/counseling experience to be gained (check all that apply):

- ☐ Rehabilitation Center
- ☐ Child & Adolescent
- ☐ Adult
- ☐ Family Treatment
- ☐ Other
- ☐ Judicial/Corrections
- ☐ Individual Counseling
- ☐ Group Counseling

____
Describe

Describe specifically, and in detail, what work experience will be obtained to meet the criteria for Recovery Support work experience in the four (4) domains: (1) advocacy; (2) ethical responsibility; (3) mentoring and education; and (4) recovery and wellness support. Work experience shall not include counseling. (201 KAR 35:070)

____
____
____
____
____
____
____
____

Describe specifically, and in detail, how supervision will focus on recovery support in the four (4) domains: (1) advocacy; (2) ethical responsibility; (3) mentoring and education; and (4) recovery and wellness support.(201 KAR 35:070)

____
____
____
____
____
____
____

I, as applicant, affirm that all information provided by me on this form is true and accurate and I affirm the following:

- That I have read the board Law and Regulations related to supervised experience and that all supervised experience will be completed in accordance with board rules;
- That I will meet with my supervisor at a minimum of 2 hours twice a month of documented supervised experience;
- That I will abide by all rules of the board, including ethics requirements;
- That I understand the temporary registration or registration is only valid while I practice under supervision;
- That I notify the board if this supervisory arrangement is terminated; and
- That I understand any additional supervisors and settings shall be approved by the board in advance.

____ ____________________________
Signature of Applicant Date

____
Printed Name

This agreement shall not be effective until the board has issued the letter approving the agreement.

I, as the board approved supervisor of the above named applicant, affirm that all information provided by me on this form is true and accurate and I affirm the following:

- That all supervised experience will be completed in accordance with the Law and Regulations related to supervised experience and all subsequent board rules.
- That I will provide supervision to the above name applicant at least 2 hours twice a month of documented experience.
- That I understand the full professional responsibility for services of the supervisee shall rest with the supervisor.
- That I understand the supervisory arrangement is only valid while my credential remains in good standing.
- That I will notify the board if the supervisory arrangement is terminated.
- That I understand that I shall not serve as a supervisor of record for more than twelve persons obtaining experience for peer support/certification/licensure at the same time.

____ ____________
Signature of Supervisor Date

APPLICANT AND SUPERVISOR SHOULD KEEP A COPY OF THIS FORM FOR RECORDS

BOARD USE ONLY

☐ **Approved by ______ Date: __________________**
(Initials of Reviewer)

☐ **Deferred by by ______ Date: __________________**
(Initials of Reviewer)

____
____

☐ **Denied by ________**
(Initials of Reviewer)

____
____

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PEER SUPPORT SPECIALIST
VERIFICATION OF SUPERVISION

This section must be completed by the applicant and signed by the supervisor. Make as many copies of these pages as needed. Number each page.

Documentation of 25 hours of direct supervision by a Board-Approved Certified Alcohol and Drug Counseloror a Licensed Clinical Alcohol and Drug Counselor must be documented in the four domains: 1. Advocacy; 2. Mentoring/Education; 3. Recovery/Wellness Support; or 4. Ethical Responsibilities. Methods of supervision include: face-to-face, video, or observation.

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

Applicant Name________________________________ **Total Number of Hours** ____________

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SUPERVISION EVALUATION FOR PEER SUPPORT SPECIALIST

(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 ________ (Date) to ________ (Date), which includes approximately hours of face to face 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	2	3	4	5	6
Weak	Fair	Average	Above Average	Superior	NA

____________ A. Respect for client.

____________ B. Care and concern for client.

____________ C. Genuineness with client.

____________ D. Empathy with client.

____________ E. Flexibility with client.

____________ F. Spontaneity with client.

____________ G. Capacity for appropriate self-disclosure.

____________ H. Sense of immediacy.

____________ I. Concreteness.

Applicant's Name ______________________________

Performance Competencies

Evaluate the applicant as you feel he/she demonstrates his/her abilities in the area of recovery support. Mark the rating most nearly descriptive of the applicant's demonstrated skills using the scales given.

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

________ A. Advocacy

________ B. Ethical Responsibility

________ C. Mentoring and Education

________ D. Recovery and Wellness Support

PROFESSIONAL AND ETHICAL CONDUCT:

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

2. Practicing recovery support or advocacy under a false or assumed name or the impersonation of another credential holder 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: ______________________________
   ____

Describe what you believe to be significant strengths and / or deficiencies of the applicant (attach additional pages, if needed):

_____

I recommend ______________________________ for registration as a peer support specialist.
Applicant's Name

I do not recommend ______________________________ for registration as a peer support specialist.
Applicant's Name

Signature: ______________________________ Credential: ______________________________

Current Address: ______________________________

____

Date Signed: ______________