Upper Midwest Indian Council on Addictive Disorders (UMICAD)
P.O. Box 69
L'Anse, Michigan 49946
ph. (906)524-4411
Fax (906)524-4415

General Information Sheet - Certified Alcohol/Drug Counselor Application

I am applying for ________ Certified Alcohol/Drug Counselor I (CADC I) ________ Certified Alcohol/Drug Counselor II (CADC II)

________ Certified Alcohol/Drug Counselor III (CADC III)

________ I have enclosed a copy of my International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse ICRC/AODA Certification examination test results. Or

________ I have enclosed a copy of my UMICAD Written Examination test results.

Also

________ I have enclosed the application fee of $150.00 (please make check payable to UMICAD)

Last Name: ____________________ First Name: ____________________ MI: ________
(please print or type)

List all the following information regarding your current clinical practice site/agency location. (note: if you have an additional clinical practice site(s), copy this page, provide the requested information, and attach it to this General Information Sheet)

Site Name: ____________________ Telephone # ____________________

Street: ____________________ Fax # ____________________

City/Township ____________________ Email: ____________________

County: ____________ State: ____________ Zip Code: ____________

Your Title: ____________________ How many hours per week at this site: ________

Home Address: ____________________ Telephone # ____________________

City/Township ____________________ Email: ____________________

County: ____________ State: ____________ Zip Code: ____________ S.S. # ____________

I have asked the certified counselor or certified clinical supervisor (CADC II, CADC III, CCS I, or CCS II) who supervised my substance use disorder counseling experience to complete the COUNSELOR EVALUATION FORM:

Supervisor's Name: ____________________ Credential(s) ____________ Phone# ____________

I have asked the following persons to complete and forward counselor professional reference forms to The Upper Midwest Indian Council On Addictive Disorders (UMICAD). (Please list three people, other than your supervisor, who know you professionally and can assess your AODA work, knowledge and skills.).

Name of Reference	Credential(s)	Telephone

ASSURANCES

I. I certify that all the enclosed application materials were prepared by me; and are true and correct

II. I hereby acknowledge receipt of the Upper Midwest Indian Council on Addictive Disorder, Inc. (UMICAD) counselor *code of conduct* and do agree to its terms.

III. I understand that the UMICAD credential certificate remains the property of the UMICAD.

IV. I understand that if my counselor certification is suspended or revoked as a result of my breaching the UMICAD counselor *code of conduct,* I will return my credential certificate to the UMICAD Office immediately.

Name: ______________________________
(please print or type)

Signature: ______________________________

Date: ______________

Note: The remaining questions and responses are optional. Your responses will be held confidential; and **will not affect** the decisions made concerning your application for a UMICAD counselor classification. Your responses continue to provide valuable information which allows the UMICAD to evaluate current trends in the AODA profession. The UMICAD would appreciate your responding to the following questions.

What is your date of birth? ______________

What is your Gender? ______ Male ______ Female

What is your ethnic background?

______ African American ______ Asian American ______ Caucasian

______ Multiracial ______ Hispanic/Latino ______ Native American

______ Other: ______________________________
(please specify)

Last Name ______________________ First Name ______________________

EDUCATION & TRAINING RESUME

COURSE/CLASSROOM INFORMATION

Complete a copy of this form for each course/seminar attended. **USE ONE PAGE PER COURSE**

(See certification handbook pages for requirements and directions on completing this form)

Training Offered By: ______________________

Trainer's Name: ______________________

Trainer's Agency: ______________________

Title of Course, Seminar, Conference track, etc: ______________________

Number of CEU's ____________

Description of Content: ______________________

This Course, Seminar, Conference track, etc. was endorsed by: ______________________

PROFESSIONAL EXPERIENCE RESUME

LAST NAME: ______________________ FIRST NAME: ______________________

see certification handbook for requirements and directions on completing this form

(6000 hours of supervised work experience specific to the ADC Domains)

In the past ________ months, I have spent ____________ hours counseling in one-to-one, family and groups. How many of these hours were spent counseling using an individual modality setting (one-to-one)? ____________

please list positions chronologically beginning with present position (or most recent position if not currently working).

Present position Dates of Employment from ____________ to ____________ @ ________ Hours per week

Total hours worked at present position ________ of which ________ hours in S.U.D. counseling and ________ hours of other counseling.

Agency name: ______________________

Agency address: ______________________

City: ____________ State: ____________ Zip: ____________ Ph: ____________

Your job title: ______________________ Supervisor's name: ______________________

Supervisor's title/credentials: ______________________

1) In this position, I have spent ____________ hours performing direct client counseling in one-to-one, family, and groups.

2) Of the hours listed above in blank 1, how many hours were spent counseling the **substance use disorder client** in one-to-one, family, and groups? ____________

3) Of the hours listed above in blank 2, how many hours were spent counseling the **substance use disorder client** using an individual modality (one-to-one)? ____________

Describe all duties and function in this position below (attach copy of agency job description)

Present # 2 Dates of Employment from ____________ to ____________ @ ________ Hours per week

Total hours worked at present position ________ of which ________ hours in S.U.D. counseling and ________ hours of other counseling.

Agency name: ______________________

Agency address: ______________________

City: ____________ State: ____________ Zip: ____________ Ph: ____________

Your job title: ______________________ Supervisor's name: ______________________

Supervisor's title/credentials: ______________________

1) In this position, I have spent ____________ hours performing direct client counseling in one-to-one, family, and groups.

2) Of the hours listed above in blank 1, how many hours were spent counseling the **substance use disorder client** in one-to-one, family, and groups? ____________

3) Of the hours listed above in blank 2, how many hours were spent counseling the **substance use disorder client** using an individual modality (one-to-one)? ____________

Describe all duties and function in this position below (attach copy of agency job description)

PROFESSIONAL EXPERIENCE RESUME

LAST NAME: ______________________ FIRST NAME: ______________________

see certification handbook for requirements and directions on completing this form (6000 hours of supervised work experience specific to the ADC Domains)

In the past ________ months, I have spent ____________ hours counseling in one-to-one, family and groups. How many of these hours were spent counseling using an individual modality setting (one-to-one)? ____________

please list positions chronologically beginning with present position (or most recent position if not currently working).

Present # 3 Dates of Employment from ____________ to ____________ @ ________ Hours per week

Total hours worked at present position ________ of which ________ hours in S.U.D. counseling and ________ hours of other counseling.

Agency name: ______________________

Agency address: ______________________

City: ______________ State: ____________ Zip: ____________ Ph: ____________

Your job title: ______________________ Supervisor's name: ______________________

Supervisor's title/credentials: ______________________

1) In this position, I have spent ____________ hours performing direct client counseling in one-to-one, family, and groups.

2) Of the hours listed above in blank 1, how many hours were spent counseling the **substance use disorder client** in one-to-one, family, and groups? ____________

3) Of the hours listed above in blank 2, how many hours were spent counseling the **substance use disorder client** using an individual modality (one-to-one)? ____________

Describe all duties and function in this position below (attach copy of agency job description)

Present # 4 Dates of Employment from ____________ to ____________ @ ________ Hours per week

Total hours worked at present position ________ of which ________ hours in S.U.D. counseling and ________ hours of other counseling.

Agency name: ______________________

Agency address: ______________________

City: ______________ State: ____________ Zip: ____________ Ph: ____________

Your job title: ______________________ Supervisor's name: ______________________

Supervisor's title/credentials: ______________________

1) In this position, I have spent ____________ hours performing direct client counseling in one-to-one, family, and groups.

2) Of the hours listed above in blank 1, how many hours were spent counseling the **substance use disorder client** in one-to-one, family, and groups? ____________

3) Of the hours listed above in blank 2, how many hours were spent counseling the **substance use disorder client** using an individual modality (one-to-one)? ____________

Describe all duties and function in this position below (attach copy of agency job description)

EXPERIENCE FOR EDUCATION OPTION

LAST NAME: ______________________________ FIRST NAME: ______________________

**<u>appropriate non UMICAD accredited Master's/Doctorate Degree:</u> A clinically focused Master's/Doctorate degree from an accredited school of higher education with a course of study in human services (i.e. community counseling, mental health, social work, rehabilitation counseling, or psychology) UMICAD reserves the right to disqualify any course of study it deems does not meet standard.*

I have completed: (check only one)

____ a master's or doctorate degree from a accredited academic based institution. I am counting my degree for 4000 hours of work experience and 500 hours direct substance use disorder (S.U.D.) counseling experience and 125 hours of S.U.D. counseling one-to-one

____ a master's or doctorate degree from a non accredited academic based institution. I am asking for approval to count my degree for 4000 hours of work experience and 500 hours direct substance use disorder (S.U.D.) counseling experience and 125 hours of S.U.D. counseling one-to-one

____ a baccalaureate degree from a accredited academic based institution. I am counting my degree for 2000 hours of work experience and 250 hours direct substance use disorder (S.U.D.) counseling experience and 67 hours of S.U.D. counseling one-to-one

____ an associate degree from a accredited academic based institution. I am counting my degree for 1000 hours of work experience and 125 hours direct substance use disorder (S.U.D.) counseling experience and 33 hours of S.U.D. counseling one-to-one

<u>I have enclosed documentation of my degree (an official university transcript indicating completion of the course of study and the award of a degree). Do not send originals</u>

College/University: ______________________________

Location (City, State): ______________________________

Human Services area: ______________________________

Academic Degree awarded: ______________________________

Date Degree awarded: ______________________________

Your full name(s) during the time you attended above institution (if different than name appearing throughout this application): ______________________________

CORE FUNCTION TRAINING

LAST NAME: ______________________________ FIRST NAME: ______________________

CORE FUNCTION TRAINING REQUIREMENT; 300 HOURS (10 hrs minimum in each domain or 12 core function)

Name of Supervisor/Trainer: ____

Supervisor's Credentials:

____ CADC II*	Certification Number:	____________________
____ CADC III*	Certification Number:	____________________
____ CCS I	Certification Number:	____________________
____ LADC	License Number:	____________________
____ CSW**		
____ Licensed Physician**		
____ Licensed Psychologist**		
____ Other/Specify	____________________	

Supervisor's Title: ____

Agency Name: ________________________ Agency Address: ____________________

City: ________________________ State: __________________ Zip: __________

Agency Phone # ________________________

Please indicate number of hours spent in each core function:

(see minimum hours required in each core function area in the certification handbook)

Screening	______	Case Management	______
Intake	______	Crisis Intervention	______
Orientation	______	Client Education	______
Assessment	______	Referral	______
Treatment Planning	______	Reports & Record Keeping	______
Counseling	______	Consultation	______
		Total Hours	______

If you received core function training in more than one agency or from more than one trainer, please duplicate this form using one copy for each agency and/or trainer

COUNSELOR EVALUATION FORM FOR: ______________________________

(print applicant's name)

*****CONFIDENTIAL*****

Dear Certified Clinical Supervisor or Certified Counselor,

Your employee listed above is applying to the Upper Midwest Indian Council on Addictive Disorders (UMICAD) for certification as a Certified Alcohol and Drug Counselor. The information requested is an essential part of the Board's evaluation of the competence of the applicant and must be on file before the application can be processed.

The UMICAD believes that your observation will have developed a more complete and accurate impression of the knowledge and skills of the applicant than is available from other sources. Your evaluation plus that received from the other references and the data furnished by the applicant will be used in determining eligibility for certification. The process is only as good as you and the others make it be careful and truthful reporting.

Please complete all information and return the evaluation form within one week. Your cooperation is very much appreciated

Supervisor's Name:	SUPERVISOR, PLEASE NOTE: In the scale listed below, a rating of:
Title & Credentials:	1 is equivalent to Poor 2 is equivalent to Fair 3 is equivalent to Acceptable 4 Is equivalent to Good 5 is equivalent to Excellent
Agency:	
Agency Address:	On the basis of your knowledge of the above named counselor, rate his/her skill in each area listed below. Circle the appropriate number or check the other box.
City/State/Zip	
Agency phone #	

Areas of Skill	Poor Excellent	Don't Know	Not Applicable
1. Exhibits skill in active listening (attending, paraphrasing)	1 2 3 4 5		
2. Exhibits skill in probing	1 2 3 4 5		
3. Exhibits skill in summarizing	1 2 3 4 5		
4. Exhibits skill in reflection	1 2 3 4 5		
5. Exhibits skill in interpretation	1 2 3 4 5		
6. Exhibits skill in confrontation	1 2 3 4 5		
7. Exhibits skill in self-disclosure	1 2 3 4 5		
8. Exhibits warmth	1 2 3 4 5		
9. Exhibits respect	1 2 3 4 5		
10. Exhibits empathy	1 2 3 4 5		

11. exhibits concreteness	1 2 3 4 5		
Areas of Skill	**Poor Excellent**	**Don't Know**	**Not Applicable**
12. Exhibits empathy	1 2 3 4 5		
13. Skill in recognizing and clarifying dysfunctional behavior and its ramifications for the individual client	1 2 3 4 5		
14. Skill in motivation the client to actively participate in treatment.	1 2 3 4 5		
15. Skill in the practical use of three counseling approaches other than self-help groups, which are appropriate for treatment of the individual alcohol/drug abusing/dependant client	1 2 3 4 5		
16. Skill in the practical use of group counseling techniques	1 2 3 4 5		
17. Skill in the appropriate selection of individual, group and/or family counseling approaches according to individualized client needs.	1 2 3 4 5		
18. Skill in assessing and intervening in crisis, including assessment of dangerousness to self or others.	1 2 3 4 5		
19. Skill in developing and implementing individualized treatment plans according to identified client needs.	1 2 3 4 5		
20. Skill in problem-solving techniques, goal setting and decision making in conjunction with clients.	1 2 3 4 5		
21. Skill in termination of counseling.	1 2 3 4 5		
22. Skill in client intake process.	1 2 3 4 5		
23. Skill in initial and on-going client evaluation process.	1 2 3 4 5		
24. Skill in interpretation and assessment of case records.	1 2 3 4 5		
25. Skill in evaluating and periodically updating or modifying the treatment plan and its strategies.	1 2 3 4 5		
26. Skill in identifying the additional resources and services best suited for the individual client.	1 2 3 4 5		
27. Skill in directing the client to additional resources and services	1 2 3 4 5		
28. Skill in maintaining follow-up with the client and with service providers to assure that the client's needs are met	1 2 3 4 5		
29. Skill in the efficient productive handling and coordination of, and involvement with, clients throughout the treatment process, from initial intervention or intake through disposition, termination and follow-up.	1 2 3 4 5		
30. Skill in the maintenance of up-to-date, accurate and understandable case files and records, including history, intake, treatment plan, progress notes, reports and correspondence, referral dispositions and termination or discharge summary.	1 2 3 4 5		
31. Skill in treating client files and records in accordance with the client's best interest and with all federal, state, local and agency regulations, especially those regulations governing confidentiality. This includes disclosures that occur in the discussion of confidential material as part of intra-or-inter-agency stuffing's, consultation, referral or client advocacy.	1 2 3 4 5		
32. Skill in verbal and written communication with professional colleagues and clients.	1 2 3 4 5		

SUPERVISOR'S STATEMENT

I hereby certify that I have been in a position to observe and have first-hand knowledge of

______________________________ work at ______________________________

I have observed the applicant's work from ________________ to ________________

(mm/dd/yy) (mm/dd/yy)

Describe the procedures you have used to supervise and evaluate the applicant below (attach additional sheets if necessary):

I HEREBY CERTIFY THAT THIS RATING IS, TO THE BEST OF MY KNOWLEDGE, TRUTHFUL AND REFLECTS AS ACCURATELY AS POSSIBLE MY KNOWLEDGE OF THE APPLICANT.

Signature

Date

THE UMICAD CERTIFICATION BOARD, INC. RESERVES THE RIGHT TO REQUEST FURTHER INFORMATION FROM YOU CONCERNING THIS APPLICANT.

DO NOT RETURN THIS FORM TO THE APPLICANT!! Return this form directly to:

UMICAD
P.O. Box 69
L'Anse, Michigan 49946

COUNSELOR PROFESSIONAL REFERENCE FORM FOR: ______________________________

(print applicant's name)

The applicant listed above is applying to the Upper Midwest Indian Council on Addictive Disorders (UMICAD) for certification as a Certified alcohol and Drug Counselor. References must be included as part of the application. We ask that you please **complete both sides** of this reference form and forward it to the Certification Board as soon as possible.

the UMICAD believes that certification should be based on input from a variety of sources including the observations of persons who have known the applicant **professionally.** For this reason, all applicants are required to list three persons who will complete this reference form. Your evaluation plus those received from others and the data furnished by the applicant will be used in determining eligibility for certification. The process is only as good as you and the others make it by careful and truthful reporting.

Please complete all information and return the evaluation form within one week. Your cooperation is very much appreciated

	PLEASE NOTE: In the scale listed below, a rating of:
(Person completing reference form) please print or type	1 is equivalent to Poor
Name:	2 is equivalent to Fair
Title & Credentials:	3 is equivalent to Acceptable
Agency:	4 Is equivalent to Good
Agency Address:	5 is equivalent to Excellent
City/State/Zip	On the basis of your knowledge of the above named counselor, rate his/her skill in each area listed below. Circle the appropriate number or check the other box.
Agency phone #	

Areas of Skill	Poor Excellent	Don't Know	Not Applicable
1. Common Sense	1 2 3 4 5		
2. Poise	1 2 3 4 5		
3. Enthusiasm	1 2 3 4 5		
4. Reliability	1 2 3 4 5		
5. Personal and Professional Honesty	1 2 3 4 5		
6. Empathy	1 2 3 4 5		
7. Ability to Work with Others	1 2 3 4 5		
8. Ethics	1 2 3 4 5		
9. Knowledge of AODA field	1 2 3 4 5		
10. Effectiveness of Counseling Approach and Techniques	1 2 3 4 5		
11. Appropriateness of Counselor - Counselee Relationships	1 2 3 4 5		

12. Communication Skills	1 2 3 4 5		

GENERAL REMARKS: ______________________________

I HEREBY CERTIFY THAT THIS RATING IS, TO THE BEST OF MY KNOWLEDGE, TRUTHFUL AND REFLECTS AS ACCURATELY AS POSSIBLE MY KNOWLEDGE OF THE APPLICANT.

I have known the applicant listed on the other side for ________ years. My relationship with applicant was/is

____

(indicate nature of relationship such as co-worker, colleague, etc.)

____

Signature

____

Date Signed

THE UMICAD CERTIFICATION BOARD, INC. RESERVES THE RIGHT TO REQUEST FURTHER INFORMATION FROM YOU CONCERNING THIS APPLICANT.

DO NOT RETURN THIS FORM TO THE APPLICANT!! Return this form directly to:

UMICAD
P.O. Box 69
L'Anse, Michigan 49946

Continuing Education Form

List each training course, seminar, workshop, etc., date(s), contact hours, substance abuse specific or related using this format.

DO NOT ATTACH DOCUMENTATION (make copies of this form if additional space is required.)

Applicant Name | Date

Title of Training | Contact Hours | Specific/Related

Endorsed by | Date(s) of training

Title of Training | Contact Hours | Specific/Related

Endorsed by | Date(s) of training

Title of Training | Contact Hours | Specific/Related

Endorsed by | Date(s) of training

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Applicant Name | Date

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