RHODE ISLAND BOARD FOR CERTIFICATION OF CHEMICAL DEPENDECY PROFESSIONALS
31 Smith Avenue - 3 Rear - Greenville, RI 02828
Phone: (401) 349-3822 FAX (401) 349-3833

PLEASE CHECK ONE: ________ACDP _________ACDP II (Master's level)
Testing Date Requested: _____March _____June _____September _____December

APPLICATION FOR CERTIFICATION AS AN ADVANCED CHEMICAL DEPENDENCY PROFESSIONAL II or ADVANCED CHEMICAL DEPENDENCY PROFESSIONAL

NOTE: A mandatory prerequisite for licensure is the applicant's Certification as an Advanced Chemical Dependency Professional II, Advanced Chemical Dependency Professional or equivalent certification from another State.

1. Full Name:____
   First Middle Last (Maiden)

2. Residence Address:____
   Street City/Town State Zip Code

3. Mailing Address:____
   Street City/Town State Zip Code

4. Telephone Number: (Home) ______________________ (Work) ________________________________

5. Social Security Number: _____________________ Email:____

6. Highest Educational Degree: __________________________ Granted By: __________________________
   (Institution)

7. Other Colleges/Universities attended:
   College Dates Degree/Sem. Hrs. to Date Major
   ____
   ____

8. Have you ever been licensed/certified in any state?______________________________________
   If yes, give state(s), date of licensure, license number, current status, expiration date(s).
   ____

9. Have you ever been convicted of a felony violation of any state or federal law? ______
   If yes, explain by attachment. NOTE: Non-disclosure may be grounds for denial of licensure.

10. Have you ever had any disciplinary actions against any license including, but not limited to: Revocation, suspension, or probation?____

11. If Yes, identify type of license sanctioned, state license was sanctioned in, what type of sanction was/is against your license, and date of sanction____

12. Optional Information:
    Race: ___Caucasian ____Black/Afro American ____Asian ____Hispanic ____American Indian/Alaskan Native ____Other

    Requested Test Language: Please check only one ___English ____French ____Spanish

Please note: When selecting TEST DATES, applicants must take the written examination on the test date selected. The RIBCCDP is charged $70.00 for each written examination ordered whether it is used or not. If an applicant does not take the written examination on the test date they have selected, a test fee of $70.00 will be required to sit for the next test date.

ASSURANCE AND RELEASE

I______________________________, of _________________________________ do hereby submit the following information, assurances and release relating to my initial certification or renewal of certification/licensure with the Rhode Island Board for the Certification of Chemical Dependency Professionals (RIBCCDP)/Rhode Island Board for Licensing of Chemical Dependency Professionals (RIBLCDP)

I acknowledge and understand in answering the following questions that submitting fraudulent, deceitful or misleading statements will be grounds for denial or revocation of certification or renewal of certification.

Have you ever applied for certification/licensure as a chemical dependency professional in another state?
____yes ____no

1) Have you ever had any action taken against your certification/license?
____yes ____no
If the answer to Number Two (2) is Yes, please provide details on reverse side

3) Have you ever been disciplined in any way by a Certification/Licensing Board or Professional Organization?
____yes ____no
If the answer to Number Three (3) is yes, please provide details on reverse side.

I hereby certify that I have read this entire application and that all the material contained herein is true, accurate and complete. I further understand that any intentionally false or misleading statements or omissions shall result in the denial or revocation of my certification/license or renewal of certification/license.

I hereby certify that all information contained in this application and any supporting documents is true to the best of my knowledge. I further certify that I do not use any controlled substances or any alcoholic beverages to the extent that the use impairs my ability to conduct with safety to the public the practice authorized by the license for which I am applying.

I hereby certify that I have read and subscribed to the Ethical Standards and Code of Conduct for Chemical Dependency Professionals prescribed by RIBCCDP.

- I authorize RIBCCDP/RILBCDP, its members, officers and employees, to investigate my background as it relates to the statements contained in my application and further consent to the release of information by third parties to RIBCCDP/RILBCDP which information relates directly to my application and statements contained therein so long as said information remains confidential.
- I further agree to hold RIBCCDP/RILBCDP, its members, officers, employees and examiner's harmless and free from all liability from complaints, causes of action, suits, claims, demands and damages of every nature or kind pertaining or arising out of or relating in any manner whatsoever to actions taken by RIBCCDP/RILBCDP in investigating my application and making a determination regarding my certification.
- I further authorize the RIBCCDP/RILBCDP to release all documentation/information of application for certification/renewal along with all documentation of ethics complaints, Disciplinary Hearings, and disciplinary sanctions taken against me to the Department of Health, the ICRC/AODA and the Rhode Island Board of Licensing for Chemical Dependency Professionals.

I have read and understand the above.

______________________________	______________________________
Print Name	Witness
______________________________	______________
Signature	Date
______________________________	______________________________
Address	City, State, Zip Code

CLINICAL SUPERVISOR'S EVALUATION FORMS:

I have given the Clinical Supervisor's Evaluation Form to the following Clinical Supervisors.

Name:____
Telephone #:____
Name of Agency:____
Mailing Address:____
____

Name:____
Telephone #:____
Name of Agency:____
Mailing Address:____
____

Name:____
Telephone #:____
Name of Agency:____
Mailing Address:____
____

PROFESSIONAL REFERENCES:

I have requested the following individuals to forward their recommendations to RIBCCDP (Please list three (3) people, other than your supervisors, who know you PROFESSIONALLY and can attest to your PROFESSIONAL SKILLS). Provide your references with a copy of pages 8 to 10. Enclose and envelope addressed to RIBCCDP.

Name: ____
Address:____
Telephone #:____

Name:____
Address:____
Telephone #:____

Name:____
Address:____
Telephone #:____

PLEASE NOTE: The RIBCCDP reserves the right to request further information from all employers and other persons listed on the application form. The RIBCCDP and its review committees reserve the option to request an oral interview with the applicant. This information will be used strictly to evaluate the professional competence of a counselor and will be kept confidential by RIBCCDP. Further information may be requested in order to verify training, employment, etc. This information is not available to other persons without the written consent of the applicant.

RHODE ISLAND BOARD FOR THE CERTIFICATION OF
CHEMICAL DEPENDENCY PROFESSIONALS
31 Smith Avenue - 3 Rear
Smithfield, Rhode Island 02917

CLINICAL SUPERVISOR'S REFERENCE FORM
CONFIDENTIAL

Dear Clinical Supervisor:

Your employee named on the accompanying form is applying to the Rhode Island Board for the Certification of Chemical Dependency Professionals (RIBCCDP) and Rhode Island Board for Licensing of Chemical Dependency Professionals (RILBCDP) for certification/licensure as indicated below. The information requested here 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.

Requirements for Clinical Supervisors:

Clinical Supervisor credentials:

1) Chemical Dependency Clinical Supervisor (CDCS/LCDS), or;
2) Master's degree in Behavioral Sciences with two (2) years clinical experience and documentation of 120 clock hours Substance Abuse Specific training. Included in this 120 clock hours must be 30 hours chemical dependency clinical supervisor education which includes training in the following Domains: Assessment/Evaluation, Counselor Development, Management/Administration, and Professional Responsibilities, or;
3) LCDP/ACDP or LCDP/ACDP II with 30 clock hours Clinical Supervisor training. This training must include education in the following Domains: Assessment/Evaluation, Counselor Development, Management/Administration, and Professional Responsibilities, or;
4) Ph.D. in Behavioral Science or M.D. with documentation of two (2) years of specialization/experience in the Chemical Dependency field, or;
5) Recognized Clinical Supervisor (RCS)

RIBCCDP believes that you, as a Clinical Supervisor, 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 together with those received from other references and the data furnished by the applicant will be used to determine eligibility for certification. The process can be only as good as you and others make it by careful and truthful reporting.

The Rhode Island Certification Board reserves the right to request further information from you concerning this applicant. Your cooperation will be very much appreciated in this certification effort.

Please return the completed evaluation along with documentation of the above requirements or a copy of your RCS certificate.

RIBCCDP
_____ACDP II
_____ACDP

CLINICAL SUPERVISOR'S EVALUATION FORM

APPLICANT:_________________________________ DATE:______________________

CLINICAL SUPERVISOR:____

SUPERVISOR'S CREDENTIALS:____

TELEPHONE #:_________________________ PROGRAM:________________________

ADDRESS:____

A.The following items represent the skills needed by a Chemical Dependency Professional. Evaluate the above named applicant as you feel he/she demonstrates their abilities in each area. Mark the rating most nearly descriptive of the counselor's demonstrated skills.

PLEASE NOTE: Make your evaluations using the scale below.

A rating of 1 is equivalent to NOT APPLICABLE
2 is equivalent to DON'T KNOW
3 is equivalent to POOR
4 is equivalent to AVERAGE
5 is equivalent to ABOVE AVERAGE
6 is equivalent to SUPERIOR

NOTE: The applicant must earn an average of 4 & be recommended by their supervisor to qualify for licensure.

1 2 3 4 5 6

{} {} {} {} {} {} 1. **Screening**- The process by which a client is determined appropriate and eligible for admission to a particular program.

{} {} {} {} {} {} 2. **Intake-** The administrative and initial assessment procedures for admission to a program.

{} {} {} {} {} {} 3**. Orientation**- Describing the client:
-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.

{} {} {} {} {} {} 4. **Assessment-** Those procedures by which a counselor/program identifies and Evaluates an individual's strengths, weaknesses, problems and needs for the development of the treatment program.

{} {} {} {} {} {} 5. **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 on the treatment methods and resources to be used.

Individual
1 2 3 4 5 6
{} {} {} {} {} {} 6. **Counseling-** (Individual, Group & Significant Others) - The utilization of special skills to assist individuals, families or groups in achieving objectives through:

Group
{}{}{}{}{}{} -exploration of a problem and its ramifications

Significant Others -examination of attitudes and feelings;
-consideration of alternative solutions, and;
{}{}{}{}{}{} -decision making.

1 2 3 4 5 6

{} {} {} {} {} {} 7. **Case Management**- Activities which bring services, agencies, resources of people together within a planned framework of action toward the achievement of established goals. It may involve liaison activities and collateral contracts.

{} {} {} {} {} {} 8. **Crisis Intervention**- Those services which respond to an alcohol/other drug abuser's needs during acute emotional/physical distress.

{} {} {} {} {} {} 9. **Client Education**- Provision of information to individuals and groups, concerning Alcohol and other drug abuse and the available services and resources.

{} {} {} {} {} {} 10**. Referral**- Identifying the needs of a client that cannot be met by the counselor or agency and assisting that client to utilize the support systems and community resources available.

{} {} {} {} {} {} 11. **Reports & Recordkeeping**- Charting the results of the assessment and treatment plan; writing reports, progress notes, discharge summaries and other client- related data.

{} {} {} {} {} {} 12. **Consultation**- Relating with counselors and other professionals in regard to the client treatment (services) to assure comprehensive quality care for the client.

{} {} {} {} {} {} 13. **Relapse Prevention**, discharge planning, follow-up and aftercare.

B. Evaluate the applicant as you observe(d) him/her in the following areas of interpersonal relationships with clients:

1 2 3 4 5 6

{} {} {} {} {} {} 1. Respect for the client.

{} {} {} {} {} {} 2. Care and concern for the client.

{} {} {} {} {} {} 3. Genuiness with client.

{} {} {} {} {} {} 4. Empathy with client

{} {} {} {} {} {} 5. Flexibility with client.

{} {} {} {} {} {} 6. Judgment with client.

{} {} {} {} {} {} 7. Spontaneity with client.

{} {} {} {} {} {} 8. Capacity for confrontation with client.

{} {} {} {} {} {} 9. Capacity for appropriate self-disclosure.

{} {} {} {} {} {} 10. Sense of immediacy.

{} {} {} {} {} {} 12. Ability to set appropriate boundaries.

c. EVALUATORS STATEMENT

Where did you receive your training in counseling?

____

How long have you been employed by this program?

____

Professional certificates or license you hold____

Are you involved in the administration/management of the program at which you are employed?
_____ a) no
_____ b) Yes, limited to clinical aspects (i.e., supervision of counselors)
_____ c) Yes, limited to administrative responsibilities such as budgeting.
_____ d) Yes, both clinically and administratively

What is/was the overall size of his/her substance abuse case-load?
____

Average number of hours per week applicant worked in substance abuse specific individual counseling?
____

Average number of hours applicant worked in substance abuse specific group counseling?
____

Average number of hours applicant worked in substance abuse specific family counseling?
____

Average number of hours per week applicant worked in other significant and related substance abuse activities?
Describe:____
____

Total number of hours per week applicant spent providing substance abuse specific services____________________

For what period of time, have you provided substance abuse specific supervision for this applicant?
From________________ to___________________

Comments/additional information you feel may be pertinent:
____
____

I HEREBY CERTIFY THAT I HAVE BEEN IN A POSITION TO OBSERVE AND HAVE FIRSTHAND KNOWLEDGE OF ___________________________'S WORK AT _____________________________________
(Name of Counselor) (Name of Working Setting)

_____I recommend this applicant for certification
_____I have some reservations in recommending this applicant:
_____I do not recommend this applicant.

I hereby certify that all of the above materials is, to the best of my knowledge, true.

____
Signature Agency Title Date

PLEASE SUBMIT DOCUMENTATION OF THE REQUIRED CREDENTIALS AS STATED ON PAGE 16.

DO NOT RETURN THIS FORM TO APPLICANT - PLEASE RETURN TO THE BOARD.

RHODE ISLAND BOARD FOR THE CERTIFICATION OF CHEMICAL DEPENDENCY PROFESSIONALS

31 Smith Avenue - 3 Rear
Greenville, Rhode Island 02828

R.I Certification Board:

ACDP II - Advanced Chemical Dependency Professional II
ACDP - Advanced Chemical Dependency Professional

Professional Reference Form
Confidential

Dear :____________________________:

I am applying to the Rhode Island Board for the Certification of Chemical Dependency Professionals (RIBCCDP) and Rhode Island Board for Licensing of Chemical Dependency Professionals (RILBCDP) for licensure as indicated below. References must be included as part of the application. Please complete the reference material enclosed and return it to the Board.

Your prompt attention to this would be very much appreciated as my application will not be processed until the Board receives this recommendation from you.

Sincerely,

____
(Signature of applicant)

RIBCCDP believes that licensure should be based on input from a variety of sources, especially the observations of persons who have known the applicant professionally. For this reason, all applicants are required to list three references who will complete this Professional Reference Form. Your evaluation together with those received from others and the data furnished by the applicant will be used in determining eligibility for certification. The process can be only as good as you and others make it by careful and truthful reporting.

Please return the completed evaluation within one week to the Board. Your cooperation will be very much appreciated.

Sincerely,

The Rhode Island Board For The Certification
Of Chemical Dependency Professionals
_____ACDPII
_____ACDP

PROFESSIONAL REFERENCE FORM

Applicant's Name:____

The following areas represent skills and knowledge needed by a Licensed Chemical Dependency Professional. Evaluate the applicant as you feel he/she demonstrates his/her abilities in each area. Mark the rating most nearly descriptive of the counselor's demonstrated ability.

A rating of 1 is equivalent to NOT APPLICABLE
2 is equivalent to DON'T KNOW
3 is equivalent to POOR
4 is equivalent to AVERAGE
5 is equivalent to ABOVE AVERAGE
6 is equivalent to SUPERIOR

1 2 3 4 5 6
{} {} {} {} {} {} 1. Common sense in dealing with client.

{} {} {} {} {} {} 2. Respect for client.

{} {} {} {} {} {} 3. Empathy with client.

{} {} {} {} {} {} 4. Care and concern for client

{} {} {} {} {} {} 5. Flexibility with clients.

{} {} {} {} {} {} 6. Spontaneity with client.

{} {} {} {} {} {} 7. Capacity for confrontation with client.

{} {} {} {} {} {} 8. Capacity for appropriate self-disclosure.

{} {} {} {} {} {} 9. Concreteness.

{} {} {} {} {} {} 10. Ability to treat client information in accordance with state and federal confidentiality regulations.

{} {} {} {} {} {} 11. Ability to communicate effectively with client and co-workers.

{} {} {} {} {} {} 12. Knowledge of the Chemical Dependency field.

{} {} {} {} {} {} 13. Capacity to act in an ethical manner with client.

{} {} {} {} {} {} 14. Problem recognition and evaluation: Ability to apply knowledge of physical, behavioral, attitudinal and effective manifestations of substance abuse to determine its existence and degree of progression.

{} {} {} {} {} {} 15. Counseling: Ability to facilitate appropriate change in client with regard to mood-altering, chemical substances.

{} {} {} {} {} {} 16. Ability to set appropriate limits with clients.

GENERAL REMARKS:

____
____
____
____

Person completing Reference:

Your Name:____

Address:____
# of Street City State Zip

Telephone#:(____)______________________________

Position:____

I hereby have known ______________________________ for ______ years.
(Name of Applicant)

My relationship with him/her was/is____
____

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:____

PLEASE NOTE: APPLICANTS MUST EARN AN AVERAGE OF 4 TO QUALIFY FOR CERTIFICATION.

PHOTOCOPY FORMS AS NEEDED

PLEASE RETURN THIS FORM TO THE BOARD

PROFESSIONAL EXPERIENCE RESUME

Begin with your most recent employment and work backward. Include relevant military service.

EMPLOYER:____

TYPE OF INSTITUTION/ESTABLISHMENT:____________________________

____

FULL ADDRESS:____

NAME OF IMMEDIATE SUPERVISOR:______________________________

SUPERVISOR'S POSITION:____

TITLE OF YOUR POSITION:____

HRS. PER WEEK ______ FROM / / TO / /

YOUR DUTIES AND SPECIALTY:___________________________________
____
____

EMPLOYER:____

TYPE OF INSTITUTION/ESTABLISHMENT:____________________________
____

FULL ADDRESS:____

NAME OF IMMEDIATE SUPERVISOR:______________________________

SUPERVISOR'S POSITION:____

TITLE OF YOUR POSITION:____

HRS. PER WEEK _____ FROM / / TO / /

YOUR DUTIES AND SPECIALTY:___________________________________
____
____

PLEASE PHOTOCOPY THIS FORM AS NEEDED

EXECUTIVE PROGRAM DIRECTOR
EXPERIENCE VERIFICATION FORM FOR ACDP II & ACDP APPLICANTS

I_________________________________ herein certify that ____________________________________has been

employed **within the past five (5) years** as a chemical dependency counselor **, at

____

for ___________hours*, from ______________to________________.

****

I_________________________________ herein certify that_________________________________has been employed

prior to the past five (5) years as a chemical dependency counselor **, at

____

for ___________hours*, from ______________to________________.

This facility is licensed/accredited/recognized by: ____as

a_______________________________effective as of ___________________________________.
Date

____
Signature

____
Date

*<u>**hours must be documented cumulatively (total of hours worked)**</u>
****describes a principle job function. Principle function**
must be chemical dependency counselor.

<u>PLEASE PHOTOCOPY AS NEEDED</u>
<u>ATTACH OFFICIAL JOB DESCRIPTION FROM FACILITIES WHERE EXPERIENCE</u>
<u>IS SUBMITTED FOR CREDIT</u>

TABLE II

TRAINING AND EDUCATION RESUME

A. Substance Abuse Specific Training:

#	TRAINING	DATE ATTENDED	CLOCK HOURS
1	**Confidentiality of Drug & Alcohol Client Records (Required)**		**12**
2	**Ethics (required)**		**6**
3	**HIV/AIDS/Viral Hepatitis Curriculum based risk reduction RIBCCDP approved (Required)**		**6**
4	**12 Hours Medication Assisted Therapy & Attitudes of Medication in the Recovery Process (Will be required as of (6/1/2008)**		**12**
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

TOTAL HOURS ________________________

TABLE II
TRAINING AND EDUCATION RESUME

B. Counselor Training in Knowledge/Skill Base Performance Domains:

#	TRAINING	DATE ATTENDED	CLOCK HOURS
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			

TOTAL
HOURS _______________

TABLE III

The requirements, as outlined, are by group clusters of Core Functions. This grouping of skills acquisitions recognizes that employment sites segment the counselor Core Functions into specific job descriptions. However, the well-rounded counselor will have had minimum supervision in each of the four groups.

"NOTE: A minimum of 20 hours are required in each Core Function for ACDP II/ACDP. However, the total accumulated hours for ACDPII/ACDP must be 300."

	ACDPII/ACDP
GROUP A	
Screening Intake Orientation Assessment	80 HRS.
GROUP B	
Treatment Planning Counseling Case Management Crisis Intervention	120 HRS.
GROUP C	
Client Education Referral	40 HRS.
GROUP D	
Reports and Recordkeeping Consultation Relapse prevention, discharge planning, follow-up and aftercare.	60 HRS.

TOTALS: 300 hrs.

"NOTE: A minimum of 20 hours is required in each Core Function for ACDP II/ACDP. However, the total accumulated hours for ACDP II/ACDP must be 300."

CLINICAL SUPERVISION RECEIVED

CORE FUNCTIONS **# HOURS** **Clin.Sup. Initials**

GROUP A:

Screening - The process by which a client is determined appropriate and eligible for admission to a particular program.

________ ______________
(#Hrs) **(Clin. Sup Initials)**

Intake - The administrative and initial assessment procedures for admission to a program.

________ ______________
(#Hrs) **(Clin. Sup Initials)**

Orientation - Describing to the client: -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.

________ ______________
(#Hrs) **(Clin. Sup Initials)**

Assessment - Those procedures by which a counselor/program identifies and evaluates an individual's strengths, weaknesses, problems and needs for the development of the treatment plan.

________ ______________
(#Hrs) **(Clin. Sup Initials)**

GROUP B:

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 on the treatment methods.

________ ______________
(#Hrs) **(Clin. Sup Initials)**

Counseling - (Individual, Group & Significant Others) The utilization of special skills to assist individuals, families or groups in achieving objective through: exploration of a problem and its ramifications ; examinations of attitudes and feelings; consideration of alternative solutions, and; decision making

________ ______________
(#Hrs) **(Clin. Sup Initials)**

T
TOTAL HOURS___________

Supervisor’s Signature____Date:______________

"NOTE: A minimum of 20 hours is required in each Core Function for ACDP II/ACDP. However, the total accumulated hours for ACDP ii?ACDP must be 300."

CLINICAL SUPERVISION RECEIVED

CORE FUNCTIONS **#HOURS** **Clin.Sup. Initials**

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.

________ ______________
(#Hrs) **(Clin. Sup Initials)**

Crisis Intervention - Those services which respond to an alcohol/drug abuser's needs during acute emotional and/or physical distress.

________ ______________
(#Hrs) **(Clin. Sup Initials)**

GROUP C:
Client Education - Provision of information to individuals and groups, concerning alcohol and other drug abuse and the available services and resources.

________ ______________
(#Hrs) **(Clin. Sup Initials)**

Referral - Identifying the needs of the client that cannot be met by the counselor or agency and assisting the client to utilize the support systems community resources available.

________ ______________
(#Hrs) **(Clin. Sup Initials)**

GROUP D:
Reports and Recordkeeping - Charting the results of the assessments and treatment plan; writing reports, progress notes, discharge summaries and other client-related data.

________ ______________
(#Hrs) **(Clin. Sup Initials)**

Consultation - Relating with counselors and other professionals in regard to client treatment (services) to assure comprehensive quality care for the client.

________ ______________
(#Hrs) **(Clin. Sup Initials)**

Relapse Prevention, discharge planning, follow up and aftercare.

________ ______________
(#Hrs) **(Clin. Sup Initials)**

TOTAL HOURS:__________

Supervisor's Signature____Date:_____________

COMMITTEE ON SPECIAL NEEDS

The Committee on Special Needs was established by the Rhode Island Board for the Certification of Chemical Dependency Professionals in September, 1992, to address and comply with those relevant sections and articles of the American's with Disabilities Act of 1990 (ADA) as they pertain to the RIBCCDP's credentialing and certification/licensure process. The Committee will strive to ensure access to the certification process to all applicants and maintain its certification standards. To this end, the Committee on Special Needs has set forth the following protocol:

1. All portfolios for all credentialed disciplines will include both the statement of need for special accommodations and medical release and/or other source, effective May 1, 1993. The Board shall be responsible for approving these forms, and the Committee will be responsible for ensuring that they are included in all portfolios. The Committee shall be responsible for updating these forms as needed, subject to Board approval.

2. Applicants will be required to submit the request for special accommodations to the Board no less that sixty days prior to the date designated for the administration of the appropriate examination.

3. Applicants will be required to submit the medical release and supporting documentation with the portfolio application by the designated deadline (forty-five days prior to the examination).

4. The Board's Administrative Staff will be responsible for referring all requests for special accommodations to the Committee on Special Needs. The Committee will Approve/Disapprove requests for special accommodations on a case-by-case basis, utilizing the judgment and discretion of the Committee to determine whether the applicant is an "individual with a disability" within the meaning of the ADA and whether the accommodations requested by the applicant are reasonable. A requested accommodation can only be refused if it would fundamentally alter the measurement of the skills or knowledge the exam is intended to test or would result in an undue burden. In cases where a request is denied, the Committee will convey this information to the Board for its consideration and final determination. The Committee shall refer any request to the Board, for accommodations that exceed reasonable financial responsibility in compliance with criteria established by the ADA.

5. The Committee will be responsible for approving the request and making the reasonable accommodations for each of the individual situations. This will include the contracting of interpreters and scribes, as well as securing the necessary equipment. The Committee will establish a comprehensive resource list to facilitate this process.

6. The Committee shall be responsible for ensuring that reasonable accommodations are indeed provided where approved and work with the Quality Assurance Committee to ensure that the standards and criteria of the credentialing process are upheld.

7. Applicant appeals and/or grievances will be directed to the Board for its action to be addressed through the Board's existing procedures.

8. This Board reserves the right to seek legal counsel when necessary for clarification of the ADA law or legal action on the part of an applicant has been indicated.

9. All requests for accommodations and any supporting documentation or medical information must be kept strictly confidential.

Policies for the Written Examination:

1) All translators must be approved by the Board, must not be a friend, relative or co-worker of the applicant and must be able to speak the "standard" language.

2) All translators must follow the exact protocol set forth by the ICRC/AODA for administration of all tests.

3) Translators role is simply to read, not interpret, what is presented; interpretation of questions is inappropriate.

Questions may be repeated if necessary.

4) Translation of questions read is audiotaped.

5) Test is proctored in "standard" language.

6) Time is extended according to ICRC/AODA guidelines.

7) Applicants who request the written examination be translated into their native language must pay all fees incurred. In addition, the applicant must choose an organization approved by the Board to provide this service.

RHODE ISLAND BOARD FOR THE CERTIFICATION OF CHEMICAL DEPENDENCY PROFESSIONALS

ACCOMMODATION REQUEST FORM

The information requested below and any documentation regarding your disability and your request for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission. **Also please supply any documentation (e.g., letter from a physician or other professional, evidence of a prior diagnosis or accommodation, etc.) which support this request.**

NAME:____

ADDRESS:____

____

____

PHONE#:____________________________________ **S.S.#:**___________________

ACCOMMODATIONS REQUESTED FOR THE ___________________**EXAMINATION**

PLEASE CHECK ALL THAT APPLY:

_____Accessible Testing Site
_____Reader as accommodation for visual impairment
_____Scribe as accommodation for visual or motor impairment
_____Scribe as accommodation for learning disability
_____Extended time
_____Time-and-a-half **_____Double time**
_____More than double time (specify):
____
_____Separate testing area
_____Translator (specify standard language)
____
_____Other:
____

Comments:
____

____

Signed:______________________________________ **Date:**_____________________

RHODE ISLAND BOARD FOR THE CERTIFICATION OF CHEMICAL DEPENDENCY PROFESSIONALS

CONSENT FOR THE RELEASE OF HEALTH CARE INFORMATION

Applicant's Name:____

Date of Birth:______________________________

I, ____, hereby authorize

____ to
(Name and Address of Health Care Provider)

disclose and release to the Rhode Island Board for the Certification of Chemical Dependency Professionals, 31 Smith Avenue - 3 Rear, Greenville, Rhode Island 02828, all health care information relevant to the accommodation request made in the attached Accommodation Request Form which is incorporated herewith including, but not limited to, diagnoses and recommendations as to accommodations. This information is needed for the purpose of reviewing my request for accommodation in taking a certification examination.

I understand that I may revoke this consent at any future time in writing and that this consent expires upon completion of the certification process, or two years from the date of this release, whichever is earlier.

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Signature of Applicant

____
Date