



Please check if you are applying for:

Written Examination
 Oral Examination
 Written and Oral Examinations

Date exam passed

Certified Alcohol and Drug Counselor (C.A.D.C.)
 Licensed Clinical Alcohol and Drug Counselor (L.C.A.D.C.)
 Licensure by Reciprocity

Attach two, full-face passport-style photographs (2"x 2") of your head and shoulders, taken within the past six months.

Two photographs are required with each application.

Do not use staples to attach the photographs.

New Jersey Office of the Attorney General
 Division of Consumer Affairs
 State Board of Marriage and Family Therapy Examiners
 Alcohol and Drug Counselor Committee
 124 Halsey Street, 6th Floor, P.O. Box 45040
 Newark, New Jersey 07101
 (973) 504-6582

Application for Licensure as a Clinical Alcohol and Drug Counselor or Certification as an Alcohol and Drug Counselor

Date: _____

A nonrefundable application filing fee of \$75, in the form of a check or money order made out to the State of New Jersey, must be submitted with this application. (Applicants should understand that if the application filing fee is paid with a personal check, and the check is returned by the bank due to insufficient funds, the next step in the licensure or certification process will be delayed until the fee is paid.)

The Division is precluded by law from disclosing to the public the place of residence of licensees or applicants, without their consent. However, you are required to provide an address that may be released to the public in our directories or in response to other requests (by putting a check in the appropriate box). If you provide your place of residence as your public address of record, we will assume that you have consented to have that address be disclosed. If you do not consent to the disclosure of your place of residence, you should provide an address of record other than your place of residence that may be released to the public. One of your addresses must include a street, city, state and ZIP code.

Information that you provide on this application may be subject to public disclosure as required by the Open Public Records Act (OPRA).

Please print clearly. You must answer all of the questions on this application.

Personal Information

Date of birth: _____
Month Day Year

Place of birth: _____
City State Country

1. Name Mr. _____
 Mrs. _____
 Ms. _____
Last name First name Middle initial Maiden name

2. Address

Home: _____
Street or P.O. Box City State ZIP code County

_____ Telephone number (include area code) _____ E-mail address

Business: _____
Name of company Telephone number (include area code)

_____ Street City State ZIP code County

Mailing: _____
Street or P.O. Box City State ZIP code County

6. Illegal Use of Controlled Dangerous Substances

The question below pertains to the illegal use of controlled dangerous substances. Please read the definitions carefully. Your responses will be treated confidentially and retained separately. Please be aware that you have the right to elect not to answer this question if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing. You must fully respond to all other questions on the application. Your application for licensure or certification will be processed if you claim the Fifth Amendment privilege against self-incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question that you have refused to answer on the basis on the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law, (N.J.S.A. 45:1-20).

“Currently” does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, or within the previous 365 days, whichever is longer.

“Illegal use of controlled dangerous substance” means the use of a controlled dangerous substance obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

- a. Are you currently engaged in the illegal use of controlled dangerous substances? (As stated above, “currently” is defined as “recently enough... [to] have an ongoing impact...” or “within the previous 365 days,” whichever is longer.)

Yes No

If you answered “Yes,” are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?

Yes No

Applicant’s signature

Date

7. Have you previously applied for a license or certificate as an Alcohol and Drug Counselor in New Jersey, any other state, the District of Columbia or in any other jurisdiction? Yes No
 If "Yes," when? _____
8. Have you ever passed an oral and/or written alcohol and drug counseling examination in New Jersey, any other state, the District of Columbia or in any other jurisdiction? Yes No
 If "Yes," please attach a copy of your examination scores to this application.
9. Have you ever been summoned; arrested; taken into custody; indicted; tried; charged with; admitted into pre-trial intervention (P.T.I.); or pled guilty to any violation of law, ordinance, felony, misdemeanor or disorderly persons offense, in New Jersey, any other state, the District of Columbia or in any other jurisdiction? (Parking or speeding violations need not be disclosed, but motor vehicle violations such as driving while impaired or intoxicated must be.) Yes No
10. Have you ever been convicted of any crime or offense under any circumstances? This includes, but is not limited to, a plea of guilty, non vult, nolo contendere, no contest, or a finding of guilt by a judge or jury. Yes No
 If "Yes," provide a copy of the judgment of conviction and the release from parole or probation. Please provide a complete explanation. (Attach additional sheets of paper to this application.)
11. Do you currently hold, or have you ever held, a professional license or certificate of **any** kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? Yes No

If "Yes," for each license or certificate held, provide the date(s) held and the number(s). If the license or certificate was issued under a different name, please provide that name. _____

	Last name	First name	Middle initial
_____	_____	_____	_____
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expired
_____	_____	_____	_____
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expired
_____	_____	_____	_____
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expired
_____	_____	_____	_____
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expired
_____	_____	_____	_____
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expired

12. Have you ever been disciplined or denied a professional license or certificate of any kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? Yes No
13. Have you ever had a professional license or certificate of any type suspended, revoked or surrendered in New Jersey, any other state, the District of Columbia or in any other jurisdiction? Yes No
14. Has any action (including the assessment of fines or other penalties) ever been taken against your professional practice by any agency or certification board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? Yes No
15. Have you ever been named as a defendant in any litigation related to the practice of alcohol and drug counseling or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? Yes No
16. Are you aware of any investigation pending against a professional license or certificate issued to you by a professional board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? Yes No
17. Are there any criminal charges now pending against you in New Jersey, any other state, the District of Columbia or in any other jurisdiction? Yes No
18. Have you ever been sanctioned by or is any action pending before any employer, association, society, or other professional group related to the practice of alcohol and drug counseling or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? Yes No

If the answer to any of the above questions, numbers 12 through 18, is "Yes," provide a complete explanation of the circumstances leading to the action, and any supporting documentation, on separate sheets of paper.

Education

1. What is the name and address of the high school you attended? _____
Name of high school

Street address City State /Country ZIP code

2. What years did you attend high school? _____

3. Did you graduate from high school? Yes No

If "Yes," what was the date of your graduation? _____
Month Year

If "No," did you study to receive a G.E.D. certificate? Yes No

If "Yes," please provide the name and address of the educational institution that issued your G.E.D. certificate and the date the certificate was issued.

Name of educational institution

Street address City State ZIP code

Date certificate was issued

4. What is the name and address of the colleges or universities you have attended?

a) _____
Name of college or university

Street address City State ZIP code

b) _____
Name of college or university

Street address City State ZIP code

c) _____
Name of college or university

Street address City State ZIP code

d) _____
Name of college or university

Street address City State ZIP code

5. List all of the degrees that you have received from recognized colleges or universities. Please have each college or university forward to the Committee the **official transcript** for each degree that you have earned. (See page 7.)

Educational institution	Inclusive years	Title of Degree, Diploma or Certificate	Major	Date granted
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Graduate Level Academic Course Work for L.C.A.D.C.

(You should supply the information on this page only if you are applying for recognition as a Licensed Clinical Alcohol and Drug Counselor.)

As set forth in the regulations, the graduate semester hours in course work will include graduate semester hours received in the following areas. Please list which courses indicated on your transcript(s) satisfy the relevant areas. Only graduate courses should be listed, not undergraduate course work. If you were enrolled in a combined bachelor's/master's program, only the master's level course work will be accepted. Doctoral course work may also be accepted. Each course may be listed only once.

Area	Course title and Course number	Hours <small>(Indicate semester hours)</small>	College/University
Counseling theory and practice.	a. _____ b. _____ c. _____	_____ _____ _____	_____ _____ _____
The helping relationship.	a. _____ b. _____ c. _____	_____ _____ _____	_____ _____ _____
Human growth and development, and maladaptive behavior.	a. _____ b. _____ c. _____	_____ _____ _____	_____ _____ _____
Lifestyle and career development.	a. _____ b. _____ c. _____	_____ _____ _____	_____ _____ _____
Group dynamics, processing, counseling and consulting.	a. _____ b. _____ c. _____	_____ _____ _____	_____ _____ _____
Assessment of individuals.	a. _____ b. _____ c. _____	_____ _____ _____	_____ _____ _____
Social and cultural foundations.	a. _____ b. _____ c. _____	_____ _____ _____	_____ _____ _____
Research and evaluation.	a. _____ b. _____ c. _____	_____ _____ _____	_____ _____ _____
The counseling profession.	a. _____ b. _____ c. _____	_____ _____ _____	_____ _____ _____
Pharmacology and Physiology.	a. _____ b. _____ c. _____	_____ _____ _____	_____ _____ _____

(All applicants must complete and submit Schedules A and B which are included in this application.)

Academic Degree Verification
(Only for Licensed Clinical Alcohol and Drug Counselor Applicants)

Applicant's name (please print): _____

Name appearing on transcripts or diplomas (if different from above):

Social Security number of applicant: _____

College/university _____

Degree awarded: _____ Major: _____

Date degree was granted: _____

I hereby authorize the college or university above to forward a certified copy of my transcript directly to the:

State Board of Marriage and Family Therapy Examiners
Alcohol and Drug Counselor Committee
124 Halsey Street, 6th Floor
P.O. Box 45040
Newark, NJ 07101

Note: Applicants should send this form directly to the college/university with the fee required by the college or university. The application process cannot proceed until we receive the official transcript.

Date : _____

Applicant's name (please print): _____

Applicant's signature: _____

Applicant's address _____

AFFIDAVIT

This affidavit is to be executed by the applicant before a notary public:

State of: _____

County of: _____

} ss.

In completing this affidavit and application form, I swear (or affirm) that the information provided is true, including all copied documents to the best of my knowledge and belief. I understand that any omission, inaccuracies, or failure to make full disclosures may be deemed sufficient to deny licensure or certification or to withhold renewal of or suspend or revoke a license or certificate issued by the Committee and may subject the applicant to other penalties.

I further swear (or affirm) that I have read N.J.S.A. 45:2D-1 et seq., together with the Rules and Regulations of the Alcohol and Drug Counselor Committee, N.J.A.C. 13:34C-1 through 6.4, and fully understand that in receiving licensure or certification from the Committee, I bind myself to be governed by them.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for licensure or certification. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Committee.

I hereby authorize the Addiction Professionals Certification Board of New Jersey, Inc. or any other state alcohol and drug certification board, to release to the Alcohol and Drug Counselor Committee and the State Board of Marriage and Family Therapy Examiners any and all records concerning allegations of ethical or professional violations made against me during the period when I was licensed or certified by that body, or whether my licensure or certification has ever been denied, suspended or revoked.

Applicant's signature

Sworn and subscribed to before me this _____

day of _____, _____
Month Year

Name of Notary Public (please print)

Signature of Notary Public



Schedule A

Supervisor's Forms

300 Hours of Supervised Practical Training

If you have been previously certified as an alcohol and drug counselor by an International Certification Reciprocity Consortium affiliated board, you may submit verification from the Addiction Professionals Certification Board of New Jersey in lieu of completing Schedule A.

Please put a check in the box next to the type of application you are submitting.

L.C.A.D.C. application C.A.D.C. application

Applicant's name: _____

Supervisor(s) name: _____

You should send a photocopy of this page to **every** supervisor and/or agency that provided this training.

(All practicum hours must have been completed within the three-year period immediately preceding the submission of this application.)

Core functions of alcohol and drug counseling	Hours required	When completed (month/year)	Supervisor's signature
1. Screening	15 hours	_____	_____
2. Intake	15 hours	_____	_____
3. Orientation	15 hours	_____	_____
4. Assessment	15 hours	_____	_____
5. Treatment Planning	35 hours	_____	_____
6. Individual Counseling	35 hours	_____	_____
7. Group Counseling	35 hours	_____	_____
8. Family Counseling	30 hours	_____	_____
9. Case Management	20 hours	_____	_____
10. Crisis Intervention	15 hours	_____	_____
11. Client Education	15 hours	_____	_____
12. Referral	15 hours	_____	_____
13. Consultation	15 hours	_____	_____
14. Reports/Recordkeeping	25 hours	_____	_____

I hereby certify that the supervised hours listed above were completed as noted.

Applicant's signature

Date

Documentation of 3,000 Hours of Related Work Experience Pursuant to N.J.A.C. 13:34C-2.3(b)

Please put a check in the box next to the type of application you are submitting.

L.C.A.D.C. application C.A.D.C. application

Instructions: This form should be completed if you are applying for licensure as a clinical alcohol and drug counselor or for certification as an alcohol and drug counselor. You may make photocopies of this page. Your experience must be in a 12-core-function alcohol and drug treatment position. Experiential hours may go back only five years.

All positions being documented must be accompanied by:

- an official job description signed by your supervisor and program director
- a program description (brochure or flyer) signed by the program director
- each job must include one Supervisor Evaluation Form (included in this application)
- a current resume of your clinical supervisor
- your current resume (as the applicant).

Applicant's name: _____

Employer's name: _____

Employer's address: _____

Program director: _____

Name of supervisor(s): _____

Your job title: _____ Dates of employment: _____ to _____

Please put a check in the box next to the title of the position you held. Counselor Intern Trainee Volunteer

(Note: The number of hours indicated in the answers to questions number 2 and 3 must equal the total number of hours indicated in the answer to question number 1.)

1. How many hours of supervised experience in alcohol and drug counseling are you documenting? _____

2. Of the hours documented in question number 1, how many hours in **direct** (face-to-face) client counseling are you documenting?

3. Of the hours documented in question number 1, how many were spent in all other core-function areas? _____

Applicant's signature

Date

Employer/ Supervisor's signature

Supervisor Information Form

Please put a check in the box next to the type of application the applicant is submitting.

L.C.A.D.C. application C.A.D.C. application

Note to supervisor: The Alcohol and Drug Counselor Committee of the State Board of Marriage and Family Therapy Examiners believes that licensure and certification should be based on input from a variety of sources, including the observations of people who supervise the applicant. For this reason, each applicant is required to obtain an evaluation from a clinical supervisor. Your evaluation, among others, and data furnished by the applicant will be used in determining eligibility for licensure or certification. As this process can only be effective with careful and truthful reporting, all information gathered in the evaluation process is confidential.

Please return this form and the attached ratings to the address listed on page one. In the event that you cannot rate the applicant on the items, please indicate so, and return this form to the Committee.

The supervisor must submit a copy of his or her resume or a statement about his or her background with this evaluation.

Applicant's name: _____

Agency's name: _____

Agency's address: _____

Name of supervisor(s): _____

Title of supervisor(s): _____ Telephone number (include area code): _____

Length of time you have:

A. Known the applicant _____

B. Provided direct supervision of this applicant _____

Please complete:

I hereby certify that I have been in a position to directly supervise the above-named person's work. In my judgment, this applicant's eligibility and professional experience (check one) is is not consistent with licensure or certification standards as set forth by the Alcohol and Drug Counselor Committee of the State Board of Marriage and Family Therapy Examiners. The information that I am providing is my best judgment of the above-named person's capabilities to be: (check one)

licensed as a clinical alcohol and drug counselor, or certified as an alcohol and drug counselor.

The type(s) of supervision I have used with this counselor include those checked below.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Audio/video tapes | <input type="checkbox"/> Case discussions | <input type="checkbox"/> Group supervision | <input type="checkbox"/> One-way mirror observation |
| <input type="checkbox"/> Case presentations | <input type="checkbox"/> Individual supervision | <input type="checkbox"/> Telephone consultation | <input type="checkbox"/> Other |

Supervisor's signature

Date

Professional licensure, degrees or certifications: _____

I am a Certified Clinical Supervisor

Supervisor Evaluation Form

Please put a check in the box next to the type of application the applicant is submitting.

L.C.A.D.C. application C.A.D.C. application

Applicant's name: _____

Evaluator's name: _____

Note: Please rate the applicant in each area using the following scale:

- 0 = No basis for judgment
- 1 = Inadequate
- 2 = Needs development
- 3 = Acceptable
- 4 = Good
- 5 = Outstanding

Area of knowledge, skills or competency

- 1) Communication
 - a) Oral _____
 - b) Written _____

- 2) Knowledge of Alcoholism/Drug Abuse
 - a) Physiological _____
 - b) Pharmacological _____
 - c) Psychological _____

- 3) Evaluation and Client Assessment
 - a) Knowledge of:
 - i) Human growth and development _____
 - ii) Family dynamics and interaction _____
 - iii) Signs and symptoms of alcoholism and drug abuse _____
 - iv) Signs and symptoms indicating referral for medical, psychological or other assessment _____
 - b) Analytical skills:
 - i) Assessing stages of alcoholism/abuse _____

Area of ethical standards

- 1) Orientation in all efforts towards a primary goal of recovery for the client and his or her family. _____
- 2) Respect for confidentiality of records, materials and communication concerning clients. _____
- 3) Respect for the client by maintaining an objective, nonpossessive professional relationship. _____
- 4) No discrimination among clients or professionals on the basis of race, color, creed, age, sex or sexual orientation. _____
- 5) Respect for the rights and views of other alcohol and/or drug workers and other professionals. _____
- 6) Respect for institutional policies and cooperation with management functions.
Initiative toward improving institutional policies and management functions. _____

- 7) Evidence of genuine interest in helping people with alcohol and/or drug problems and dedication to helping lead clients to methods of helping themselves as much as possible. _____
- 8) Willingness to access one's own personal and vocational strengths and limitations, biases and effectiveness. The ability and willingness to recognize when it is in the client's best interest to refer or release him or her to another individual or program. _____
- 9) Willingness to take personal responsibility for continued professional growth through further education or training. _____
- 10) Total commitment to providing the highest quality of care through both personal effort and the utilization of any other health professional or services which may assist the client in his or her recovery program. _____

Certification

I hereby certify that I have provided a minimum of _____ hours of face-to-face clinical supervision per month including _____ hours of individual supervision and _____ hours of group supervision.

Supervisor's signature

Date

*** Additional comments may be made below.***

Self-Help Meeting Verification Form

Please put a check in the box next to the type of application you are submitting.

L.C.A.D.C. application C.A.D.C. application

Applicant's name: _____
 (Specified below are the minimum number of self-help meetings required for this application.)

Minimum Number of Meetings Required:

A.A. - 5 ALANON - 5 N.A. - 5 OTHER - 15

<u>Date</u>	<u>A.A. location</u>		<u>Date</u>	<u>Name of other self-help groups</u> <small>(Can include additional A.A., ALANON, N.A. groups or other self-help groups.)</small>
1) _____	_____	1)	_____	_____
2) _____	_____	2)	_____	_____
3) _____	_____	3)	_____	_____
4) _____	_____	4)	_____	_____
5) _____	_____	5)	_____	_____
	<u>ALANON location</u>	6)	_____	_____
		7)	_____	_____
		8)	_____	_____
		9)	_____	_____
		10)	_____	_____
		11)	_____	_____
	<u>N.A. location</u>	12)	_____	_____
		13)	_____	_____
		14)	_____	_____
		15)	_____	_____

As required for licensure as a clinical alcohol and drug counselor or certification as an alcohol and drug counselor in the State of New Jersey, I certify that I have attended the meetings listed on this form.

Applicant's signature

Date

As the applicant's supervisor, I certify that the applicant has provided documentation that he or she has attended the meetings listed above.

Supervisor's signature

Date



Official Use Only

Dual License

License Type 1

Applicant's Number

License Type 2

Applicant's Number

Official Use Only

Resubmit

Board or Committee

New Jersey Office of the Attorney General

Division of Consumer Affairs

State Board of Marriage and Family Therapy Examiners

Alcohol and Drug Counselor Committee

P.O. Box 45040

Newark, New Jersey 07101

(973) 273-8050

**CERTIFICATION AND AUTHORIZATION FORM
FOR A CRIMINAL HISTORY BACKGROUND CHECK**

Directions: Answer all of the questions on this form.

1. Name Mr. Mrs. _____ (_____)
 Ms. Last First Middle Maiden Name

2. Address _____
Street or P.O. Box City State ZIP code

3. Date of birth ___/___/___ Sex: Male Female
Month Day Year

4. Social Security number _____/_____/_____

5. Have you completed the fingerprinting process for any **Board or Committee of the New Jersey Division of Consumer Affairs** since November 2003? Yes No

If "No," you will receive a separate mailing from the Board or Committee regarding the criminal history background process. Please send no payment now.

If "Yes," please provide the following information and follow the instructions outlined below:

Board or committee requiring the fingerprinting

Month and year you were fingerprinted

If you were fingerprinted after November 2003 as part of the criminal history background process for licensure or certification by any other **Board or Committee of the New Jersey Division of Consumer Affairs**, you will not be required to be fingerprinted a second time. However, the Division must perform a criminal history background check each time you apply for licensure or certification. The fee for this background check will be **\$18.75**. Payment should be made in the form of a check or money order payable to the State of New Jersey and should accompany your application packet.

6. Have you ever been arrested and/or convicted of a crime or offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.) Yes No

Every such conviction on record must be disclosed. A true copy of every police report, judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in the denial of an initial application.**

Note: Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.

Your continuing responsibility to disclose convictions of crimes or offenses: You **must** notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.

CERTIFICATION

I, _____, in making this application to the Board or Committee for certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Signature of applicant

Date