Appendix IV

CERTIFICATION APPLICATION
FOR
ALCOHOL AND OTHER DRUG ABUSE
PROFESSIONALS

Name: _____
Last First Middle

Address: _____ _____ ____ _____
Street or PO Box City State Zip

Daytime Telephone: _____ Date of Birth: _____

E-Mail Address _____

Gender: _____ Race: _____ *(For Statistical purposes only)*

NAADAC/ SCAADAC Membership Number: _____ Date of Expiration: _____

(NAADAC membership number must be enclosed for application to be received at member rate.)

TYPE OF CERTIFICATION APPLIED FOR:

- ❒ **CERTIFIED ADDICTIONS COUNSELOR I**
- ❒ **CERTIFIED ADDICTIONS COUNSELOR II**
- ❒ **CERTIFIED CLINICAL SUPERVISOR**
- ❒ **CERTIFIED ADDICTIONS COUNSELOR II UPGRADE**
  Submit coversheet only with required documents
- ❒ **AOD RECIPROCITY REQUESTED**
- ❒ **LICENSED PROFESSIONAL RECIPROCITY REQUESTED**

INSTRUCTIONS*:* Please provide detailed information for all sections of this application. *Please print legibly or type.* Incomplete or unsigned applications will be returned to applicants for completion, causing delay or disqualification. A resume may be attached but will not be accepted as a substitute for a completed application form.

EDUCATION: List education received to date. Please note that an official transcript must support all college work. Applicants must contact their respective academic institution(s) and request that official transcripts are forwarded directly to the SCAADAC Certification Commission. Transcripts submitted by applicants cannot be accepted and will not be reviewed.

Level of Education	Name and Full Address of School	Hours	Date of Graduation	Degree Awarded
High School				
College Undergraduate				
College Graduate				
Other				

WORK EXPERIENCE: Rather than request a complete work history, we ask that you list your present employment, then from your past employment select only those work experiences which you feel fit the description of qualifying experience.

Name of Employer:	
Address of Employer:	Telephone Number
Your Job Title:	Length of Employment: From (Month/Year) To (Month/Year)
Name and Title of Immediate Supervisor:	Number hours/Week:
Description of Duties:	

Name of Employer:	
Address of Employer:	Telephone Number
Your Job Title:	Length of Employment: From (Month/Year) To (Month/Year)
Name and Title of Immediate Supervisor:	Number hours/Week:
Description of Duties:	Reason for leaving:

Name of Employer:	
Address of Employer:	Telephone Number
Your Job Title:	Length of Employment: From (Month/Year) To (Month/Year)
Name and Title of Immediate Supervisor:	Number hours/Week:
Description of Duties:	Reason for leaving:

TRAINING AND ACADEMIC COURSES: Applicants must submit copies of training certificates or other verification of attendance and request that official college transcripts are sent to the SCAADAC Certification Commission.

1. Are you currently licensed or certified in S.C. in a health or human services field? ❒ YES ❒ NO

   If YES, by whom? _____

   License Number _____ Expiration Date _____

2. Have you ever been subject to disciplinary action as a result of violations of law or ethics? ❒ YES ❒ NO
   If YES, attach a statement of explanation, include when and where this occurred as well as action and disposition.

3. Have you ever been convicted of a crime other than minor traffic violations? ❒ YES ❒ NO
   If YES, attach a narrative statement of explanation; include when and where this occurred as well as action and disposition.

Assurance and Release of Information

PLEASE READ CAREFULLY

I certify that all information provided in this application is accurate and complete. I understand that untrue or incomplete information may result in being disqualified from becoming certified or in having my certification revoked.

I authorize the South Carolina Association of Alcoholism and Drug Abuse Counselors Board to conduct any necessary investigations; to contact current or former employers to verify employment or relevant work experience; and to release information about my certification status to my employer.
I agree to abide by the ***South Carolina Association of Alcoholism and Drug Abuse Counselors Code of Ethics*** and understand that any violation may result in disqualification from becoming certified or having my certification revoked.

I understand that the South Carolina Association of Alcoholism and Drug Abuse Counselors Certification Commission retains ownership of all certification certificates and agree to return my certificate(s) upon request.

I recognize and understand that the members of the SCAADAC Certification Commission are the sole and only judges of the qualifications required for receiving or maintaining certification. I further recognize that the SCAADAC Certification Commission reserves the right to modify or alter at any time the standards, qualifications, rules, policies, or procedures in connection with the certification process.

I agree to the above statements and release of information regarding my certification application.

Signature of Applicant

Date

Mail Application Package To:

SCAADAC Certification Commission
1215 Anthony Avenue
Columbia, SC 29201