



Letter of Agreement for Recertification

Name: _____
Last First Middle

Address: _____
Street or PO Box City State Zip

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

I _____ certify that all information required for recertification as a _____ is accurate and complete. I understand that untrue or incomplete information may result in having my certification revoked.

I understand that I may be randomly selected for audit of training hours and that I will be required to verify all continuing education/training by submitting the following:

- Training certificates (containing trainee's name, training name, number of clock hours for training event); or
- Official transcripts of undergraduate, graduate or professional studies forwarded by issuing institution

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. Failure to provide proof of continuing education/training requirements may result in a hearing, suspension or revocation of certification.

I agree to the above statements regarding my recertification application.

Signature of Applicant _____ Date _____

Pay online with credit or debit card and email to info@scaadac.org or mail with check or money order to: SCAADAC Certification Commission, 1215 Anthony Avenue, Columbia, SC 29201.

SCAADAC South Carolina Association of Alcoholism and Drug Abuse Counselors – TRAINING VERIFICATION

NOTE: Do NOT send training certificates at this time.

Certification Period (date of last Certification approval to current Expiration Date) _____ to _____ Certification Level CACI CACII CCS

TRAINING DATE	CONTINUING EDUCATION / TRAINING TITLE 40 clock hours required 2 clock hours of Ethics required Training Certificates to include Trainer & Trainee names and the number of clock hours and/or Official Transcripts of undergraduate, graduate or professional studies	# CORE FUNCTION (describes training)	Check (✓) Category of Clock Hours			# CLOCK HOURS
			Max 20 hrs Applicant is trainer	Max 20 hrs Home Study	Attendance - Face to Face	
	<i>Ethics Training:</i>					

KEY: 1-Screening & Intake 2-Orientation 3-Assessment 4-Treatment Planning 5-Counseling
6-Case Management 7-Crisis Intervention 8-Client Education 9-Reports & Record Keeping
10-Case Consultation 11-Termination & Continuing Care

GRAND TOTAL CLOCK HOURS: _____