IAAP

The Indiana Association for Addiction Professionals

Indiana Association for Addiction Professionals Certification Application

I. Personal Data

Name _____ Date _____

Address _____ City/State/Zip _____

Phone (w) ____/_____ (h) ____/_____ (c) ____/_____

FAX ____/_____ Email _____

Employer_____ City/State/Zip _____

II. Certification Level

Please indicate the certification level for which you are applying:

____APIT ____ICAC I ____ICAC II

Are you an IAAP member: ___No ___Yes ID #_____ Expiration Date _____

III. Licensure/Certification/Education Record

Current License/Certification: Please list each license and/or certification you currently hold:

Credential # Issuing Authority Expiration Date

_____

_____

_____

Note: Copies of current licenses/certifications must be attached.

Exam: Date to take _____ or Date taken _____

If taken, please give us the Level: _____ and Score: _____ of your NAADAC written examination. (Exam must have been within 4 years of this application.)

Training Hours Summary and Continuing Education Forms

Please attach copies of all training events (college transcripts, conference/seminar training certificates, CEUs, etc.) up to a total of 270 contact hours for Level I and 450 contact hours for Level II.

_____ Graduate Level Hours; Institution: _____

_____ Undergraduate Hours; Institution: _____

_____ Training Hours (Must attach copies of certificates and the continuing education forms)

_____ Other (Subject to IAAP approval): _____

_____ Total Hours

IV. Career History

In providing your addiction counseling career history, please list your current position first and work backwards until you have document three years (ICAC I) or five years (ICAC II) supervised full-time work experience in the addiction field. Attach additional pages as needed.

Employer: _____

Address: _____ City/State/Zip _____

Job Title: _____ From (M/Y) _____ to (M/Y) _____

Brief job description:

_____

_____

Supervisor's Name: _____ Telephone ____/_____

Employer: _____

Address: _____ City/State/Zip _____

Job Title: _____ From (M/Y) _____ to (M/Y) _____

Brief job description:

_____

_____

Supervisor's Name: _____ Telephone ____/_____

Employer: _____

Address: _____ City/State/Zip _____

Job Title: _____ From (M/Y) _____ to (M/Y) _____

Brief job description:

_____

_____

Supervisor's Name: _____ Telephone ____/_____

V. Verification of Work Experience

In the box provided below, have your supervisor (or other knowledgeable individual) verify your work experience, counseling skills and the contents of this application.

By affixing my signature hereto, I verify that I have supervised the person named in this application for ____ years, and that, to the best of my knowledge, the career history listed above is accurate and true. I further verify that the applicant is able to competently perform all required counseling skills and functions, and performs them within accepted ethical guidelines.

Signature: _____ Date: _____

Title: _____ Telephone: ____/_____

Agency Verification

If the supervisor is no longer with the agency; the candidate can obtain employment verification from the Personnel/Human Resources Manager to verify Full-Time/Part-Time employment, years employed and in what capacity.

By affixing my signature hereto, I verify that the supervisor named in this application worked for our agency during the years listed in this application, and that, to the best of my knowledge, the career history listed above is accurate and true.

Signature: _____ Date: _____

Title: _____ Telephone: ____/_____

VI. Application Checklist

____ Application Form

____ Demographic Profile

____ License/Certification Copy

____ Education/Training Certificate Copies/Continuing Education Forms

____ Examination Grade Sheet or Examination Application

____ Supervisor's Signature (Section IV)

____ Your Signature (Section X)

____ Payment ICAC I or II (IAAP Member ____ / Non-Member ____)

VII. Payment

Amount Enclosed: _____ Check (payable to IAAP) _____ Money Order ____

VII. Demographic Information

The information requested below is necessary for IAAP to accurately portray the profile of our members as we meet with government officials and decision-makers of insurance carriers, HMOs, etc. Through collection of this data about ICAC credentialed counselors, we can sharpen the focus of our lobbying efforts and more efficiently represent you and your colleagues. Providing this data will have no effect on the evaluation of your application.

Please circle the appropriate letter:

1. Primary Job Function:
a. Counselor
b. Clinical Supervisor
c. Program Director
d. Administrator/ CEO
e. Other: _____

2. Work Setting:
a. Hospital
b. Residential Facility
c. Local/State/Federal Agency
d. Private Practice
e. Criminal Justice System
f. Other: _____

3. Years of employment in the addiction field:
a. 0-3
b. 4-6
c. 7-10
d. over 10

4. Are you certified/licensed as a:
a. Licensed Professional Counselor
b. Rehabilitation Counselor
c. Social Worker
d. Psychologist
e. Nurse
f. Physician
g. Psychiatrist
h. Clergy
i. Other: _____

5. Highest degree earned:
a. High School Diploma/Equivalent
b. Associates Degree
c. Bachelor's Degree
d. Master's Degree
e. Doctoral Degree
f. Other: _____

IX. Optional Information

Information related to race, ethnic background, age, and gender is requested to assist in ensuring that we are complying with Federal guidelines pertaining to equal opportunity. As we work with various agencies, it is apparent that this information, positively showing equality of opportunity and a broad base of representation from all aspects of society, will assist in our overall efforts.

6. Race:
a. Caucasian
b. Native American
c. African American
d. Hispanic/Latino
e. Asian/Pacific Islander
f. Other: _____

7: Gender
a. Male
b. Female
c. Other: _____

8. Age
a. 0-17
b. 18-25
c. 26-35
d. 36-45
e. 46-55
f. 56-65
g. Over 65

X. Candidate Affirmation

By affixing my signature hereto, I affirm that: the information on this application is true, accurate, correct, and complete: that I agree to abide by the principles within the IAAP Code of Ethics; and that my current license and/or certificate is not encumbered in any manner, nor has been subject to any criminal or ethical complaints.

I hereby authorize the IAAP Certification Committee to contact any institution, organization or individual listed on or included within this Application for verification on my addiction counseling history. I understand that IAAP Certification Committee retains physical ownership of all certificates, and my make available certificate holder names and other information to potential service users.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

___ Application Approved. By affixing my signature hereto, I verify that I have reviewed this application and found it complete and correct.

Reviewer: _____ Date: _____

___ Application NOT Approved. By affixing my signature hereto, I verify that I have reviewed this application and found it incomplete or incorrect, and needing the following information/correction(s) for approval:

_____

_____

Reviewer: _____ Date: _____

Decision Approved by: _____ Date: _____

(Cert. Board Chair)