

MARKING INSTRUCTIONS: Mark heavy and dark, filling the circles completely. Please print clearly.

A	B	C	D	E	F	1	2	3	4
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Candidate Information

Please enter your Name exactly as it appears on your current Government-Issued Photo I.D.

First Name

M.I.

☐ Mr.

☐ Mrs.

☐ Ms.

☐ Dr.

Male ☐ Female ☐

[illegible]

Home Address - Number and Street	Apartment Number

City															State		Zip / Postal Code					

Daytime Phone - -

Best way to be contacted ☐ Receive phone call ☐ Email ☐ Text

[illegible]

Choice of Examination Language:

Special Needs

If you have any special needs / requirements please describe below:

☐ English ☐ Spanish

Eligibility and Background Information

Darken only one choice for each question, unless otherwise directed.

A. FOR WHICH EXAMINATION ARE YOU APPLYING?

☐ ADC ☐ AADC ☐ CS ☐ PS

B. HAVE YOU TAKEN THIS EXAMINATION BEFORE?

☐ No ☐ Yes

If yes, indicate month, year and name under which the examination was taken.

Date (month/year): _____

Name: _____

C. ARE YOU CURRENTLY CERTIFIED IN ADDICTION COUNSELING BY IC&RC?

☐ ADC ☐ AADC ☐ CS ☐ PS

○ N/A

D. ARE YOU A MEMBER OF NAADAC / AUSAP?

☐ No ☐ Yes (NOTE: Membership is not required)

E. HOW DID YOU ACQUIRE YOUR ALCOHOLISM AND DRUG ABUSE COUNSELING TRAINING?

- ☐ Specialty training in alcoholism/drug abuse counseling
- ☐ Specialty training as part of a degree program
- ☐ Alcoholism/drug abuse counseling course as part of degree program
- ☐ Continued education courses
- ☐ On-the-job training
- ☐ Other

F. IN WHAT TYPE OF SETTING DO YOU PRACTICE?

- ☐ Private Practice
 ☐ State/federal agency
- ☐ Private treatment center
 ☐ Employee assistance program
- ☐ Halfway house
 ☐ Other - explain below
- ☐ Hospital program

G. IN WHICH OF THE FOLLOWING DO YOU SPEND AT LEAST TEN HOURS PER WEEK?

- ☐ Counseling clients with alcohol/drug-related problems
- ☐ Other counseling
- ☐ Clinical supervision
- ☐ Assessment and referral
- ☐ Prevention/Community service
- ☐ Outreach
- ☐ Research/Evaluation
- ☐ Administration
- ☐ Professional and staff development
- ☐ Other

H. PERCENT OF WORKING TIME CURRENTLY SPENT IN ALCOHOLISM AND DRUG ABUSE COUNSELING:

- ☐ Less than 25% ☐ 51% to 75%
- ☐ 25% to 50% ☐ More than 75%



STATE APPLICATION FOR
INTERNATIONAL CREDENTIALING
ADDICTION PROFESSIONALS' EXAMINATIONS

Mail AUSAP
P.O. Box 901418
Sandy, UT 84090
Email: ausap@ausap.org

Eligibility and Background Information

I. TREATMENT OR MODALITY YOU PROVIDE:

- ☐ Inpatient only ☐ Halfway House
☐ Outpatient only ☐ Other - explain _____
☐ Inpatient and Outpatient

J. PROFESSIONAL BACKGROUND:

- ☐ Counselor ☐ Nurse
☐ Rehabilitation Therapist ☐ Physician other than Psychiatrist
☐ Administrator ☐ Psychiatrist
☐ Social Worker ☐ Clergy
☐ Psychologist ☐ Other _____

K. EXPERIENCE IN ALCOHOLISM AND ADDICTION COUNSELING:

- ☐ Less than 3 years ☐ 5 years
☐ 3 years ☐ 6 to 10 years
☐ 4 years ☐ More than 10 years

Additional Information

Special Accommodations

- ☐ ASL Translator
☐ Extended Time
☐ Large Font
☐ Scribe
☐ Private Room
☐ Reader

Optional

Age Range:

- ☐ Under 25
☐ 25 to 29
☐ 30 to 39
☐ 40 to 49
☐ 50 to 59
☐ 60 +

Other: _____

L. HIGHEST ACADEMIC LEVEL:

- ☐ Less than high school graduate
☐ High school graduate or equivalent
☐ Vocational or technical school graduate
☐ Some college
☐ Associate degree
☐ Bachelor's degree
☐ Master's degree
☐ Doctoral degree
☐ Other _____

M. FROM WHICH INSTITUTION DID YOU ACHIEVE
YOUR DEGREE?

N. IN WHICH OF THE FOLLOWING ARE YOU LICENSED
OR HOLD CERTIFICATION OR REGISTRATION?

(Darken all that apply)

- ☐ Social Work
☐ Psychology
☐ Counseling
☐ Medicine
☐ Nursing
☐ Employee assistance programming
☐ Marriage and family therapy
☐ Other _____

** You may be required to provide a professionals / see our website for additional information

Release Authorization

Must be completed by all candidates authorizing release of test results to a state.

State

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Please print the two letter state abbreviation in the boxes provided.

I hereby authorize the International Certification and Reciprocity Consortium (IC&RC) to release the results of my Certification Examination for Addiction Counselors to the state indicated. I understand that those test results will be used only for state certification at this time. **

CANDIDATE SIGNATURE: _____

DATE: _____

State Board Approval

- ☐ ADC **APPROVED BY:**
☐ AADC
☐ CS
☐ PS

State Board Representative Signature

Date: _____

** A copy of the test results will also be provided to Utah Department of Professional Licensing