

O Other

STATE APPLICATION FOR INTERNATIONAL CREDENTIALING ADDICTION PROFESSIONALS' EXAMINATIONS

Mail AUSAP

P.O. Box 901418

Sandy, UT 84090 Email: ausap@ausap.org

MARKING INSTRUCTIONS: Mark heavy and dark, filling the circles completely. Please print								print c	learly.	rly.			В	С	\mathcal{D}	E	F	1	2	3	4				
Candidate Information Please enter your Name exactly as it appears on your current Government-Issued Photo I.D.																									
	Firs	t Name		-		-	r —	r —	-		r —	-	r —	1	1	г	1	1		1	1	1			M.I.
0	Mr. Mrs.																								
0	Ms.					1				1						l									
O Dr.																									
Last	Name			T	1	1	r –	r –	1	1	r –	1	r –	1		T		1			1	1	Suffix	(Jr., Sr	., etc.)
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Home	e Address - I	Number	and St	reet	1		1	1	1		1		1							1			Apartn	nent N	umber
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Ema	il Address	Please	enter	only C	DNE ei	mail ad	ddress	. Use	two lir	nes if v	our er	nail ac	ddress	does	not fit	in one	line.)								
		-		-	-		-	-			-														
Choi	Choice of Examination Language: Special Needs If you have any special needs / requirements please describe below:																								
O English O Spanish										•															
	-																								
Eliai	Eligibility and Background Information																								
	en only on						ss oth	erwise	e direc	ted.															
Α.	FOR WHI												F.	IN W	нат т	YPE	DF SF	TTING			RACT	ICF?			
<i>7</i> u	O AD		-	AAD			CS		0	PS				0		e Practi					-	ederal	agency		
в.	HAVE YC				-			ORE2	•					O Private treatment center O Employee assistance program							m				
υ.	_		-											O Halfway house O Other - explain below											
	O No O Yes If yes, indicate month, year and name under which the examination was taken.											0						9	Other	- expiai	II DEIOW				
	-			nd nam	e under	which tr	ne exam	ination	was tar	ken.			_		-	tal prog							_		
	Date (mo	nth/yea	r):									-	G.			OF TH				0 10	USPE	IND A	I		
-	Name:								-		LEAST TEN HOURS PER WEEK?														
C.	ARE YOU CURRENTLY CERTIFIED IN ADDICTION										Counseling clients with alcohol/drug-related problems														
	COUNSE	LING E	BY IC8	RC?		_			_						Other	counse	eling								
	O AD		0	AAD	С	0	CS		0	PS					Clinica	al supe	rvision								
	O N/A														Asses	sment	and re	ferral							
D.	ARE YOU A MEMBER OF NAADAC / AUSAP?											Preve	ention/C	ommu	nity se	vice									
	O No O Yes (NOTE: Membership is not required)										I)		Outreach												
Ε.	E. HOW DID YOU ACQUIRE YOUR ALCOHOLISM AND													Research/Evaluation											
	DRUG ABUSE COUNSELING TRAINING?													Administration											
	O Specialty training in alcoholism/drug abuse counseling													Professional and staff development											
	O Specialty training as part of a degree program													Other											
	O Alcoholism/drug abuse counseling course as part of degree program											н.	PERCENT OF WORKING TIME CURRENTLY SPENT												
	~		0			5.220	P							IN ALCOHOLISM AND DRUG ABUSE COUNSELING:											
											н.	IN ALCOHOLISM AND DRUG ABUSE COUNSELING:													
	O On-the-job training											\mathbf{O}	Less t	than 25	%		\mathbf{O}	51% t	o 75%						

O 25% to 50%

O More than 75%



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I.	TRE	ATMENT OR MODALITY YO	U PRO	VIDE:	L.	HIGHEST ACADEMIC LEVEL:					
	0	Inpatient only	0	Halfway House		O Less than high school graduate					
	0	Outpatient only	0	Other - explain		O High school graduate or equivalent					
	0	Inpatient and Outpatient				O Vocational or technical school graduate					
J.	PRC	FESSIONAL BACKGROUNI):			O Some college					
	0	Counselor	0	Nurse		O Associate degree					
	0	Rehabilitation Therapist	0	Physician other than Psychiatrist		O Bachelor's degree					
	0	Administrator	0	Psychiatrist		O Master's degree					
	0	Social Worker	0	Clergy		O Doctoral degree					
	0	Psychologist	0	Other		O Other					
К.	EXP	ERIENCE IN ALCHOLISM A	ND AD	DICTION COUNSELING:	м.	FROM WHICH INSTITUTION DID YOU ACHIEVE					
	0	D Less than 3 years		5 years		YOUR DEGREE?					
	0	3 years	0	6 to 10 years							
	0	O 4 years		More than 10 years	Ν.	IN WHICH OF THE FOLLOWING ARE YOU LICENS					
						OR HOLD CERTIFICATION OR REGISTRATION?					
Add	tiona	I Information				(Darken all that apply)					
Spec	ial A	ccommodations		Optional		O Social Work					
О	ASL	Translator		Age Range:		O Psychology					
О	Exte	nded Time		O Under 25		O Counseling					
О	Larg	e Font		O 25 to 29		O Medicine					
О	Scrib	be		O 30 to 39		O Nursing					
О	Priva	ate Room		O 40 to 49		O Employee assistance programming					
О	Rea	der		O 50 to 59		O Marriage and family therapy					
Othe	r:			O 60 +		O Other					

Release Authorization

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

State

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:

Stat	e Board A	pproval		
0	ADC	APPROVED BY:		
0	AADC		Date:	
0	CS	State Board Representati	ve Signature	_
0	PS			
		** A copy of the test	t results will also be provided to Utah Departmen	t of Professional Licensing