Michigan Certification Board for Addiction Professionals

APPLICATION FORMS

for

Certified Clinical Supervisor
(IC&RC reciprocal)

CCS

Certified Clinical Supervisor
(CCS)
Directions for Submitting Application

Submit your application forms in the following order with supporting documents.

1. Application - (Submit copy of any name change legal documents).

2. Experience - Documentation of Experience form(s).

3. Education - Documentation of Education form.

4. Code of Ethics – Sign Code of Ethics.

5. Fees & mailing Instructions – Submit all forms, documentation and $150.00 (check or money order) non-refundable two-year certification fee payable to MCBAP (online application manual included).

Mail to:

MCBAP
2111 University Park Drive
Suite 600
Okemos, MI 48864

Certified Clinical Supervisor
(CCS)
APPLICATION

(All information must be typed or legibly printed)

I - Personal Information

Name_____
(As you want it to appear on your certificate)

Address_____ _____
Street Apt.

_____ _____ _____
City State Zip Code

_____ _____
Email Address Highest Level of Education

Business Address _____ _____
Street Suite

_____ _____ _____
City State Zip Code

(_____)_____ (_____)_____ _____
Home Telephone Business Telephone Soc. Sec. Number
(Last 4 digits only)

II - Signature Requirement

I hereby certify that all the above information is true and accurate. In signing, I am applying for the Certified Clinical Supervisor credential.

_____ _____
Applicants Signature Date

_____ _____
Supervisor Signature (verifying applicant signature) Date

III - Fees and Mailing Instructions

Submit all forms, documentation and $150.00 (check or money order) non-refundable two-year certification fee payable to MCBAP.

Mail to: **MCBAP**
2111 University Park Drive
Suite 600
Okemos, MI 48864

Pay Now

Print Form

Reset Form

Certified Clinical Supervisor
(CCS)
DOCUMENTATION OF EXPERIENCE

(All information must be typed or legibly printed)

Experience must be specific to the IC&RC performance domains (Appendix A). Section II, III and IV should be completed by the applicants supervisor, program director or personnel office. Additional copies of these forms may to be made**. Include a copy of the applicant's formal job description.**

Section I - Applicant Information

Name_____

Address_____ Apt. _____

City_____ State _____ Zip Code _____

Section II - Program Information - *To be completed by the applicant's supervisor, program director or personnel office.*

Program name_____

Program address_____

Program state license number _____ Telephone # (_____)_____

Section III - Documentation of Experience - *To be completed by the applicant's supervisor or program director or personnel office.*

Applicant's Position _____

Beginning Date _____ Ending Date _____

Counseling - AODA counseling work experience (minimum of 10,000 hours) _____

Clinical Supervision - AODA supervisor work experience (minimum of 4,000 hours) _____

Face- to- Face – direct clinical supervision (minimum of 200 hours) _____

Section IV – By signing below, I attest the applicant (Section I), performed adequately at the program (Section 2), providing AODA counseling and AODA Clinical Supervision.

_____

Signature and title of Supervisor, Program Director or Personnel Manager

Certified Clinical Supervisor
(CCS)
DOCUMENTATION OF EDUCATION

(All information must be typed or legibly printed)

Thirty- (30) contact hours of didactic training in clinical supervision is required; this must include a minimum of four (4) hours of training in each of the following performance domains: assessment/evaluation, counselor development, professional responsibility and management/administration. Document each training course, seminar, workshop, etc., date(s) and contact hours using this format. Attach certificates of completion or other documentation verifying attendance at the below listed educational events. **(Make copies of this form if additional space is required.)**

_____

Applicant Name

Title training course, seminar, workshop, etc.	Date(s)	Contact	Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact	Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact	Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact	Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact	Hours
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Title training course, seminar, workshop, etc.	Date(s)	Contact	Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact	Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact	Hours

Certified Clinical Supervisor
(CCS)
EDUCATION Form for Undocumented Events

(All information must be typed or legibly printed)

This form is to be used to verify undocumented education and in-service trainings. If you don't have certificates of completion for specific workshops, you must fill out this sheet and have your supervisor or program director sign the bottom to verify that you have attended these trainings. Listing trainings on this form should be the exception in your documentation. **You should make every effort to locate missing verification of educational hours before using this form**. This form can also be used to document in-service trainings. This Form May Be Duplicated.

Applicant Name

Title training course, seminar, workshop, etc.	Date(s)	Contact	Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact	Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact	Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact	Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact	Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact	Hours
Title training course, seminar, workshop, etc.	Date(s)	Contact	Hours

Signature Requirement:

I hereby certify that all the above information is true and accurate.

Applicant's Signature Date

Supervisor, Program Director or Personnel manager signature

Certified Clinical Supervisor
(CCS)
Testing, Academic Degree and Code of Ethics Agreement

(Please type or print legibly)

I – Testing – enter date in space provided and submit a copy of verifying document for the exam

A. IC&RC/Clinical Supervisor examination passed on _____

II - Academic Degree Equivalents for Experience - to use an academic degree for part of the experience requirement, please complete the following and attach documentation verifying highest degree obtained.

Associate's degree equivalent: ☐ **1000 hours**

Bachelor's degree equivalent: ☐ **2000 hours**

Master's degree equivalent: ☐ **4000 hours**

_____ _____

Degree Date Earned

_____

College or University

_____

Major/Minor Course of Study

III – Code of Ethics Agreement

I, the undersigned individual, agree to adhere to the Code of Ethical Standards for Certified Clinical Supervisors (see appendix B) and understand that violation of the Ethical Standards for Certified Clinical Supervisors may result in suspension, sanctions or revocation of certification.

_____ _____

Applicant Signature Date

Certified Clinical Supervisor
(CCS)
Data Collection Form

This data is important in identifying the on-going status of substance abuse workforce in the state of Michigan. The information will assist with identification of future needs, e.g. competency standard, credentialing, training, education, future funding and other planning activities. The aggregate data will be shared with groups such as providers, Regional Coordinating Agencies, Office of Drug Control Policy, elected officials and other interested parties.

Type of service in which you spend the majority of your time

☐ Prevention
☐ Detoxification
☐ Residential
☐ Intensive Outpatient
☐ Outpatient
☐ Methadone
☐ Supervision/Management/Administration

Typical hours worked per week in substance abuse treatment or prevention work

___Hours

Primary role/responsibility function

☐ Primary Therapist
☐ Didactics
☐ Case Management
☐ AAR Screener/Assessor
☐ Clinical Supervisor
☐ Medical/Psychiatric
☐ Administrator
☐ Residential Aid/Milieu Technician
☐ Other _____

Annual salary from treatment or prevention work (optional)

☐ $ 0 - $10,000
☐ $31,000 - $40,000
☐ $61,000 - $70,000
☐ $11,000 - $20,000
☐ $41,000 - $50,000
☐ $71,000 - $80,000
☐ $21,000 - $30,000
☐ $51,000 - $60,000
☐ $81,000 – $90,000 plus

Gender (optional) ☐ Female ☐ Male

Primary Race/Ethnic Group (optional)

☐ White/Caucasian (non-Hispanic) ☐ Asian American

☐ Black/African American (non-Hispanic) ☐ Native American/Indian

☐ Native Hawaiian/Pacific Islander ☐ Alaska Native

☐ Hispanic/Latino ☐ Arab/Chaldean

☐ Other (please specify) _____

Certification(s)/Licensure(s) (identify ALL and if temporary status)

_____

_____