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**NAVAL SCHOOL OF HEALTH SCIENCES**



**ALCOHOL & DRUG  
COUNSELOR**

***ADC II***  
***(Reciprocal)***

***CERTIFICATION***  
***PORTFOLIO***

*(Rev 12-02)*

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## PREFACE

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Many professions have used Portfolios as a collection of visual samples of a candidate's work, e.g. sketches, pictures, or sculpture. However, when applied to the counseling field, portfolios contain descriptive information. This type of Portfolio indicates the candidate's job-related knowledge and skills, and usually includes the following components:

- **Work Experience**
- **Formal Training and Education**
- **Structured Experiences**

This document has been designed and developed to be compatible with and an introduction to the International Certification & Reciprocity Consortium/ Alcohol and Other Drug Abuse (IC&RC/AODA) International Certification Standards. The following sections contain sample forms and application materials necessary for reciprocal certification or recertification.

## BACKGROUND

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The Alcohol and Drug Counselor II (ADC II) certification is considered a more advanced Navy/Marine Corps certification than the ADC I. Navy and Marine Corps personnel certified at this level are expected to have a broad range of experience and to be leaders and role models in the field of Alcohol and Drug Counseling. IC&RC/AODA considers individuals certified at the ADC II level as meeting minimum international entry-level standards.

This credential, unlike the ADC I, is reciprocal to other IC&RC/AODA boards. Reciprocity, however, does not mean "right to practice." Individual states or countries, despite being member boards of IC&RC/AODA, may require additional education or testing prior to allowing an individual the right to practice as a counselor in their jurisdiction.

The U.S. Navy Certification Board (USNCB), as a member of IC&RC/AODA, has jurisdiction only over those individuals working for the U.S. Navy or Marine Corps. Once certified, an individual may maintain their certification with the USNCB, only as long as they remain on active duty, or for civilians, remain working for the Department of the Navy.

# ELIGIBILITY REQUIREMENTS

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## *ADC II - Alcohol and Drug Counselor II (Reciprocal)*

- \_\_\_ 1. 270 Hours of AODA training related to the IC&RC Performance Domains + **6 hours** of documented ethics training, (completion of NDACS fulfills only 3 hours of this ethics requirement.)
  
- \_\_\_ 2. 3 years/6000 hours of supervised work experience. A Behavioral Science degree may be substituted as follows:
  - Behavioral Science AA Degree + 2.5 years/5000 hours
  - Behavioral Science BA Degree + 2 years/4000 hours
  - Behavioral Science MA/Ph.D. Degree + 1 year/2000 hours
  
- \_\_\_ 3. 300 hours of Supervised Practical Training: Minimum of 10 hours in each of the 13 Core Functions.
  
- \_\_\_ 4. Adhere to the Navy Drug and Alcohol Counselor Code of Ethics through a signed statement
  
- \_\_\_ 5. Favorable recommendation by Chain of Command and Clinical Supervisor/Preceptor
  
- \_\_\_ 6. Pass IC&RC/AODA written examination (USN provides a free study guide upon acceptance of application for ADC II).
  
- \_\_\_ 7. Pass IC&RC/AODA Case Presentation Method (CPM) Oral Examination (Candidate is responsible for all costs associated with this event).
  
- \_\_\_ 8. **Re-Certification** - 60 AODA CEH's in 3 years or two (2) AODA counseling related 3-semester-hour college courses

## INSTRUCTIONS

1. All pages numbered ADC II – 1 through 19 in this portfolio must be completed for initial certification. If applying for **recertification**, read each page to ensure applicability.
2. All forms must be submitted as originals, **NO** duplicates, facsimile, or electronic submissions will be accepted.
3. It is highly encouraged to maintain copies of all submissions.
4. Mail all applications to the U.S. Navy Certification Board at:  
NSHS NDACS  
ATTN: CERTIFICATION OFFICE  
NAVSUBASE BLDG 500  
140 SYLVESTER ROAD  
SAN DIEGO, CA 92106-3521
5. The Competency Assessment Form should be completed by the Clinical Preceptors/Supervisors who supervise your work as a drug and alcohol counselor prior to your certification. **It is your responsibility** to ensure that you have the form completed by any supervising individual who may be leaving your command before you are ready to submit your Portfolio.
6. The USNCB will return incomplete applications via the chain of command.
7. The Case Presentation Method is commonly referred to as the Oral Exam. The Orals are the responsibility of the applicant

## ADDENDUM

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These are supplemental forms designed to support your development as an addictions professional. It is recommended that you familiarize yourself with these resources prior to beginning the initial application process:

- A. Quarterly Feedback Form
- B. NDACS Syllabus
- C. Case Presentation Method Preparation
- D. Reciprocity Application
- E. International Application

## GLOSSARY

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<b>ADC</b>	Alcohol and Drug Counselor
<b>AODA</b>	Alcohol and Other Drug Abuse
<b>ATF</b>	Alcohol (Addiction) Treatment Facility (no longer authorized, provided as historical reference only)
<b>ATOD</b>	Alcohol, Tobacco and Other Drug
<b>BUMED</b>	Bureau of Medicine and Surgery
<b>CCS</b>	Certified Clinical Supervisor
<b>CPM</b>	Case Presentation Method
<b>HQMC</b>	Headquarters U.S. Marine Corps
<b>IC&amp;RC/AODA</b>	International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse
<b>LIP</b>	Licensed Independent Practitioner
<b>MTF</b>	Military Treatment Facility
<b>NAADAC</b>	National Association of Alcohol and Drug Abuse Counselors
<b>NDACS</b>	Navy Drug and Alcohol Counselor School
<b>SARP</b>	Substance Abuse Rehabilitation Program

***The forms contained in this Portfolio are originals.  
Please make sufficient copies prior to use!***

***All entries must be legible***

## **PRIVACY ACT STATEMENT**

***THIS IS NOT A CONSENT FORM TO RELEASE CERTIFICATION INFORMATION  
PERTAINING TO YOU.***

1. Authority for the collection of information including Social Security Number (SSN).

*Applicable sections of United States Code 301 and Departmental Regulations*

2. Principal purposes for which this information is intended to be used.

*This form provides you the advice required by The Privacy Act of 1974. The information will facilitate and document your certification process. The Social Security Number (SSN) is required to identify and retrieve certification records.*

3. Routine uses.

*The primary use of this information is to provide, plan and coordinate certification of personnel who serve in clinical roles as Alcohol and Drug Counselors. Other possible uses are to compile statistical data, conduct research, determine suitability for assessment as a Alcohol and Drug Abuse Counselor, and conduct authorized investigations.*

4. Whether disclosure is mandatory or voluntary and the effect on the individual of not providing the information.

*The requested information is voluntary. If not furnished, certification of the individual will not be accomplished and the individual will not be authorized to serve in clinical positions as a Alcohol and Drug Abuse Counselor.*

Your Signature merely acknowledges that you have been advised of the forgoing. If requested, a copy of this form will be provided to you.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**REFERENCES**

Current Immediate Supervisor Name: \_\_\_\_\_  
Last First MI

Rank/Rate: \_\_\_\_\_ Title: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

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(If not currently working as a counselor, list most recent Director and Preceptor information below)

Facility Director Name: \_\_\_\_\_  
Last First MI

Rank/Rate: \_\_\_\_\_ Title: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

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Preceptor Name: \_\_\_\_\_  
Last First MI

E-mail address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Personal Reference (REQUIRED)**

(Someone who has worked with you and/or can vouch for your Counselor Competency)

Name: \_\_\_\_\_  
Last First Middle

E-mail address: \_\_\_\_\_

Work Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ - \_\_\_\_\_

Phone: Commercial: (\_\_\_\_) \_\_\_\_\_ DSN: \_\_\_\_\_

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## EDUCATION

### Instructions.

- **Submit copies** of all certificates, diplomas, or transcripts.
- Course descriptions are required for all courses that have not been pre-approved by the U.S. Navy Certification Board.
- Supporting documentation is **REQUIRED!!**
- This form should also be used to document all continuing education hours for recertification purposes.

1. Did you attend NDACS?

Yes  No

Class # \_\_\_\_\_ Graduation Date: \_\_\_\_\_

2. Have you completed six hours of ethics education/training?

Yes  No

(If Yes, insert documentation immediately following this page. If No, then STOP and complete a six hour ethics training regimen prior to submitting this application. NDACS graduates need only 3 additional hours of documented ethics training.)

3. Have you earned a degree or certificate from a college or university during this certification period?

Yes  No

School name: \_\_\_\_\_ Location \_\_\_\_\_

Type of Degree/Certificate \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Area of Concentration \_\_\_\_\_

Hours: \_\_\_\_\_

4. List all alcohol and other drug abuse courses/continuing education completed during this certification period. (If applying for initial certification and have not attended NDACS, list all courses being used to qualify for initial certification.)

**(Start with the most recent)**

A. Institution/conference/presenter name: \_\_\_\_\_

Course title: \_\_\_\_\_

Start Date \_\_\_\_\_ End Date: \_\_\_\_\_

Location \_\_\_\_\_

Hours: \_\_\_\_\_

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**(Duplicate and renumber this page if additional sheets are necessary)**

B. Institution/conference/presenter name: \_\_\_\_\_

Course title: \_\_\_\_\_

Start Date \_\_\_\_\_ End Date: \_\_\_\_\_

Location \_\_\_\_\_ Hours: \_\_\_\_\_

C. Institution/conference/presenter name: \_\_\_\_\_

Course title: \_\_\_\_\_

Start Date \_\_\_\_\_ End Date: \_\_\_\_\_

Location \_\_\_\_\_ Hours: \_\_\_\_\_

D. Institution/conference/presenter name: \_\_\_\_\_

Course title: \_\_\_\_\_

Start Date \_\_\_\_\_ End Date: \_\_\_\_\_

Location \_\_\_\_\_ Hours: \_\_\_\_\_

E. Institution/conference/presenter name: \_\_\_\_\_

Course title: \_\_\_\_\_

Start Date \_\_\_\_\_ End Date: \_\_\_\_\_

Location \_\_\_\_\_ Hours: \_\_\_\_\_

F. Institution/conference/presenter name: \_\_\_\_\_

Course title: \_\_\_\_\_

Start Date \_\_\_\_\_ End Date: \_\_\_\_\_

Location \_\_\_\_\_ Hours: \_\_\_\_\_

G. Institution/conference/presenter name: \_\_\_\_\_

Course title: \_\_\_\_\_

Start Date \_\_\_\_\_ End Date: \_\_\_\_\_

Location \_\_\_\_\_ Hours: \_\_\_\_\_

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## **CURRENT COUNSELOR CERTIFICATIONS**

What Alcohol or Other Drug Abuse (AODA) counselor certification(s) do you hold?  
(If none put "N/A" in first line and proceed to next page)

**Certification Board/Agency Name:** \_\_\_\_\_  
(e.g. U.S. Navy Certification Board (USNCB))

Cert. title: \_\_\_\_\_ Cert # \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
(e.g. ADC I)

(If certified by agency other than USNCB then include the following)

Address: \_\_\_\_\_

Number, Street, Suite Number

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ -

Telephone: (\_\_\_\_) \_\_\_\_\_ Email address (if known): \_\_\_\_\_

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**Certification Board/Agency Name:** \_\_\_\_\_  
(e.g. U.S. Navy Certification Board (USNCB))

Cert. title: \_\_\_\_\_ Cert # \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
(e.g. ADC I)

(If certified by agency other than USNCB then include the following)

Address: \_\_\_\_\_

Number, Street, Suite Number

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ -

Telephone: (\_\_\_\_) \_\_\_\_\_ Email address (if known): \_\_\_\_\_

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**Certification Board/Agency Name:** \_\_\_\_\_  
(e.g. U.S. Navy Certification Board (USNCB))

Cert. title: \_\_\_\_\_ Cert # \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
(e.g. ADC I)

(If certified by agency other than USNCB then include the following)

Address: \_\_\_\_\_

Number, Street, Suite Number

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ -

Telephone: (\_\_\_\_) \_\_\_\_\_ Email address (if known): \_\_\_\_\_

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## **PROFESSIONAL/VOLUNTEER WORK EXPERIENCE**

### **NOTES:**

- A normal work year is calculated to be 2,080 hours minus any leave or extended TAD periods.
- The USNCB recognizes no more than 40 hours per week when calculating work experience.
- It is the USNCB policy to scrutinize any application that is submitted with the bare minimum three years experience.

### **Military Work Setting**

1. Are you currently working as a full time AODA counselor in a military treatment facility?

Yes  No

(If no go to # 2)

What is the Facility name? \_\_\_\_\_

What is your position title? \_\_\_\_\_

Describe the primary responsibilities of your position? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Start Date: \_\_\_\_\_ mo/day/yr End Date: \_\_\_\_\_ mo/day/yr

2. List all previous military AODA treatment work experience:

Facility Name: \_\_\_\_\_ Position: \_\_\_\_\_

Describe position responsibilities: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Start Date: \_\_\_\_\_ mo/day/yr End Date: \_\_\_\_\_ mo/day/yr

Facility Name: \_\_\_\_\_ Position: \_\_\_\_\_

Describe position responsibilities: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Start Date: \_\_\_\_\_ mo/day/yr End Date: \_\_\_\_\_ mo/day/yr

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3. If currently working in a military treatment facility have the Facility Director complete the following section:

**Facility director verification of work experience hours.**

Through direct observation, review of fitness/evaluation reports, or other documentation of work experience, I certify that the applicant has completed \_\_\_\_\_ hours of AODA counseling work as of \_\_\_\_\_.

mo/day/yr

Director name:(print)\_\_\_\_\_ Signature \_\_\_\_\_

4. **Applicant's affidavit of military work experience hours.**

I certify that I have worked in the above treatment setting(s) providing direct counseling services to AODA clients for the periods listed.

Applicant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Civilian Work Setting**

**Note:** If applying for recertification and/or no longer working in a military treatment facility list any civilian or volunteer work in this section. If none, go to the Code of Ethics on page ADC II - 10

5. List all paid or volunteer work experience. Each entry requires supporting documentation on agency letterhead.

Agency/Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Number, Street, Suite Number

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ - \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Is this Paid or Volunteer? \_\_\_\_\_

mo/day/yr

mo/day/yr

Describe, in detail, what duties you perform at this job: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How many hours a week, on average, do you perform these duties? \_\_\_\_\_ Weekly Work Hours: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Have you attached documentation that supports all of the above? **Yes**  **No**

(If No then the above work experience will not be counted for certification/recertification purposes.)

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**(Duplicate and renumber this page if additional sheets are necessary)**

Agency/Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
Number, Street, Suite Number

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ -

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Is this Paid or Volunteer? \_\_\_\_\_  
mo/day/yr mo/day/yr

Describe, in detail, what duties you perform at this job: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How many hours a week, on average, do you perform these duties? Weekly Work Hours: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Have you attached documentation that supports all of the above? **Yes**  **No**

(If No then the above work experience will not be counted for certification/recertification purposes.)

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Agency/Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
Number, Street, Suite Number

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ -

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Is this Paid or Volunteer? \_\_\_\_\_  
mo/day/yr mo/day/yr

Describe, in detail, what duties you perform at this job: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How many hours a week, on average, do you perform these duties? Weekly Work Hours: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Have you attached documentation that supports all of the above? **Yes**  **No**

(If No then the above work experience will not be counted for certification/recertification purposes.)

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## **Code of Ethics for ADC II**

### **I. Personal Responsibility**

- A.** I am responsible for providing the highest quality of care to those who seek my professional service.
- B.** I am responsible for having knowledge of organizational policies and guidelines and will demonstrate respect for these procedures. I will take the initiative, in an appropriate manner; to improve on policies and procedures if doing so will best serve the interest of the patients.
- C.** I am responsible for my own conduct at all times. This includes, but is not limited to, my physical, emotional and mental well being as well as the use of alcohol and other mood-changing substances.
- D.** I am responsible for protecting the integrity and accountability of this profession by reporting violations of these ethical standards by other counselors.

### **II. Patient Welfare**

- A.** I will engage the patient in a therapeutic process based on simple, clear, and easily understood communication.
- B.** I will refer patients to another program or individual when it is determined to be in their best interest.
- C.** I will ensure the presence of an appropriate setting for clinical work to protect the patient from harm and the profession from discredit.
- D.** In the execution of my duties, I will not discriminate against any person(s), e.g., patients, staff, or any recipient of professional services. I will not engage in any action that violates the civil and/or legal rights of person(s).

### **III. Legal and Moral Standards**

- A.** I acknowledge that my moral, ethical, and legal standards of behavior are a personal matter to the same degree as they are for other military and civilian counselors, except as these may compromise the fulfillment of my professional responsibilities.
- B.** I will not participate in, condone, or be associated with fraud, dishonesty or misrepresentation.

### **IV. Competence**

- A.** I will limit my services to the areas in which I am trained and competent. I will not offer services or use techniques outside the scope of services for drug and alcohol counselors.



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## **COMPETENCY ASSESSMENT FORM**

**(Do not complete this section for recertification)**

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### **EVALUATOR QUALIFICATIONS**

- This section must be completed by an individual who meets the definition and requirements as a Clinical Preceptor and/or Clinical Supervisor as defined in the current certification instruction.
- LIPs, CCS, or other supervisors meeting the criteria of a clinical supervisor, are encouraged to provide an evaluation of the applicant's competence. In cases where significant discrepancies exist between the evaluations, the Preceptor, Clinical Supervisor and individual should resolve the discrepancy before submission for certification.
- All evaluators must have had responsibility for supervising or training the applicant for a minimum of 90 days.

Candidate Name: \_\_\_\_\_  
Last First Middle

Facility name and location where applicant is/was being observed: \_\_\_\_\_

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### **Preceptor Information:**

Preceptor: \_\_\_\_\_  
(print or type) Name Title Affiliation / Credentials

E-mail address: \_\_\_\_\_

Length Supervised by Preceptor: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
months mo/day/yr mo/day/yr

Preceptor verification of length of supervision: \_\_\_\_\_  
Signature Date

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### **Clinical Supervisor Information**

Clinical Supervisor: \_\_\_\_\_  
(print or type) Name Title Affiliation / Credentials

E-mail address: \_\_\_\_\_

Length Supervised by Clinical Supervisor: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
months mo/day/yr mo/day/yr

Supervisor verification of length of supervision : \_\_\_\_\_  
Signature Date

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**CORE FUNCTIONS OF THE ALCOHOL AND OTHER DRUG ABUSE  
COUNSELOR:**

Alcohol and Drug Counselor II (ADC II) competence is based on demonstrated proficiency in the 13 Core Functions and the 49 associated Global Criteria identified in the following tables. The certification process is one measure of competence. Addiction professionals are not required to be experts in all these functions, but as a candidate for ADC II the applicant must be able to demonstrate a minimum level of competence in each of the 13 Core Functions. This form not only serves to represent an evaluation of the applicant’s competence, but also as a means of documenting the required hours of supervision. A total of 300 hours of Supervised Practical Training must be documented on this form with a **minimum of 10 hours in each Core Functions**. Remember that although many of the functions and tasks may overlap, depending on the nature of the counselor's practice, each represents a specific aspect of counselor skills.

**Table Instructions:**

- **Hours of Supervised Practical Training should be annotated for each core function, not for each Global criteria.**
- **The evaluator, preferably the Clinical Preceptor, should take into account all previous supervisor evaluations when completing these tables and is responsible for verifying and documenting the total hours of supervision accumulated in each core function.**
- **Since the Case Presentation Method (CPM) will evaluate the applicant’s knowledge and skills in each Global Criteria, all of the areas in the following tables must be rated. Not Observed indicates the applicant may not be entirely ready for certification as an ADC II.**

Place an ‘X’ in the appropriate Box. Use a 1 as the LOWEST rating, 5 as the HIGHEST.

AREA OF COMPETENCY	1	2	3	4	5	N/O	Hours
<b>SCREENING</b> The process by which a patient is determined to be appropriate and eligible for admission to a particular program.							
<b>GC1-Evaluate symptoms:</b> Evaluate psychological, social, and physiological signs and symptoms of alcohol and other drug use and abuse.	<input type="checkbox"/>						
<b>GC2-Appropriateness:</b> Determine the client’s appropriateness for admission or referral.	<input type="checkbox"/>						
<b>GC3-Eligibility:</b> Determine the client's eligibility for admission or referral.							
<b>GC4-Coexisting Conditions:</b> Identify any co-existing conditions (medical, psychiatric, physical, etc.) that indicate a need for additional professional assessment and/or services.	<input type="checkbox"/>						
<b>GC5-Laws/Policies:</b> Adhere to applicable laws, regulations and agency policies governing alcohol and other drug abuse services.	<input type="checkbox"/>						

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AREA OF COMPETENCY	1	2	3	4	5	N/O	Hours
<b><i>INTAKE</i></b>							
The administrative and initial assessment procedures for admission to a program.							
<b>GC6-Admission Documents:</b> Complete required documents for admission to the program.	<input type="checkbox"/>						
<b>GC7-Eligibility Documents:</b> Complete required documents for program eligibility and appropriateness.	<input type="checkbox"/>						
<b>GC8-Signed Consents:</b> Obtain appropriately signed consents when soliciting from or providing information to outside sources to protect client confidentiality and rights.	<input type="checkbox"/>						
<b><i>ORIENTATION</i></b>							
Describing to the patient the general nature and goals of the program; rules governing patient conduct and infractions that can lead to disciplinary action or discharge from the program; hours during which services are available in a non-traditional setting; treatment costs to be borne by the patient, if any; and patient rights							
<b>GC9-Program Goals:</b> Provide an overview to the client by describing program goals and objectives for client care.	<input type="checkbox"/>						
<b>GC10-Rules/Client Obligations:</b> Provide an overview to the client by describing program rules, and client obligations and rights.	<input type="checkbox"/>						
<b>GC11-Program Operation:</b> Provide an overview to the client of program operations.	<input type="checkbox"/>						
<b><i>ASSESSMENT</i></b>							
Those procedures by which a counselor/program identifies and evaluates an individual's strengths, weaknesses, problems and needs for the development of the treatment plan.							
<b>GC12-History:</b> Gather relevant history from client including but not limited to alcohol and other drug abuse using appropriate interview techniques.	<input type="checkbox"/>						
<b>GC13-Methods/Procedures:</b> Identify methods and procedures for obtaining corroborative information from significant secondary sources regarding clients' alcohol and other drug abuse and psychosocial history.	<input type="checkbox"/>						
<b>GC14-Assessment Tools:</b> Identify appropriate assessment tools.	<input type="checkbox"/>						
<b>GC15-Explain Techniques:</b> Explain to the client the rationale for the use of assessment techniques in order to facilitate understanding.	<input type="checkbox"/>						
<b>GC16-Diagnostic Evaluation:</b> Develop a diagnostic evaluation of the client's substance abuse and any co-existing conditions based on the results of all assessments in order to provide an integrated approach to treatment planning based on the client's strengths, weaknesses, and identified problems and needs.	<input type="checkbox"/>						

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AREA OF COMPETENCY	1	2	3	4	5	N/O	Hours
<b>TREATMENT PLANNING</b>							
Process by which the counselor and the patient: identify and rank problems needing resolution; establish agreed upon immediate and long-term goals; decide on a treatment process and the resources to be utilized							
<b>GC17-Explain Results:</b> Explain assessment results to client in an understandable manner.	<input type="checkbox"/>						
<b>GC18-Identify/Rank Problems:</b> Identify and rank problems based on individual client needs in the written treatment plan.	<input type="checkbox"/>						
<b>GC19-Immediate/Long-Term Goals:</b> Formulate agreed upon immediate and long-term goals using behavioral terms in the written treatment plan.	<input type="checkbox"/>						
<b>GC20-Methods/Resources:</b> Identify the treatment methods and resources to be utilized as appropriate for the individual client.	<input type="checkbox"/>						
<b>COUNSELING</b>							
The utilization of special skills to assist individuals, families or groups in achieving objectives through: exploring a problem and its ramifications; examining attitudes and feelings; considering alternative solutions; and decision-making							
<b>GC21-Theory(ies):</b> Select the counseling theory (ies) that apply (ies).	<input type="checkbox"/>						
<b>GC22-Techniques Problems:</b> Apply technique(s) to assist the client, group, and/or family in exploring problems and ramifications.	<input type="checkbox"/>						
<b>GC23-Techniques Behavior:</b> Apply technique(s) to assist the client, group, and/or family in examining the client's behavior, attitudes, and/or feelings if appropriate in the treatment setting.	<input type="checkbox"/>						
<b>GC24-Individualize:</b> Individualize counseling in accordance with cultural, gender, and lifestyle differences.	<input type="checkbox"/>						
<b>GC25-Interact:</b> Interact with the client in an appropriate therapeutic manner.	<input type="checkbox"/>						
<b>GC26- Client Solutions:</b> Elicit solutions and decisions from the client.	<input type="checkbox"/>						
<b>GC27 –Implement:</b> Implement the treatment plan.	<input type="checkbox"/>						
<b>CASE MANAGEMENT</b>							
Activities which bring services, agencies, resources or people together within a planned framework of action toward the achievement of established goals. It may involve liaison activities and collateral contacts.							
<b>GC28 –Coordinate Services:</b> Coordinate services for client care.	<input type="checkbox"/>						
<b>GC29-Explain Rationale:</b> Explain the rationale of case management activities to the client.	<input type="checkbox"/>						

*The forms contained in this Portfolio are originals.  
Please make sufficient copies prior to use!*

*All entries must be legible*

AREA OF COMPETENCY	1	2	3	4	5	N/O	Hours
<b><i>CRISIS INTERVENTION</i></b> Those services that respond to an alcohol and/or other drug abuser's needs during acute emotional and/or physical distress.							
<b>GC30-Recognize Crisis:</b> Recognize the elements of the client crisis.	<input type="checkbox"/>						
<b>GC31-Implement Action:</b> Implement an immediate course of action appropriate to the crisis.	<input type="checkbox"/>						
<b>GC32-Enhance Treatment:</b> Enhance overall treatment by utilizing crisis events.	<input type="checkbox"/>						
<b><i>CLIENT EDUCATION</i></b> Provision of information to individuals and groups concerning alcohol and other drug abuse and the available services and resources							
<b>GC33-Present Information:</b> Present relevant alcohol and other drug use/abuse information to the client through formal and/or informal processes.	<input type="checkbox"/>						
<b>GC34-Services/Resources:</b> Present information about available alcohol and other drug services and resources.	<input type="checkbox"/>						
<b><i>REFERRAL</i></b> Identifying patient needs that cannot be met by the counselor or agency, and assisting the patient in utilizing support systems and available community resources.							
<b>GC35-Needs Cannot Meet:</b> Identify need(s) and/or problem(s) that the agency and/or counselor cannot meet.	<input type="checkbox"/>						
<b>GC36-Explaining Rationale:</b> Explain the rationale for the referral to the client.	<input type="checkbox"/>						
<b>GC37-Match Needs/Resources:</b> Match client needs and/or problems to appropriate resources.	<input type="checkbox"/>						
<b>GC38-Confidentiality:</b> Apply regulations appropriately.	<input type="checkbox"/>						
<b>GC39-Utilize Resources:</b> Assist the client in utilizing the support systems and community resources available.	<input type="checkbox"/>						
<b><i>REPORTS/RECORD KEEPING</i></b> Charting the results of the assessment and treatment plan, writing reports, progress notes, discharge summaries and other patient-related data.							
<b>GC40-Prepare Reports/Records:</b> Prepare reports and relevant records integrating available information to facilitate the continuum of care.	<input type="checkbox"/>						
<b>GC41-Chart Ongoing Information:</b> Chart pertinent ongoing information pertaining to the client.	<input type="checkbox"/>						
<b>GC42-Utilize Information:</b> Utilize relevant information from written documents for client care.	<input type="checkbox"/>						



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Please make sufficient copies prior to use!*

*All entries must be legible*

**CERTIFICATION TESTING INFORMATION**

**DANTES/EDUCATION OFFICER AFFIDAVIT**

Only the DANTES Testing Officer may administer the written AODA examination. Instructions for administering the examination, will be forwarded to the DANTES Test Control Office. The examination may **ONLY** be administered on the dates set by IC&RC/AODA. Both you and the DANTES Test Control Officer (TCO) will receive notification of the test date via official correspondence. Please have the DANTES TCO complete the following form.

Testing Official Name: Mr./Ms./Mrs.  
(Please Print Legibly) (circle one) First MI Last

Physical Shipping Address: \_\_\_\_\_  
(for UPS/FED-EX delivery)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ - \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ DSN: \_\_\_\_\_

FAX: ( \_\_\_\_\_ ) \_\_\_\_\_ E-mail address: \_\_\_\_\_

I certify that I am the designated DANTES Testing Official and that I will follow established procedures in order to protect the certification examination against compromise. I will notify the USNCB if there are any discrepancies in the testing procedures.

Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Alternate DANTES Contact information : Please provide alternate point of contact information, if applicable.

Alternate Testing Official Name: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_



## ***QUARTERLY FEEDBACK FORM***

Place an 'X' in the appropriate box. Use a **1 as the LOWEST** rating, **5 as the HIGHEST** and **N/O to indicate NOT OBSERVED**. An "Hours" column has been provided to indicate the approximate amount of time spent in supervised practical training in each Core Function. A space for comments on each Core Function has been provided. Each of the Global Criteria (GC) need not be evaluated each time a counselor is given feedback.

AREA OF COMPETENCY	1	2	3	4	5	N/O	Hours
<b><i>SCREENING</i></b>	<input type="checkbox"/>						
GC1-Evaluate Symptoms	Comments:						
GC2-Appropriateness							
GC3-Eligibility							
GC4-Coexisting Conditions							
GC5-Laws/Policies							
<b><i>INTAKE</i></b>	<input type="checkbox"/>						
GC6-Admission Documents	Comments:						
GC7-Eligibility Documents							
GC8-Signed Consents							
<b><i>ORIENTATION</i></b>	<input type="checkbox"/>						
GC9-Program Goals	Comments:						
GC10-Rules/Client Obligations							
GC11-Program Operations							
<b><i>ASSESSMENT</i></b>	<input type="checkbox"/>						
GC12-History	Comments:						
GC13-Methods/Procedures							
GC14-Assessment Tools							
GC15-Explain Techniques							
GC16-Diagnostic Evaluation							
<b><i>TREATMENT PLANNING</i></b>	<input type="checkbox"/>						
GC17-Explain Results	Comments:						
GC18-Identify/Rank Problems							
GC19-Immediate/Long-Term Goals							
GC20-Methods/Resources							
<b><i>COUNSELING</i></b>	<input type="checkbox"/>						
GC21-Theory(ies)	Comments:						
GC22-Techniques (Problems)							
GC23-Techniques (Behavior)							
GC24-Individualize							
GC25-Interact							
GC26-Client Solutions							
GC27-Implement Treatment Plan							
<b><i>CASE MANAGEMENT</i></b>	<input type="checkbox"/>						
GC28-Coordinate Services	Comments:						
GC29-Explain Rationale							

AREA OF COMPETENCY	1	2	3	4	5	N/O	Hours
<b><i>CRISIS INTERVENTION</i></b>	<input type="checkbox"/>						
GC30-Recognize Crisis	Comments:						
GC31-Implement Action							
GC32-Enhance Treatment							
<b><i>CLIENT EDUCATION</i></b>	<input type="checkbox"/>						
GC33-Present Information	Comments:						
GC34-Services/Resources							
<b><i>REFERRAL</i></b>	<input type="checkbox"/>						
GC35-Needs Cannot be Met	Comments:						
GC36-Explaining Rationale							
GC37-Match Needs/Resources							
GC38-Confidentiality							
GC39-Utilize Resources							
<b><i>REPORT/RECORD KEEPING</i></b>	<input type="checkbox"/>						
GC40-Prepare Reports/Records	Comments:						
GC41-Chart Ongoing Information							
GC42-Utilize Information							
<b><i>CONSULTATION</i></b>	<input type="checkbox"/>						
GC43-Issues Beyond Skill	Comments:						
GC44-Consult Resources							
GC45-Laws/Policies							
GC46-Explain Rationale							
<b><i>PROFESSIONAL DEVELOPMENT</i></b>	<input type="checkbox"/>						
GC47-Demonstrate Code of Ethics	Comments:						
GC48- Utilize a Range of Options							
GC49- Professional Judgment							

Comments:

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Counselor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Preceptor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Site Manager's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NAVY DRUG AND ALCOHOL COUNSELOR SCHOOL (NDACS)**

<b>Course No.</b>	<b>Topic</b>	<b>Hours</b>
<b><u>Introductory Lessons</u></b>		
Intro - 1	Height/Weight/Body Fat Measurement	1.0
Intro - 2	ADMINISTRATION, Records and Forms Kiersey-Bates Temperament Survey	1.0
Intro - 3	Introductions	3.0
Intro - 4	NDACS Overview	3.0
<b><i>Unit – 1 Introduction to Navy Drug and Alcohol Counseling Program</i></b>		
1.1	Overview of Navy Substance Abuse Program Continuum of Care, 12 Steps, meeting requirements, film "Bill W"	5.0
* 1.2 *	Introduction to Group Meeting	4.0
* 1.3 *	Principles of effective Communication - Rules of communication, group membership, Johari's Window, listening skills	6.0
<b><u>Unit – 2 The Science of Substance Abuse and Addiction/Dependency</u></b>		
2.1	Overview of Social Use, Substance Abuse and Addiction/Dependency	2.0
2.2	Bio-Psycho-Social Aspects of Substance Abuse and Addiction/Dependence - Familiarization with Cross-walk, Dimensions	8.0
2.3	Pharmacology/Toxicology	8.0
2.4	Assessment of Substance Abuse and Addiction/Dependence - CAGE, SALCI, MAST, DSM-IV, AUDIT, SASSI, ASI	5.0
<b><i>Unit - 3 Counseling Psychology and Communication</i></b>		
3.1	Overview of Counseling - 1:1, Group Models	2.0
3.2	Overview of Human Development	2.0
* 3.3 *	Basic Characteristics and Techniques for Substance Abuse and Addiction/Dependency Counseling	8.0
* 3.4 *	Advanced Characteristics and Techniques for Substance Abuse and A/D Counseling	7.0
* 3.5 *	Individual Counseling	2.0
* 3.6 *	Single and Co-facilitating Groups	3.0
* 3.7 *	Group Dynamics – Group Leadership, Group tasks/behaviors, roles, interventions, stages of group development	7.0
* 3.8 *	Process Group Techniques – Content/process, process illumination, leadership skills	7.0
* 3.9 *	Structured Group Techniques – Solution focused therapy	4.0
3.10	Brief Therapy Techniques in Counseling – RET, solution focused, brief therapy	4.0

Course No.	Topic	Hours
<i>Unit – 4 Treatment Issues in Substance Abuse and Addiction/Dependency Counseling</i>		
4.1	<i>Overview of Treatment Issues</i>	1.0
* 4.2 *	<i>Defense Mechanisms and Resistance</i>	2.0
4.3	<i>Anger in Substance Abuse and Addiction/Dependency</i>	2.0
* 4.4 *	<i>Self-esteem, Guilt and Shame Issues</i>	2.0
* 4.5 *	<i>Grief and Loss Issues</i>	2.0
* 4.6 *	<i>Family of Origin Issues</i>	3.0
* 4.7 *	<i>Family Dynamics in Substance Abuse and Addiction/Dependency Counseling</i>	6.0
* 4.8 *	<i>Sexuality Issues – Healthy Boundaries</i>	5.0
* 4.9 *	<i>HIV and AIDS</i>	3.0
* 4.10 *	<i>Cultural Issues</i>	4.0
* 4.11 *	<i>Victimization and Perpetration Issues</i>	4.0
4.12	<i>Post-Traumatic Stress Disorder (PTSD)</i>	1.0
4.13	<i>Personality Traits and Disorders in Substance Abuse and Addiction/Dependence</i>	7.0
4.14	<i>Dual Diagnosis in Substance Abuse and Addiction/Dependence</i>	3.0
4.15	<i>Cross-Addiction</i>	1.0
* 4.16 *	<i>Crisis Intervention</i>	2.0
4.17	<i>Cardio-Pulmonary Resuscitation (CPR)</i>	8.0
<i>Unit – 5 Continuum of Care</i>		
5.1	<i>Overview of Continuum of Care</i>	1.0
* 5.2 *	<i>Motivational Interviewing</i>	8.0
5.3	<i>Screening Assessment</i>	8.0
5.4	<i>Intake Assessment</i>	4.0
5.5	<i>Treatment Planing – Individualized, art expression, journalizing, poe</i>	8.0
* 5.6 *	<i>Case Management and Documentation – Determining progress along dimensions, progress notes(narrative), IDT's/MDT's, staffing, discha planning, narrative summary, and referrals</i>	6.0
5.7	<i>Continuing Care</i>	
<i>Unit – 6 Personal and Professional Development</i>		
6.1	<i>Ethical Responsibilities</i>	4.0
6.2	<i>Class Presentations</i>	16.0
6.3	<i>Stress Management Techniques</i>	2.0
6.4	<i>Managing Personal Issues</i>	2.0
6.5	<i>Certification Examination</i>	3.0
6.6	<i>Portfolio Orientation</i>	1.0
6.7	<i>Intern Training Program</i>	1.0

Total Didactic Hours: 213

Total Practicum Hours: 120

Total Group Hours: 67

Total Hours: 400

\* Indicates a Mandatory Group following the Module

***DIRECTIONS FOR PREPARING A CASE FOR THE CPM***

**PLEASE NOTE: YOUR CASE MUST BE TYPED AND SHOULD PRESENT THE CASE OF AN ACTUAL CLIENT.**

- I. The case you present must be related to the certification you are seeking.
- II. Use an actual/typical client from your case files, one who has completed treatment or is no longer obtaining your services.
- III. Complete the demographic information on the client.
- IV. Provide the information for items A through K. Begin by typing A. SUBSTANCE ABUSE HISTORY as a subheading, follow with the narrative (story style), on the client's history of substance abuse. Proceed to Section B, PSYCHOLOGICAL FUNCTIONING.
- V. Sign the counselor's Statement on the Cover Sheet.
- VI. Give the complete case presentation to your supervisor for his or her review and signature (on the cover sheet).
- VII. Make five copies of the completed case presentation. Keep one copy for your Personal files; mail the original and four copies to the Certification Board, if required, along with your application materials.
- VIII. By submitting this case, you are pledging that you have prepared the written case independently on an actual/typical client.

**CASE PRESENTATION FORMAT**

FICTIONAL NAME: \_\_\_\_\_

AGE AT ADMISSION: \_\_\_\_\_ RACE: \_\_\_\_\_ SEX: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

EMPLOYMENT: \_\_\_\_\_

REFERRAL SOURCE: \_\_\_\_\_

CURRENT LEGAL STATUS: \_\_\_\_\_

ADMISSION DATE: \_\_\_\_\_ DISCHARGE DATE: \_\_\_\_\_

TREATMENT SETTING AND MODALITY: \_\_\_\_\_

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I. SUBSTANCE ABUSE HISTORY

1. Substance Used
2. Frequency
3. Progression
4. Severity/Amount Used
5. Onset - When Started
6. Primary Substance
7. Route of Administration
8. Effects – Blackouts, Tremors, Tolerance, DT’s, Seizures, Other Medical Complications (some of these can be included in the Physical History Section)

II. PSYCHOLOGICAL FUNCTIONING

1. Mental Status - Oriented, Hallucinations, Delusions, Suicidal, Homicidal, Judgment, Insight.

III. EDUCATIONAL/VOCATIONAL/FINANCIAL

1. Education and Work History
2. Education Level
3. Disciplinary Action (at school or work)
4. Reasons for Termination
5. Current and Past Financial Status

IV. LEGAL HISTORY (Associated with, or not associated with mood altering chemicals)

1. Charges, Arrests, Convictions
2. Current Status
3. Pending Legal Issues

V. SOCIAL HISTORY

1. Parents
2. Siblings/Rank
3. Psychological Functioning in Family
4. Substance use in Family
5. History of Social Functioning from Childhood to Present
6. Family Functioning – Including Physical, Sexual and Emotional Abuse
7. Relationship History
8. Children

VI. PHYSICAL HISTORY

1. Both Alcohol & Drug and Non-Alcohol & Drug Problems.
2. Past and Present Major Medical Problems - i.e. Disabilities, Pregnancy and Related Issues, STD, Alcohol and Drug-Related Problems

VII. TREATMENT HISTORY

1. Alcohol and Drug History
2. Psychological History

VIII. ASSESSMENT

Identify and evaluate an individuals strengths, weaknesses, problems and needs for the development of a Treatment Plan

IX. TREATMENT PLAN

Identify and rank problems needing resolutions; establishing agreed upon immediate and long-term goals; deciding on a treatment process and the resources to be utilized.

X. COURSE OF TREATMENT

Describe the counseling approaches you used your rationale for their use and any revisions you made based on the client's unique problems and responses to treatment.

XI. DISCHARGE SUMMARY

Concise descriptions of the client's overall response to treatment, including alcohol/drug status at discharge.

**Application for Counselor Reciprocity**

**HOW TO APPLY FOR RECIPROCITY:**

1. Complete this application and sign the release and authorizations.
2. Make a copy of this application to keep for your records.
3. Attach a copy of you current member board certificate (your application will be denied without this).
4. Enclose a check/money order for \$100.00 (\$90.00 if you are certified by USA/USN) to IC&RC
5. Mail complete application packet to IC&RC – 6402 Arlington Blvd, Ste 1200, Falls Church, VA 22042  
Phone (703) 294-5827 Fax: (703) 875-8867

Downloadable application: <http://www.icrcaoda.org/reciprocity/ReciprocityApplicationAODA.pdf>  
The IC&RC office will review your application and contact both certification boards involved in the reciprocity process. You will receive confirmation from your new certification board within 4 to 6 weeks.

**PLEASE PRINT OR TYPE:**

Name: \_\_\_\_\_ Daytime Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

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**RELEASE FORM - - This form expires 60 days from date of signature.**

I, \_\_\_\_\_ (your name) hereby authorize the IC&RC/AODA member board in \_\_\_\_\_ (Old state) to release all information regarding my qualification for Certification to the IC&RC/AODA member board in \_\_\_\_\_ (new state).

I, \_\_\_\_\_ (your name) also authorize the IC&RC/AODA member board in \_\_\_\_\_ (Old State) to verify, to their knowledge, whether or not I have received a reprimand, suspension, or revocation of my certificate for professional violation of the state code of conduct and/or ethics by that or any other board **at any time** during certification.

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I do \_\_\_\_ do not \_\_\_\_ wish to remain certified in both states.

If you have a Clinical Supervisor certification and wish to transfer it at no additional cost, please indicate so (if yes, then include a copy of certificate as well) YES \_\_\_\_ NO \_\_\_\_ N/A \_\_\_\_

**Authorization and Waiver**

**I hereby authorize the request and release of all records and/or information in any way relating to my certification, qualification or experience as an alcohol, drug, or AODA counselor, I understand that this includes, but is not limited to, oral or written contracts with members of the IC&RC/AODA, similar licensing or certifying agencies or another state, former employers and/or other persons or organizations having pertinent information. This is a waiver of my privilege that may otherwise exist in respect to the disclosure of such information.**

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***IC&RC/AODA International Certificate Application/Renewal***

As an ADC II alcohol and other drug abuse counselor certified by an IC&RC member board, (USNCB), you are eligible to receive an international certificate! This credential identifies you as an Internationally Certified Alcohol and Drug Abuse Counselor (ICADC).

By applying, you grant permission for your name, address, and phone number to be listed in the Directory of International Alcohol and Drug Abuse Counselors to be published at a later date by the IC&RC/AODA.

To apply for certification, or renewal, download and complete the application located at this web address: <http://www.icrcaoda.org/appdocs/ICADCApplication.pdf>

The cost is \$1.00 per month for the months remaining on your current certification. Make a check payable to IC&RC/AODA. (**Do Not** make the check out to the Navy or USNCB or it will be returned to you with your application)

Mail the application with the check or money order to:

NSHS NDACS  
ATTN: CERTIFICATION OFFICE  
NAVSUBASE BLDG 500  
140 SYLVESTER ROAD  
SAN DIEGO, CA 92106-3521