SURFACE WARFARE INSTITUTE MEDICAL

ALCOHOL & DRUG COUNSELOR

ADC II

(Reciprocal)

INITIAL CERTIFICATION PORTFOLIO

(Revised 22 January 2025)

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PREFACE

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 **REQUIRED** forms and application materials necessary for the ADC II reciprocal level certification.

BACKGROUND

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 the ADC II 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, as a result of licensure laws, may require additional education or testing prior to allowing an individual the **"right to practice**", and sometimes even become certified as a counselor in their jurisdiction. Many boards still do maintain the original definition and standards for reciprocity. Individuals need to check with the local IC&RC/AODA board for details and specifics. Board contact information can be found at http://internationalcredentialing.org/

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. Otherwise inviduals need to reciprocate to the local board where the indivdual lives or works more than 51% of the time.

ELIGIBILITY REQUIREMENTS

ADC II - Alcohol and Drug Counselor II (Reciprocal)

1. 300 Hours of AODA training related to the IC&RC Performance Domains + **6 hours** of documented ethics training, (completion of **NDACS** fulfills **only** 270 hours of the required AODA training and 3 hours of the ethics requirement, therefore 30 additional hours of **approved** substance use disorder counselor training and 3 additional hours of AODA ethics training must also be documented in this application.)

2. 3 years/6000 hours of supervised work experience. **(Submit all signed clinical work logs for clinical work experience)**. A Behavioral Science degree may be substituted as follows:

- Associates degree in behavioral science + 2.5 years/5000 hours AODA work experience
- Bachelors degree in behavioral science + 2 years/4000 hours AODA work experience
- Masters degree or higher in behavioral science + 1 year/2000 hours AODA work experience

3. 300 hours of Supervised Practical Training(Preceptorship): Minimum of 20 hours in each of the 8 Practice Domains. **(Submit all digitally signed supervision logs.)**

4. Adhere to the Navy Drug and Alcohol Counselor Code of Ethics through a signed statement

5. Submit all digitally signed clinical work logs for clinical work experience and supervision hours.

6. Favorable recommendation by Chain of Command and Clinical Preceptor/Supervisor acceptance of application for ADC II).

7. Pass IC&RC/AODA written examination (USNCB provides a free study guide upon

INSTRUCTIONS

1. All pages in this portfolio must be completed for initial certification. This is **NOT** the application for **recertification**, contact the certification office for the correct portfolio.

2. It is highly encouraged to maintain copies of all submissions.

3. Submit electronic copy of initial application package to the USNCB at: usn.san-diego.navmedotcswmica.list.ndacs-usncb@health.mil.
   (Please attempt to get all digital signature, however, if you or anyone is unable to digitally sign you will need to mail in the original signed document to the address below. Please note that only the page(s) with the original signature needs to be mailed in to NDACS. Please note this will delay processing.)

   If submitting by mail use the following address:

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

4. The Competency Assessment Form should be completed by ALL 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.

5. The USNCB will return incomplete applications via the chain of command.

RECIPROCITY

Application forms for reciprocity may be requested by contacting the USNCB directly at 619-553-8490
E-Mail: Mr. Laurian Cornia at laurian.m.cornia.civ@health.mil

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 Name: _____

Applicant's Signature: _____ Date:_____

ADC II - Alcohol and Drug Counselor II (Reciprocal)
APPLICATION

Check off items completed

__ **1.** 300 Hours of AODA training related to the IC&RC Performance Domains + **6 hours** of documented ethics training, (completion of **NDACS** fulfills **only** 270 hours of the required AODA training and 3 hours of the ethics requirement, therefore 30 additional hours of **approved** substance use disorder counselor training and 3 additional hours of AODA ethics training must also be documented separately in this application.)

__ **2.** 3 years/6000 hours of supervised work experience. **(Submit all signed clinical work logs.)** A Behavioral Science degree may be substituted as follows:

- Associates degree in behavioral science + 2.5 years/5000 hours AODA work experience
- Bachelors degree in behavioral science + 2 years/4000 hours AODA work experience
- Masters degree or higher in behavioral science + 1 year/2000 hours AODA work experience

__ **3.** 300 hours of Supervised Practical Training(Preceptorship): Minimum of 20 hours in each of the 8 Practice Domains. (Submit all signed supervision logs.)

__ **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 Preceptor/Supervisor

This application is **ONLY** for the **initial** certification and testing for the Navy's ADC II credential.

Submit to USNCB

If you get an error when trying to submit, please check the following required fields and ensure they are complete:

You may click on the listed requirement to go directly to that page.

PERSONAL DATA

Rating/Rank (Include Special Designators): _____

Name: _____ _____ _____
First Middle Last

Phone: Comm: (_____)_____Ext:_____ Cell: _____

E-mail addresses: (official) _____ Personal: _____

ADC I Certification # Expiration Date:

** New applicants please provide your SSN to NDACS Admin at 619-553-8499 in order for your file to begin processing. NDACS graduates do not need to contact NDACS Admin.

Current Site Name (e.g., SARP Rota, SARP USS STENNIS) _____

Current Position: _____
(e.g., Counselor, Senior Counselor, DDRC, Program Director, etc.)

Official Command Address: (e.g., Commanding Officer, Naval School of Health Sciences, NDACS ATTN Certification Office, 140 Sylvester Road, San Diego, CA 92106-3521)

City _____ State _____ Zip Code _____-_____
Zip + 4 required

Projected Rotation Date: _____ Next Duty Station: _____
DD/MM/YY (If known)

Address to mail certificate: (If different than current command mailing address)
Note, certificate may be mailed to a personal (home) address. Tests must be mailed to an official mailing address.

REFERENCES

Current Immediate Supervisor Name: _____
Last First MI

Rank/Rate: _____ Title: _____

E-mail address: _____ Phone: (_____) _____

(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: (_____) _____

Preceptor Name: _____
Last First MI

E-mail address: _____ Phone: (_____) _____

EDUCATION

NOTES

- ***Submit copies*** of all certificates, diplomas, or transcripts.
- Course descriptions are required for **all** college or distance learning courses.
- Supporting documentation is ***REQUIRED!!***

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 six hours AODA counselor ethics training prior to submitting this application. NDACS graduates need only 3 additional hours of documented AODA counselor ethics training.)

3. Are you requesting to substitute an applicable college degree in lieu of work experience hours? **Yes** ☐ **No** ☐

NOTE:
Behavioral Science degrees may be substituted for work experience as follows:
Associates degree + 2.5 years/5000 hours AODA work experience
Bachelors degree + 2 years/4000 hours AODA work experience
Masters degree or higher + 1 year/2000 hours AODA work experience

Behavioral science majors explore and understand the effect of human actions on relationships and decision making. Traditionally, behavioral science majors applied their skills in social work and counseling settings.
Examples of Behavioral Science degrees are: Psychology, Counseling, Social Work, Marriage and Family Counseling, etc.

School name:_____ Location_____

Type of Degree/Certificate_____

Start Date:_____ End Date: _____

MM/DD/YY MM/DD/YY

Major/Area of Concentration_____

4. List all substance use disoder counseling courses completed, including the school/course listed in number 3 above, if coursework is applicable. NDACS graduates must document 30 additional hours of substance use disorder counseling education including 3 hours of additional hours of substance use disorder counselor ethics training. These additional 30 hours and 3 hours of ethics training cannot be dupplicative of training received at NDACS. For example, a distance learning course in Basic Counseling Skills would not count towrds the 30 hours as NDACS graduates have already completed training in this area. **Fill out all fields completely for all courses/CEs.** Copies of transcripts or completion certificates along with course description/syllabus must be attached.

(Start with the most recent)

A. Institution/school name:_____

Location: _____ Course grade: _____

Course title:_____

Completion Date_____ Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/quarter,etc)** Contact/ Continuing Ed

B. Institution/school name:_____

Location: _____ Course grade: _____

Course title:_____

Completion Date_____ Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/quarter,etc)** Contact/ Continuing Ed

C. Institution/school name:_____

Location: _____ Course grade: _____

Course title:_____

Completion Date_____ Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/quarter,etc)** Contact/ Continuing Ed

D. Institution/school name:_____

Location: _____ Course grade: _____

Course title:_____

Completion Date_____ Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/quarter,etc)** Contact/ Continuing Ed

E. Institution/school name:_____

Location: _____ Course grade: _____

Course title:_____

Completion Date_____ Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/qu** Contact/ Continuing Ed

F. Institution/school name:_____

Location: _____ Course grade: _____

Course title:_____

Completion Date_____ Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/ quarter,etc)** Contact/ Continuing Ed

G. Institution/school name:_____

Location: _____ Course grade: _____

Course title:_____

Completion Date_____ Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/ quarter,etc)** Contact/ Continuing Ed

H. Institution/school name:_____

Location: _____ Course grade: _____

Course title:_____

Completion Date_____ Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/ quarter,etc)** Contact/ Continuing Ed

I. Institution/school name:_____

Location: _____ Course grade: _____

Course title:_____

Completion Date_____Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/ quarter,etc)** Contact/ Continuing Ed

J. Institution/school name: _____

Location: _____ Course grade: _____

Course title: _____

Completion Date _____ Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/qu** Contact/ Continuing Ed

K. Institution/school name: _____

Location: _____ Course grade: _____

Course title: _____

Completion Date _____ Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/ quarter,etc)** Contact/ Continuing Ed

L. Institution/school name: _____

Location: _____ Course grade: _____

Course title: _____

Completion Date _____ Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/ quarter,etc)** Contact/ Continuing Ed

M. Institution/school name: _____

Location: _____ Course grade: _____

Course title: _____

Completion Date _____ Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/ quarter,etc)** Contact/ Continuing Ed

N. Institution/school name: _____

Location: _____ Course grade: _____

Course title: _____

Completion Date _____ Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/ quarter,etc)** Contact/ Continuing Ed

O. Institution/school name:_____

Location: _____ Course grade: _____

Course title:_____

Completion Date_____ Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/qu** Contact/ Continuing Ed

P. Institution/school name:_____

Location: _____ Course grade: _____

Course title:_____

Completion Date_____ Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/ quarter,etc)** Contact/ Continuing Ed

Q. Institution/school name:_____

Location: _____ Course grade: _____

Course title:_____

Completion Date_____ Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/ quarter,etc)** Contact/ Continuing Ed

R. Institution/school name:_____

Location: _____ Course grade: _____

Course title:_____

Completion Date_____ Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/ quarter,etc)** Contact/ Continuing Ed

S. Institution/school name:_____

Location: _____ Course grade: _____

Course title:_____

Completion Date_____Hours: _____

MM/DD/YY **Specify type of hours (e.g. contact/semester/ quarter,etc)** Contact/ Continuing Ed

(Duplicate and renumber this page (e.g., ADC II – 6.1) if additional sheets are necessary)

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) MM/DD/YY MM/DD/YY

(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): ______________________________

Certification Board/Agency Name: ____
(e.g. U.S. Navy Certification Board (USNCB)

Cert. title:______________ Cert # ________________ Start Date: ____________ End Date: ____________
(e.g. ADC I) MM/DD/YY MM/DD/YY

(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): ______________________________

Certification Board/Agency Name: ____
(e.g. U.S. Navy Certification Board (USNCB)

Cert. title:______________ Cert # ________________ Start Date: ____________ End Date: ____________
(e.g. ADC I) MM/DD/YY MM/DD/YY

(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): ______________________________

PROFESSIONAL/VOLUNTEER WORK EXPERIENCE

NOTES:

- A normal work year is calculated to be 2,080 hours minus any leave or extended TAD or Individual Augmentation (IA) periods
- 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: _____ (MM/DD/YY) End Date: _____ (MM/DD/YY)

2. List all previous military AODA treatment work experience:

A. Facility Name: _____ Position: _____

Describe position responsibilities:_____

_____

Start Date: _____ (MM/DD/YY) End Date: _____ (MM/DD/YY)

B. Facility Name: _____ Position: _____

Describe position responsibilities:_____

_____

Start Date: _____ (MM/DD/YY) End Date: _____ (MM/DD/YY)

C. Facility Name: _____ Position: _____

Describe position responsibilities: _____

_____

Start Date: _____ End Date: _____
MM/DD/YY MM/DD/YY

D. Facility Name: _____ Position: _____

Describe position responsibilities: _____

_____

Start Date: _____ End Date: _____
MM/DD/YY MM/DD/YY

E. Facility Name: _____ Position: _____

Describe position responsibilities: _____

_____

Start Date: _____ End Date: _____
MM/DD/YY MM/DD/YY

F. Facility Name: _____ Position: _____

Describe position responsibilities:

_____

Start Date: _____ End Date: _____
MM/DD/YY MM/DD/YY

G. Facility Name: _____ Position: _____

Describe position responsibilities: _____

_____

Start Date: _____ End Date: _____
MM/DD/YY MM/DD/YY

3. **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: _____
MM/DD/YY

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

Note to Applicant:

If currently working in a military treatment facility have the Facillity Director complete the following section: (If not currently working at a SARP, have your most recent Facility Director complete this verification.)

Note to Facility Director: (PLEASE READ)

ADC II requires a minimum 6,000 hours of supervised work experience. Leave, TAD and IA/deployment periods **DO NOT COUNT** towards supervised work experience. (e.g., Individual graduated NDACS in March 2005. He/she spent 1 month on leave before reporting to the SARP and 3 months on Auxiliary Security Force Duty away from the field/SARP for a total of 16 weeks. Therefore 40 hours times 16 weeks equals 640 hours. If it is now March 2008, the individual now has 3 years in the field since graduation from NDACS. Therefore 3 years (2,080 hours per year) = 6,240. Since the applicant was not working as a counselor for a total of 640 hours subtract (6,240-640 = 5,600). This individual must perform 400 more hours of supervised work experience to meet the required work experience of 6,000 hours.

Note: All hours must be documented in counselor work logs and logs must be submitted with this application for review.

Through either direct observation or 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 _____.
MM/DD/YY

Director name:(print)_____

Signature _____ Date:_____
MM/DD/YY

Civilian Work Setting

5. List all paid or volunteer work experience. Each entry requires supporting documentation on agency letterhead if it is to be counted towards hours for certification. Documentation should list the total number of hours completed at each facility.

Agency/Employer: _____

Address: _____
Number, Street, Suite Number

City _____ State _____ Zip Code _____-_____

Start Date: _____ End Date: _____ Is this Paid or Volunteer?_____
MM/DD/YY MM/DD/YY

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? (If No then the above work experience will not be counted for certification purposes.) **Yes** ☐ **No** ☐

Agency/Employer: _____

Address: _____
Number, Street, Suite Number

City _____ State _____ Zip Code _____-_____

Start Date: _____ End Date: _____ Is this Paid or Volunteer?_____
MM/DD/YY MM/DD/YY

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? (If No then the above work experience will not be counted for certification purposes.) **Yes** ☐ **No** ☐

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. I will assist in any investigation of unethical behavior and cooperate with the USNCB demonstrating integrity, honor, and commitment to the Navy and the profession.

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. I will protect the confidentiality of patient information as required by law and within the reporting limitations defined by law and military regulations.

E. 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.

B. I will provide culturally sensitive and competent treatment services to patients under my care.

C. I will continue to be involved in the assessment of my personal strengths, limitations and effectiveness. I agree to continue professional growth through education, training, clinical supervision, and clinical preceptorship.

V. Patient and Professional Relationships

A. I will not enter into any non-professional relationship or commitments that conflict with the primary welfare and interests of the patient, colleagues, or supervisors.

B. Under no circumstances will I engage in sexual activities with a patient (current or previous), staff counselors, supervisors, or supervisees, nor will I engage in sexual relationships with the family members of any of these aforementioned groups. There is no specific time limit within which sexual relationships with a patient or previous patient can be shown to not potentially cause grave psychological harm, therefore the prohibition is indefinite. I will not engage in a therapeutic relationship/treatment with someone with whom I have had sexual relationships in the past.

C. I will treat patients and colleagues with respect, fairness and courtesy, and will act with integrity in dealing with them and all others who seek my professional services.

D. I will not ask for nor accept gifts or favors from patients and/or family members of patients.

E. I will not enter into non-professional social media relationships with patients or their family members or use social media/technology to access information regarding a patient without informed consent or prior written approval as part of an authorized treatment procedure.

F. I will avoid any action that might appear to impose on other's acceptance of their religious/spiritual, political, or other personal beliefs while also encouraging and supporting participation in recovery support groups.

VI. Code of Ethics Training

A. I certify I have completed 6 hours of ethics training. (Three hours of ethics is taught during NDACS.)

In addition to the above code of ethics, I will abide by the requirements and ethical standards expressed in appropriate Navy or Marine Corps instructions related to Health Care and Drug and Alcohol Counseling. I also support the combined NAADAC and IC&RC Code of Ethics.

Name: _____ Signature: _____
Print

Date:_____
MM/DD/YY

COMPETENCY ASSESSMENT FORM

(Do not complete this section for recertification)

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 submitting this application..
- 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: _____

Preceptor Information:

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

E-mail address: _____

Length Supervised by Preceptor: _____ Start Date: _____ End Date: _____
MONTHS MM/DD/YY MM/DD/YY

Preceptor verification of length of supervision: _____
Signature Date

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 MM/DD/YY MM/DD/YY

Supervisor verification of length of supervision : _____
Signature Date

OMPETENCY ASSESSMENT OF THE ALCOHOL AND OTHER DRUG ABUSE COUNSELOR:

Alcohol and Drug Counselor II (ADC II) competence is based on demonstrated proficiency in the 8 Practice Domains and the 123 associated competencies 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 8 Practice Domains. 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 supervised practical experience. A total of 300 hours of Supervised Practical Training must be documented on this form with a **minimum of 20 hours in each Practice Domain.** 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:

- **Enter only hours for supervision received in each domain below. (*This should not include non-supervision clinical work hours)**
- **The evaluator, preferably the Clinical Preceptor, should take into account all previous supervisor evaluations (LIP and CCS) when completing these tables and is responsible for verifying and documenting the total hours of supervision accumulated in each domain.**
- **To be viewed as competent in each Practice Domain the preponderance of marks should be 3 or above.**
- **Careful consideration should be given if too many "Not Observed" are marked as this indicates the applicant may not be entirely ready for certification as an ADC II.**

Rating Addiction Counseling Competencies

Clinical Preceptors and Supervisors have expressed a desire for a more descriptive rating scale on the competency assessment form below. The following rubric was adapted from the Northwest Frontier Addiction Technology Transfer Center (NFATTC) Regional Addiction Studies Workgroup rating system. The scale uses similar terminology used at NDACS and thus should be familiar to the intern counselors. The scale ranges from Ineffective to Exemplary with the expectation that an intern counselor should score a "3- Competent" rating in all Domains assessed.

Competency Levels Rating Scale	
Rating	**Definitions**
1	**Ineffective**: The counselor does not perform the task competently. Counselor may be able to explain and discuss key issues and concepts but has little practical experience or is unable to demonstrate an acceptable or safe level for patient care.
2	**Emerging**: The counselor integrates counseling knowledge and skills with a limited degree of consistency in routine counselor tasks; requires frequent supervision and monitoring.
3	**Competent**: The counselor applies counseling knowledge and skills with consistency in routine counseling interactions and responsibilities. Demonstrates proficient use of counseling characteristics and skills in performance of task.
4	**Skilled**: The counselor demonstrates, applies, and integrates counseling knowledge and skills with a high degree of consistency and effectiveness in most situations.
5	**Exemplary**: The counselor is especially skillful in demonstrating, applying and integrating counseling knowledge and skills with the highest degree of consistency and effectiveness in routine and complex clinical interactions.

AREA OF COMPETENCY	LIP	CCS	Preceptor	Hours
CLINICAL EVALUATION				
Establish rapport, including management of a crisis situation and determination of need for additional professional assistance; Gather data systematically from the client and other available collateral sources, using screening instruments and other methods that are sensitive to age, developmental level, culture, and gender; Screen for psychoactive substance toxicity, intoxication, and withdrawal symptoms; aggression or danger to others; potential for self-inflicted harm or suicide; and co-occurring mental disorders; Assist the client in identifying the effect of substance use on his or her current life problems and the effects of continued harmful use or abuse; Determine the client's readiness for treatment and change as well as the needs of others involved in the current situation; Select and use a comprehensive assessment process that is sensitive to age, gender, racial and ethnic culture, and disabilities; Document assessment findings and treatment recommendations				
	LIP	**CCS**	**Preceptor**	**Hours**
TREATMENT PLANNING				
Use relevant assessment information to guide the treatment planning process; Explain assessment findings to the client and significant others; Consider the readiness of the client and significant others to participate in treatment; Prioritize the client's needs in the order they will be addressed in treatment; Formulate mutually agreed-on and measurable treatment goals and objectives; Identify appropriate strategies for each treatment goal; Coordinate treatment activities and community resources in a manner consistent with the client's diagnosis and existing placement criteria; Develop with the client a mutually acceptable treatment plan and method for monitoring and evaluating progress; Reassess the treatment plan at regular intervals or when indicated by changing circumstances				
	LIP	**CCS**	**Preceptor**	**Hours**
REFERRAL				
Continuously assess and evaluate referral resources to determine their appropriateness; Arrange referrals to other professionals, agencies, community programs, or appropriate resources to meet the client's needs; Explain in clear and specific language the necessity for and process of referral to increase the likelihood of client understanding and followthrough; Evaluate the outcome of the referral				

AREA OF COMPETENCY	LIP	CCS	Preceptor	Hours
SERVICE COORDINATION	**LIP**	**CCS**	**Prceptor**	
Initiate collaboration with the referral source; Obtain, review, and interpret all relevant screening, assessment, and initial treatment planning information; Establish accurate treatment and recovery expectations with the client and involved significant others; Coordinate all treatment activities with services provided to the client by other resources; Summarize the client's personal and cultural background, treatment plan, recovery progress, and problems inhibiting progress to ensure quality of care, gain feedback, and plan changes in the course of treatment; Understand the terminology, procedures, and roles of other disciplines related to the treatment of substance use disorders; Contribute as part of a multidisciplinary treatment team; Demonstrate respect and nonjudgmental attitudes toward clients in all contacts with community professionals and agencies; Understand and recognize stages of change and other signs of treatment progress; Assess treatment and recovery progress, and, in consultation with the client and significant others, make appropriate changes to the treatment plan to ensure progress toward treatment goals; Describe and document the treatment process, progress, and outcome; Use accepted treatment outcome measures; Conduct continuing care, relapse prevention, and discharge planning with the client and involved significant others; Document service coordination activities throughout the continuum of care				

	LIP	CCS	Preceptor	Hours
COUNSELING **Individual / Group**				
Establish a helping relationship with the client characterized by warmth, respect, genuineness, concreteness, and empathy; Facilitate the client's engagement in the treatment and recovery process; Encourage and reinforce client actions determined to be beneficial in progressing toward treatment goals; Work appropriately with the client to recognize and discourage all behaviors inconsistent with progress toward treatment goals; Facilitate the development of basic and life skills associated with recovery; Adapt counseling strategies to the individual characteristics of the client, including but not limited to disability, gender, sexual orientation, develop-mental level, culture, ethnicity, age, and health status; Make constructive therapeutic responses when the client's behavior is inconsistent with stated recovery goals; Apply crisis prevention and management skills; Facilitate the client's identification, selection, and practice of strategies that help sustain the knowledge, skills, and attitudes needed for maintaining treatment progress and preventing relapse; Carry out the actions necessary to form a group, including but not limited to determining group type, purpose, size, and leadership; recruiting and selecting members; establishing group goals and clarifying behavioral ground rules for participating; identifying outcomes; and determining criteria and methods for termination or graduation from the group; Facilitate the entry of new members and the transition of exiting members; Facilitate group growth within the established ground rules and movement toward group and individual goals by using methods consistent with group type; Understand the concepts of process and content, and shift the focus of the group when such a shift will help the group move toward its goals; Describe and summarize the client's behavior within the group to document the client's progress and identify needs and issues that may require a modification in the treatment plan				

AREA OF COMPETENCY	LIP	CCS	Preceptor	Hours
CLIENT, FAMILY, and COMMUNITY EDUCATION				
Provide culturally relevant formal and informal education programs that raise awareness and support substance abuse prevention and the recovery process; Describe factors that increase the likelihood for an individual, community, or group to be at risk for, or resilient to, psychoactive substance use disorders; Describe warning signs, symptoms, and the course of substance use disorders; Describe the continuum of care and resources available to the family and concerned others; Understand and describe the health and behavior problems related to sub-stance use, including transmission and prevention of HIV/AIDS, tuberculosis, sexually transmitted diseases, hepatitis C, and other infectious diseases				
	LIP	**CCS**	**Preceptor**	**Hours**
DOCUMENTATION				
Demonstrate knowledge of accepted principles of client record management; Protect client rights to privacy and confidentiality in the preparation and handling of records, especially in relation to the communication of client information with third parties; Prepare accurate and concise screening, intake, and assessment reports; Record treatment and continuing care plans that are consistent with agency standards and comply with applicable administrative rules; Record progress of client in relation to treatment goals and objectives; Prepare accurate and concise discharge summaries; Document treatment outcome, using accepted methods and instruments				
	LIP	**CCS**	**Preceptor**	**Hours**
PROFESSIONAL and ETHICAL RESPONSIBILITIES				
Adhere to established professional codes of ethics that define the professional context within which the counselor works to maintain professional standards and safeguard the client; Recognize the importance of individual differences that influence client behavior, and apply this understanding to clinical practice; Use a range of supervisory options to process personal feelings and concerns about clients; Obtain appropriate continuing professional education; Participate in ongoing supervision and consultation; Develop and use strategies to maintain one's physical and mental health				
			Total Hours across all Domains	0

Comments: Preceptor (Required)

Preceptor Name (Signature) _____ Date MM/DD/YY _____

Comments: Clinical Supervisor(Optional)

Clinical Supervisor Name, (signature) _____ Date MM/DD/YY _____

Comments: LIP (Optional)

LIP Name (Signature) _____ Date MM/DD/YY _____

SUPERVISOR ENDORSEMENT

Please have your immediate supervisor write a brief endorsement, commenting on the applicant's skills and readiness to become certified at the ADC II level.

Supervisor signature: _____ Date: _____
MM/DD/YY

FACILITY/PROGRAM DIRECTOR ENDORSEMENT

Please have your immediate Facility Director, Program Director, or Department Head write a brief endorsement, commenting on the applicant's skills and readiness to become certified at the ADC II level.

Director's signature: _____ Date: _____
MM/DD/YY

COMMANDING OFFICER'S ENDORSEMENT

(May be signed by a supervisor with "By Direction" authority)

" I _____ ☐ **DO** / ☐ **DO NOT** Recommend
Commanding Officer's Name (Check One)

_____for Certification as an Alcohol and Drug Counselor II (ADC II)
Applicant's Name

Please enter any comments as desired._____

_____ _____
Commanding Officer's Signature Date
MM/DD/YY

GLOSSARY

ADC	Alcohol and Drug Counselor
AODA	Alcohol and Other Drug Abuse
ATF	Alcohol (Addiction) Treatment Facility (No longer authorized, included for historical refernce only)
ATOD	Alcohol, Tobacco and Other Drug
BUMED	Bureau of Medicine and Surgery
CCS	Certified Clinical Supervisor
HQMC	Headquarters U.S. Marine Corps
IC&RC/AODA	International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse
LIP	Licensed Independent Practitioner
MTF	Military Treatment Facility
NAADAC	National Association of Alcohol and Drug Abuse Counselors
NDACS	Navy Drug and Alcohol Counselor School
SARP	Substance Abuse Rehabilitation Program
USNCB	US Navy Certification Board