



# GREAT PLAINS AMERICAN INDIAN CREDENTIALING BOARD

PO BOX 1916  
RAPID CITY, SD 57709  
PHONE: 605-515-6080  
EMAIL: gpaicb.sd7@gmail.com

## APPLICATION FOR CERTIFICATION

A check or money order must accompany this application made payable to:  
**Great Plains American Indian Credentialing Board**

Check One	Certification	Fee
	Alcohol & Drug Counselor – Level I	\$250.00
	Alcohol & Drug Counselor – Level II	\$250.00
	Alcohol & Drug Counselor – Level III	\$250.00

Certification Track (pick one):  Academic Track  Experience Track

### PERSONAL DATA

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### CURRENT EMPLOYMENT - **\*\*Submit a copy of your current job description\*\***

Agency Name: \_\_\_\_\_

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

Job Title: \_\_\_\_\_

Name of NACC/CCDC Supervisor: \_\_\_\_\_

### STATISTICAL INFORMATION

(This information is used for statistical purposes and is necessary to establish your ICRC testing identification number.)

Gender:

Male

Female

Ethnicity:

American Indian

Hispanic/Latino

African American

Caucasian

Asian/Pacific Islander

Other



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## EDUCATION/ACADEMIC DATA

Official transcripts must be submitted for all education. If you have a college degree, you do not have to submit your high school transcripts.

High School Attended: \_\_\_\_\_

Date of Graduation: \_\_\_\_\_

GED: \_\_\_\_\_ Date: \_\_\_\_\_

Where Issued: \_\_\_\_\_

### College/University

Name	Location	Enrolled From	Enrolled To	Degree(s) Earned

### Specialized Education Documentation

List all specialized education courses. All courses must equal 3 or more semester credits and earn a "C" grade or higher.

Requirements	Name of College or University	Prefix-Course Number	Name of Course	Credit Hours	Term Taken	Grade
Example	FSU	HS212	Study of Alcohol	3	Fall 1995	B
Intro to Alcohol Use and Abuse						
Intro to Drug Use and Abuse						
Foundations of Individual Counseling						
Alcohol & Drug Group Counseling						
Alcohol & Drug Treatment Continuum						
Professional Ethics for the CD Counselor						
Counseling Families with Alcohol and other Drug Issues						
Cultural Competency						
CD-Specific Electives						



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## WORK EXPERIENCE DOCUMENTATION

All experience must be specific to chemical dependency counseling. List all relevant experience, beginning with your current place of employment. Verification must be received for all experience.

Agency Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Job Title: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_ Status: Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_ Volunteer: \_\_\_\_\_

Agency Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Supervisor: \_\_\_\_\_

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## WORK EXPERIENCE VERIFICATION

Applicant: All experience must be verified. Make a copy of this form for each agency where you completed work experience. Complete the top section and send the form to all agencies, employers, internship sites, etc. for verification of all work experience hours.

Agency Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Job Title: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_ Status: Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_ Volunteer: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Job Title: \_\_\_\_\_

### **Applicant Stop Here**

THE FOLLOWING IS TO BE COMPLETED BY THE AGENCY

The applicant listed above is applying for certification as a chemical dependency counselor. Please verify the work experience for this individual and return this form directly to the Great Plains American Indian Credentialing Board, PO Box 1916, Rapid City, SD 57709. If the above information is not correct, please correct, initial and mail with a copy of the individual's job description.

I hereby attest that the above information is true and correct. This person was involved in the supervised counseling of diagnosed alcohol and drug abuse clients with the majority of their time spent in individual, group, and/or family counseling; and, the remaining experience was related to the AODA Counselor Core Functions.

Agency Name: \_\_\_\_\_

Supervisors Name & Title: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Job Title: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_ Status: Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_ Volunteer: \_\_\_\_\_

Total number of hours of qualified work experience: \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



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## GREAT PLAINS AMERICAN INDIAN CREDENTIALING BOARD AUTHORIZATIONS AND RELEASE

I hereby attest that I have not been convicted of, plead guilty, or not contest, to any felony, or to any crime involving moral turpitude, or like offense within the past five years.

I hereby understand that being convicted of, or pleading guilty, or no contest, before a court in this state or any other state, or before any federal court for any offense punishable as a felony, or like sanction, will be grounds for denial of, or revocation of certification, recertification, or trainee recognition.

I hereby understand that if I have had a conviction, and/or pled guilty or no contest, or received a suspended imposition of sentence, it must have been at least five (5) years prior to the date of application for trainee recognition, student internship status, certification or recertification. I also understand that all sentencing requirements must be completed or satisfied prior to the date of application for any of the above.

I confirm that I have not been denied certification or licensure or had any disciplinary sanctions against me from this or any certifying or licensing authority in this or any other state.

I hereby authorize any agency, facility, organization or individual to release any and all information necessary to fully and properly evaluate my application before the Great Plains Native American Credentialing Board (GPAICB). The GPAICB reserves the right to request further information or documentation to evaluate the application and/or professional competence of individuals.

I hereby release and hold harmless the Great Plains Native American Credentialing Board, its Board of Directors, its officers, its employees and any agency, facility, organization, or individual from any and all manner of suits, actions, claims and judgments which might arise from such efforts to further substantiate and document my application.

I hereby understand that the GPAICB can deny or revoke certification, trainee recognition or student internship status on the basis of misrepresentation on my application, or any other application, to include intentionally false or misleading statements or intentional omissions. I understand that I will be barred from applying for certification or recertification for not less than two (2) years if it is proven that I have misrepresented the facts on any aspect of my application, or any other application, for trainee recognition, student internship status, certification or recertification.

I hereby certify that the information contained herein is correct and true and that I understand the application and these authorization and releases.

---

**Print name the way you would like it to appear on your certificate**

---

Signature

---

Date



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## PROFESSIONAL CODE OF ETHICS

The Professional Code of Ethics applies equally to all Certified Counselors, Counselor Trainees and individuals in the process of applying for certification. The Great Plains American Indian Credentialing Board (GPAICB) believes that all people have the rights and responsibilities through every stage of human development. The goal of the GPAICB is for addiction professionals to treat everyone with the dignity, honor and reverence that is fitting to them.

The Professional Code of Ethics entitles human beings to the physical, social, psychological, spiritual, and emotional care necessary to meet their individual needs. All Certified Professionals, Trainees, and Interns have a responsibility to adhere to the following guiding principles.

1. That I have a total commitment to provide the highest quality of care for those people who seek my professional services.
2. That I will dedicate myself to the best interests of the clients and to assist them to help themselves.
3. That, at all times I shall maintain a professional relationship with clients.
4. That I will be willing, when I recognize that it is in the best interest of the clients, to release or refer them to another program or individual.
5. That I shall adhere to the laws of confidentiality and professional responsibility of all records, materials and knowledge concerning clients.
6. That I shall not in any way discriminate against clients or professionals.
7. That I shall respect the rights and views of other professionals and clients.
8. That I shall maintain respect for the institutional policies and managements functions within agencies and institutions, but I take the initiative towards improving such policies if it will best serve the interest of the clients.
9. That I have commitment to assess my own personal strengths, limitations, biases and effectiveness on a continuing basis; that I shall continuously strive for self-improvement and professional growth through further education and/or training.
10. I have responsibility for appropriate behavior in all areas of my professional and private life to provide a positive role model especially in regard to the personal use of alcohol or other drugs.
11. That I have responsibility to myself, my clients, and other associates to maintain my physical and mental health.
12. That I respect the client's right to worship or not, according to their conscience and beliefs and that I will not impose my own beliefs, values, or standards upon them.
13. That I have a professional responsibility to understand and appreciate different cultures for persons who are or may be in my care or are recipients of my professional services. I will demonstrate sensitivity to cultural differences in my professional practices.
14. That I have regard for an individual's needs and rights to equal protection and due process.

Private conduct is a personal matter, except when such conduct compromises the fulfillment of professional responsibilities or may endanger the health and safety of clients who are or may be under my care. As a professional, I have a responsibility to report, whether obvious or perceived, any ethical violations or concerns related to my peers.

- By checking this box, I hereby understand and subscribe to the preceding professionals code of ethics and understand that any violations of the principles will be grounds for disciplinary actions and sanctions.

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Counselor Name

Date



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## SUPERVISED PRACTICAL TRAINING HOURS

Provide a description of your 300 hours of supervised practical training. You must have at least 10 hours in each area and give specific examples of how you apply the principals in your professional practice.

Applicant's Name: \_\_\_\_\_

Clinical Supervisor: \_\_\_\_\_

Agency Where Completed: \_\_\_\_\_

**SCREENING** **TOTAL HOURS**

Description:

**INTAKE** **TOTAL HOURS**

Description:

**ORIENTATION** **TOTAL HOURS**

Description:

**ASSESSMENT** **TOTAL HOURS**

Description:

**TREATMENT PLANNING** **TOTAL HOURS**

Description:

**COUNSELING** **TOTAL HOURS**

Description:

**CASE MANAGEMENT** **TOTAL HOURS**



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Description:

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**CRISIS INTERVENTION**

**TOTAL HOURS**

Description:

---

**CLIENT EDUCATION**

**TOTAL HOURS**

Description:

---

**REFERRAL**

**TOTAL HOURS**

Description:

---

**REPORTS AND RECORD KEEPING**

**TOTAL HOURS**

Description:

---

**CONSULTATION**

**TOTAL HOURS**

Description:

---

I hereby certify that all of the above information, to the best of my knowledge, true.

---

Signature of Clinical Supervisor

---

Date





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## COUNSELOR EVALUATION BY SUPERVISOR

INSTRUCTIONS FOR THE APPLICANT: Give or mail this form directly to your supervisor(s) after you have filled in the top four lines of page 10 & 11. If your present supervisor has been supervising you for less than 6 months, make a copy of the form and provide it to your immediate and past supervisor.

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**CONFIDENTIAL**

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Dear Supervisor:

The employee listed on the accompanying form is applying to the Great Plains American Indian Credentialing Board (GPAICB) for certification as an Alcohol & Drug Counselor. The information requested here is an essential part of the GPAICB evaluation of the competence of the applicant and must be on file before the application can be processed.

The GPAICB believes that your observation will provide a more complete and accurate impression of the knowledge and skills of the applicant than what is available from other sources. Your evaluation plus those received from the professional references and the data furnished by the applicant will be used in determining eligibility for certification. The process can only be as good as you and the others make it by careful and truthful reporting.

Please return the completed evaluation DIRECTLY TO:

**Great Plains American Indian Credentialing Board  
PO BOX 1916  
Rapid City, SD 57709**



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## COUNSELOR EVALUATION BY SUPERVISOR

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Title: \_\_\_\_\_

Agency Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

The following items represent the skills needed by an Alcohol & Drug Counselor. Evaluate the above applicant as you feel he/she demonstrates his/her abilities in each area. Mark the rating most descriptive of the counselor's demonstrated skills. Use N/A (not applicable) ONLY if you have never observed or have no knowledge of the applicant's skills in that area. Use the following rating scale:

	1 – POOR	2 – NEEDS IMPROVEMENT	3 – ACCEPTABLE	4 – GOOD	5 - EXCELLENT	
COUNSELOR SKILL AREA						POOR - EXCELLENT N/A
CLIENT INTAKE: The process of collecting client information for assessment purposes.	1	2	3	4	5	
CLIENT ASSESSMENT: Identification and evaluation of information to determine appropriate treatment services.	1	2	3	4	5	
CHEMICAL DEPENDENCY EVALUATION: Knowledge and application of the major theories and stages of addiction and the symptoms of chemical dependency for assessment of clients.	1	2	3	4	5	
TRIAGE: Determining appropriate and timely services for clients with knowledge of his/her problems and their intensity.	1	2	3	4	5	
CLIENT ORIENTATION: Providing clients with general goals, rules, services, rights, etc. of program services.	1	2	3	4	5	
CLIENT EDUCATION: Provision of information concerning alcohol and other drug abuse implications, available services and resources.	1	2	3	4	5	
TREATMENT PLANNING: Defining problems and needs, establishing long and short term goals and developing a treatment process and the resources to be used.	1	2	3	4	5	
COUNSELING SKILLS: (Individual, Group and Family) The utilization of special skills to assist in assessing client's problems and facilitating appropriate changes.	1	2	3	4	5	
CASE MANAGEMENT: The coordination of services, agencies, resources or people within a planned framework of action for the achievement of established goals.	1	2	3	4	5	
CRISIS INTERVENTION: Assessing, defining and responding to the needs during acute emotional and/or physical distress.	1	2	3	4	5	
REFERRAL: Identifying and limiting of appropriate services, familiarization of community and state resources available with demonstration of the referral process, including confidentiality requirements.	1	2	3	4	5	
CONSULTATION: Relating with own and other professionals to assure comprehensive, quality care for clients.	1	2	3	4	5	
PROFESSIONAL AND ETHICAL RESPONSIBILITIES: A counselor's ability to adhere to generally accepted ethical and behavioral standards of conduct and continuing professional development.	1	2	3	4	5	



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## COUNSELOR EVALUATION BY SUPERVISOR CONTINUED

Are you involved in the administration/management of the program at which you are employed?

- No
- Yes, limited to clinical aspects, i.e. supervision of counselors.
- Yes, limited to administrative responsibilities.
- Yes, both  % Clinical  % Administrative

How long have you supervised this applicant? \_\_\_\_\_

For what period of time, while under your supervision, was chemical dependency counseling the major part of this applicant's responsibilities? From \_\_\_\_\_ To \_\_\_\_\_

What is the total number of hours of work experience accumulated during this time? \_\_\_\_\_

What is/was the size of his/her substance abuse caseload? \_\_\_\_\_

Average number of hours per week he/she worked in individual counseling? \_\_\_\_\_

Average number of hours per week he/she worked in group counseling excluding DUI classes? \_\_\_\_\_

Average number of hours per week he/she spent in significant and related activities? \_\_\_\_\_

Describe those activities:

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

Comments and/or additional information you feel may be pertinent:

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

I hereby certify that I have been in a position to observe and have firsthand knowledge of the applicant's work at:

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

Name of Work Setting: \_\_\_\_\_

I recommend this applicant for certification as an Alcohol & Drug Counselor.

I have some reservations in recommending this applicant.

I do not recommend this applicant as an Alcohol & Drug Counselor.

I hereby certify that all of the above materials is, to the best of my knowledge, true.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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## PROFESSIONAL RECOMMENDATION FORMS

### **PART I – TO BE COMPLETED BY THE APPLICANT**

Complete the information below. Give this form to a professional for completion who is acquainted with your work performance and abilities. You must submit three separate recommendation forms. Be sure to provide the individual with a pre-addressed, stamped envelope so the forms can be mailed directly to the GPAICB.

Name of Applicant: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I understand that this recommendation will be used to determine my eligibility for certification and is a character reference. I therefore agree and understand that I will not be entitled to this information under any circumstances.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

### **PART II – TO BE COMPLETED BY A PROFESSIONAL OR ACADEMIC ACQUAINTANCE**

The person listed above has applied for certification as an Alcohol & Drug Counselor. The signature above authorizes you to complete this form. Your assessment will assist the GPAICB in determining the applicant's appropriateness for certification. A fair and candid report is essential, we therefore ask for the careful rating and comments about character and ability. All information submitted will be viewed as confidential and will not be open to the applicant.

Reference Name: \_\_\_\_\_

Position/Title: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_ How long have you know the applicant: \_\_\_\_\_

In what capacity do you know the applicant: \_\_\_\_\_



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## COUNSELOR REFERENCE FORM

Please rate the candidate by circling the most accurate response. Use “Don’t Know” ONLY if you have never observed or have absolutely no knowledge of the respective variable.

COUNSELOR SKILLS AREA	POOR – EXCELLENT	DON'T KNOW
Breadth of knowledge in alcohol and other drug abuse.	1 2 3 4 5	
Breadth of knowledge in core functions.	1 2 3 4 5	
Relationship ability.	1 2 3 4 5	
Communication skills.	1 2 3 4 5	
Sense of responsibility and adherence to state and federal confidentiality regulations.	1 2 3 4 5	
Empathy/Understanding.	1 2 3 4 5	
Openness/Genuineness.	1 2 3 4 5	
Honesty/Integrity.	1 2 3 4 5	
Cooperation with others.	1 2 3 4 5	
Ability to recognize and set appropriate limits with clients.	1 2 3 4 5	
Self-assessment/Insight.	1 2 3 4 5	
Ability to be objective.	1 2 3 4 5	
Flexibility/Adaptability.	1 2 3 4 5	
Emotional stability.	1 2 3 4 5	
Crisis problem solving skills.	1 2 3 4 5	
Counseling abilities and competencies.	1 2 3 4 5	

Please provide a written overall assessment of the candidate as a counselor. Comment on the intellectual and personal assets and/or liabilities that would affect the person’s practice in professional alcohol and drug counseling.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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Name of Applicant: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I understand that this recommendation will be used to determine my eligibility for certification and is a character reference. I therefore agree and understand that I will not be entitled to this information under any circumstances.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

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Position/Title: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_ How long have you know the applicant: \_\_\_\_\_

In what capacity do you know the applicant: \_\_\_\_\_



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Communication skills.	1 2 3 4 5	
Sense of responsibility and adherence to state and federal confidentiality regulations.	1 2 3 4 5	
Empathy/Understanding.	1 2 3 4 5	
Openness/Genuineness.	1 2 3 4 5	
Honesty/Integrity.	1 2 3 4 5	
Cooperation with others.	1 2 3 4 5	
Ability to recognize and set appropriate limits with clients.	1 2 3 4 5	
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Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I understand that this recommendation will be used to determine my eligibility for certification and is a character reference. I therefore agree and understand that I will not be entitled to this information under any circumstances.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

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Position/Title: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_ How long have you know the applicant: \_\_\_\_\_

In what capacity do you know the applicant: \_\_\_\_\_





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Sense of responsibility and adherence to state and federal confidentiality regulations.	1 2 3 4 5	
Empathy/Understanding.	1 2 3 4 5	
Openness/Genuineness.	1 2 3 4 5	
Honesty/Integrity.	1 2 3 4 5	
Cooperation with others.	1 2 3 4 5	
Ability to recognize and set appropriate limits with clients.	1 2 3 4 5	
Self-assessment/Insight.	1 2 3 4 5	
Ability to be objective.	1 2 3 4 5	
Flexibility/Adaptability.	1 2 3 4 5	
Emotional stability.	1 2 3 4 5	
Crisis problem solving skills.	1 2 3 4 5	
Counseling abilities and competencies.	1 2 3 4 5	

Please provide a written overall assessment of the candidate as a counselor. Comment on the intellectual and personal assets and/or liabilities that would affect the person’s practice in professional alcohol and drug counseling.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# GREAT PLAINS AMERICAN INDIAN CREDENTIALING BOARD

PO BOX 1916  
RAPID CITY, SD 57709  
PHONE: 605-515-6080  
EMAIL: gpaicb.sd7@gmail.com

## Child Support Verification

The Great Plains American Indian Credentialing Board request authorization to verify child support compliance from applicant for an Alcohol & Drug Counselor.

Name: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

By signing below, I authorize the Child Support Enforcement Division of the Department of Social Services, its employees or agents, to share below requested information about my child support to the Great Plains American Indian Credentialing Board.

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

\*\*\*\*\*

The above named individual is:

- Payments ARE being made under their Child Support Obligation
- Payments ARE NOT being made under their Child Support Obligation

DSS Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Once form is completed; please return to Dee Le Beau-Hein, GPAICB  
Administrator to [GPAICB.SD@gmail.com](mailto:GPAICB.SD@gmail.com) or mail to PO BOX 1916, Rapid City, SD  
57709. Thank you for your time!