INITIAL CIT REGISTRATION APPLICATION

Name:____ Date of Birth__________
Last First Middle or Maiden

Address:____
Street City State Zip

Home Telephone :( )____________________ Driver's License #________________

Social Security #______________Business Telephone :( )___________Ext._____

e-mail: -- (**required**)

Place of Employment:____________________ Supervisor's Name:___________

Address :____
Street City State Zip

EDUCATIONAL PROFILE: Please check the appropriate educational designation**.**
GED------High School Diploma------Associate Degree-----Bachelor Degree---Master degree-----Doctorate Degree------- If you hold a degree, please list the type of degree, the area of study in which it was earned, the college or university attended, and the dates attended._______________________

____

____

PROFESSIONAL AFFILIATIONS: Do you hold, or have you ever held licensure, certification, or registration in any other state? If yes, complete the following.

Title of Credential State Issued Date Issued Current Status

____

PROFESSIONAL EXPERIENCE:(Begin with current employer.)

Facility Name_________________________ Name Of Supervisor_____________
Facility Address ____
Street City State Zip

Business Telephone :( )_____________Ext:_____Your Job Title:_____________

Major Job Duties:____

____

Dates of Employment:____
Month/Year To Month/Year

Revised February 2014

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PROFESSIONAL EXPERIENCE:

Facility Name------------------------------------- Name of Supervisor--------------------
Facility Address ---
Street City State Zip
Business Telephone:( )-----------------Ext:-------Your Job Title:---------------------
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Major Job Duties:--

Dates of Employment:---
Month/Year To Month/Year

PROFESSIONAL EXPERIENCE:

Facility Name-------------------------------------Name of Supervisor--------------------
Facility Address ---
Street City State Zip
Business Telephone:( )-----------------Ext:-------Your Job Title:---------------------
----
Major Job Duties:--

Dates of Employment:---
Month/Year To Month/Year

STATEMENT OF UNDERSTANDING

▪ The ASACB neither registers nor certifies persons convicted of a sexual offense. Sexual offenses include, but are not limited to, any sexual offense that results in a felony conviction; any conviction, whether a felony or misdemeanor, any crime of violence involving involuntary sexual acts, incest, any conviction involving the sexual abuse of minors, or any offense that requires the perpetrator to be registered as a sexual offender under Arkansas or federal law.

• I hereby apply for counselor certification with the Arkansas Substance Abuse Certification Board (ASACB).

• I understand that certification depends on my successful completion of all requirements and criteria established by the Board.

• I understand that intentionally false or misleading statements on this application and/or my testing packet will result in my being declared ineligible for certification.

• I understand that the data from my application may be used for statistical purposes in an unidentifiable manner.

• I understand that the testing application fee becomes the property of the ASACB and that the fee is non-refundable.

Signature:---Date:--------------

For Office Use Only:

Date Received:------------------- -Check #:---------------------Rcpt. #:--------------------

Arkansas Substance Abuse Certification Board
Evergreen Place
1100 N. University Ave.
Ste. 35, Little Rock, AR
72207

Statement of Disclosure

Name:--Date Completed:--------------------------------
Mailing Address:---
--- Daytime Phone:(   )--------------------------------

YES___NO___(1) Has your license/certification to practice in any location ever been stipulated, conditioned, denied, restricted, suspended, reduced, terminated, not renewed, or placed on probation by a licensing/certifying agency? **If yes, please provide details including dates and current status.**

YES___NO___(2) Have you ever had any professional disciplinary action taken toward you? **If yes, please provide details including dates and current status.**

YES___NO___(3) Have you ever voluntarily relinquished your professional license/certification as an alternative to disciplinary action or during an investigation into your professional competence or conduct? **If yes, please provide details including dates and current status.**

YES___NO___(4) Have you had a professional liability case(s) brought and /or sustained against you in the past five years? **If yes, please provide details including dates and current status.**

YES___NO___(5) Do you have any misdemeanor or felony charges pending, or have you ever been convicted of a misdemeanor or felony, other than a minor traffic violation? **If yes, please give details including dates and current status or disposition of charges**.

YES___NO___ (6) Have you had any complaints in the past five years of your engaging in the 'sexual exploitation' of a client or former client? **If yes, please provide details including dates and current status.**

YES___NO___(7) Have you ever had a non-professional relationship with a client or former client that was sexual in nature or otherwise in violation of any ethical rules of your profession or your license/certification? **If yes, please provide details including dates and current status.**

YES___NO___(8) Do you/your organization have a written policy regarding sexual exploitation of clients?

Arkansas Substance Abuse Certification Board
Evergreen Place
1100 N. University Ave.
Ste. 35, Little Rock, AR
72207

Statement of Disclosure

Name: --Date Completed:------------------

YES___NO___(9) Does your organization have a written policy to check the past employment history of applicants?

YES___NO___(10) Have you ever been investigated for any acts alleging dishonesty, fraud, deceit or misrepresentation? **If yes, please provide details including dates and current status.**

YES___NO___(11) Has a professional liability carrier ever refused to cover you or canceled your coverage?

YES___NO___(12) Have you ever had action taken against you by any third party payor, insurance company or H.M.O including, but not limited to Medicare, Medicaid), for inappropriate utilization of medical resources?

I hereby agree that the above statements are true.

Signature--Date Signed------------------------

Arkansas Substance Abuse Certification Board

Release of Information

Name of Applicant--------------------------------------Date Completed----------------
Mailing Address--
---Daytime Phone-----------------------------
Clinical Supervisor------------------------------------Daytime Phone---------------------
Name of Agency--Daytime Phone-----------------

Dear Supervisor:

I am in the process of seeking counselor certification through the Arkansas Substance Abuse Certification Board (ASACB). I have identified you as someone in a position to verify my standard of professional performance.

I hereby give the ASACB permission to contact the persons and institutions I have listed above. I understand that this application does not guarantee certification.

I agree to hold the ASACB, its members, committees, staff and agents free from any civil liability or damage by reason of any action that is within their scope, or that arises from the performance of their duties in determining my certification or any other activity as provided by law or regulation.

This statement is designed to release you from any liability concerning information you may provide regarding my professional performance.

Applicant's Signature---------------------------------------Date Signed-------------------

Clinical Supervisor's Signature----------------------------------Date Signed--------------

Witness Signature--Date Signed-------------------

ASACB Code of Ethics Signature Page for Counselors and Counselors in Training

Name of Applicant-----------------------------------Daytime Phone--------------------
Mailing Address--

Please read and review the ***Ethics Code and Committee Process*** [Section III] and ***Standards of Practice*** [Section IV]. All persons who wish to be registered and/or certified with the ASACB must sign and return this page to the ASACB office.

I have read and understand the Arkansas Substance Abuse Certification Board Code of Ethics (Revised February 2014) for board-registered Counselors-in-Training and credentialed Alcohol and Other Drug Abuse (AODA) counselors, clinical supervisors criminal justice professionals, co-occurring disorders professionals and Peer Recovery who are certified through the ASACB. I agree to abide by and adhere to the ethical principles outlined therein. I am aware of the procedure to use when filing an ethical complaint, and of the variety of disciplinary sanctions which may be issued. I am aware of the hearing and appeals process as outlined in the **Ethics Code and Committee Process** document (Revised February 2014) found in Section III. of this manual.

Name---Cert Number------------------

Arkansas Substance Abuse Certification Board

ARKANSAS STATE POLICE

ASP-122
 # 1 STATE POLICE PLAZA DRIVE
LITTLE ROCK, AR 72209
(501) 618-8500

Identification Bureau Individual Record Check Form

Required:
1. This form **properly completed and notarized**.
2. **$ 25.00 check or money order** payable to "Arkansas State Police".
3. **Stamped envelope addressed to**:
   ASACB
   Evergreen Place
   1100 N. University Ave. Ste. 35
   Little Rock, AR 72207
4. **Mail 1-3 to the State Police at the ASP-122 address**

Full Name:____
First Middle Last Name / Maiden/Other

Date of Birth:________________Race:_______________Sex:______________

Social Security #:_________________Driver's License #:_________________
State

Mailing Address:____
Street City State Zip

I GIVE MY CONSENT FOR THE ARKANSAS STATE POLICE TO CONDUCT A CRIMINAL RECORD SEARCH ON MYSELF AND RELEASE ANY RESULTS TO THE FOLLOWING PERSON OR ENTITY.

Name: Arkansas Substance Abuse Certification Board
Mailing Address: ASACB, Evergreen Place
1100 N. University Ave. Ste. 35
Little Rock, AR 72207
(501) 749-4040

Signature____________________________________**Date**______________
First Middle Last Name Month Day Year

REQUESTS WILL NOT BE PROCESSED WITHOUT A NOTARY STAMP

STATE OF____________________

COUNTY OF__________________

Subscribed and sworn before me a Notary Public in and for the county and state aforesaid, this___________day of_______________20_____.

Notary Public Signature _______________________

Revised February 2014

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