



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
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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: _____
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?

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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 _____

Certified Clinical Supervisor's Signature _____ Date Signed _____

Witness Signature _____ Date Signed _____

Arkansas Substance Abuse Certification Board

**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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