

**MASSACHUSETTS BOARD OF SUBSTANCE ABUSE
COUNSELOR CERTIFICATION, INC.**

MBSACC

PREVENTION SPECIALIST APPLICATION

CPS

APPLICATION FORM

APPLICANT'S NAME (PRINT)

AREA BELOW IS FOR OFFICE USE ONLY - DO NOT WRITE IN THIS AREA

Date Rec'd.: _____ Ck. #: _____ Ck. Amt.: _____ Ck. Date: _____

Grp. #: _____ To Rev.: _____ Apv'd.?: Y / R / H

APPLICANT INFORMATION

(PLEASE PRINT CLEARLY)

NAME: _____
Last First M.I.

ADDRESS: _____
Number & Street or P.O. Box

City State Zip

S.S. #: _____ - _____ - _____ DOB: ____/____/____ MALE FEMALE
For Identification Purposes Only (Please Circle Gender)

AGENCY: _____

ADDRESS: _____
Number & Street or P.O. Box

City State Zip

HOME PHONE: (____) _____ CELL: (____) _____ WORK PHONE: (____) _____
Area Code Area Code Area Code Ext.

E-MAIL ADDRESS (Home): _____

E-MAIL ADDRESS (Work): _____

Due to physical limitations, special accommodations will be required in order for me to take the International Certification exam: YES NO

(If you checked "yes," an **EXAMINEE REQUEST FOR REASONABLE ACCOMMODATIONS** form will be sent to you. This form must be completed and returned to the certification office a minimum of 90 days prior to the exam.)

SUPERVISOR VERIFICATION FORMS:

List any Supervisors who will be completing a verification form for you.

NAME OF SUPERVISOR AGENCY SUPERVISOR'S JOB TITLE

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PERSONAL DATA

*This application must be returned to MBSACC. It will not be considered complete until all related documents, transcripts, and fees have been received by the Board. Applicant and supervisor answers should be full and complete. Vague and/or incomplete applications will be returned to the applicant causing a delay in the certification process. **Intentionally false and/or misleading statements could result in denial or revocation of certification.***

Please check the box that best describes your ethnic background:

- African American/Black
 Asian
 Caucasian
 Hispanic
 Native American
 Other _____
 (Please Specify)

EDUCATION:

I have earned my: High School Diploma GED

List highest degree earned: _____

Name of College/University where degree was earned? _____

List name on transcript (if different from name on this application): _____

List any/all MBSACC credentials currently held (i.e., CAC, CADC, CCS, etc.): _____

If you have ever held any other license(s)/certification(s), complete the table below. You must identify the current status of your credential(s) (i.e., Active, Lapsed, Revoked, Suspended, etc.). Failure to disclose all license(s) and/or certification(s) held and current status may result in denial of your application or other appropriate action.

STATE	LICENSE/CERTIFICATION TYPE	LICENSE/CERTIFICATION #	DATE OF ISSUANCE	STATUS

Have you ever been convicted of a felony? Yes No

*(If "Yes," you **must** give a brief description of the felony, the date it occurred, and the result of the conviction on a separate sheet of paper and attach it to the application.)*

NOTE: You are not required to furnish information for any offense committed prior to your 17th birthday or for a first conviction for any of the following misdemeanors: drunkenness, simple assault, speeding, minor traffic violations, affray or disturbance of the peace; or for a conviction of a misdemeanor where the date of such conviction or the completion of any period of incarceration resulting therefrom (whichever is later) occurred five or more years prior to the date of the application, unless you have been convicted of any other offense within five years immediately preceding the date of this application.

AUTHORIZATION & RELEASE FORM

I understand that Certification through MBSACC is an entirely voluntary process, and I agree to abide by its policies and procedures for as long as I hold Certification.

I hereby authorize MBSACC, its committees, and staff to make inquiry of any agency, facility, organization, or individual for any additional information that might be necessary to fully and properly evaluate my application for Certification and to investigate my background as it relates to statements contained in the application for Certification.

I hereby authorize MBSACC to contact any of the supervisors listed in my application, and request that each of the supervisors contacted fully and frankly respond to all inquiries made by MBSACC regarding my application. I understand that evaluations on me that are submitted by supervisors and/or colleagues are confidential, and I hereby relinquish my right to view these evaluations.

I hereby release and hold harmless MBSACC, its Board of Directors, Officers, employees, and examiners from any and all manner of suits, actions, claims, and judgments which might arise from such efforts to further document the statements and claims I have made in this application or in the processing or consideration of same.

I further agree to hold free/harmless MBSACC, its Board of Directors, Officers, employees, and examiners from any civil liability for damages or complaints by reason of any action that is within the scope of the performance of their duties which they take in connection with this application and subsequent examinations and/or the failure of MBSACC to issue Certification to me.

I acknowledge, understand, and agree that any falsification or misrepresentation of information by myself or others regarding my experience and/or qualifications will be sufficient reason for disapproval of my application or revocation of my Certification (if granted) at a later date.

Upon submittal of my application, I give permission to MBSACC, its committees, or representatives to contact and question, as necessary, any person, institution, or organization for any ethics or appeals investigation.

You must sign this form in the presence of a witness who is willing to attest to the fact that you signed in his/her presence. The witness must sign where so designated. The witness may be anyone who is familiar with your signature.

APPLICANT NAME (Please print here)

WITNESS NAME (Please print here)

APPLICANT SIGNATURE

WITNESS SIGNATURE

DATE

DATE

PROFESSIONAL WORK EXPERIENCE IN PREVENTION

PHOTOCOPY THIS PAGE BEFORE MAKING ANY ENTRIES IF YOU WILL REQUIRE ADDITIONAL SPACE IN WHICH TO LIST MORE THAN ONE JOB (OR MORE THAN ONE POSITION HELD WITHIN THE SAME AGENCY).

AN OFFICIAL JOB DESCRIPTION FOR THIS POSITION MUST BE ATTACHED AND MUST BE SIGNED AND DATED BY BOTH THE APPLICANT AND THE SUPERVISOR OF RECORD.

PLEASE NOTE: A minimum of 51% of the time working in this position should have been spent providing alcohol, tobacco, and/or other drug abuse prevention activities/services **OR** a minimum of 51% of the time should have been spent providing **supervision** of prevention activities/services.

AGENCY: _____

TYPE OF AGENCY: _____

AGENCY ADDRESS: _____

CITY

STATE

ZIP

AGENCY PHONE: (_____)
AREA CODE EXT.

APPLICANT'S JOB TITLE: _____

SUPERVISOR'S NAME: _____

SUPERVISOR'S TITLE: _____

NUMBER OF FULL-TIME HOURS WEEKLY: _____

NUMBER OF PART-TIME HOURS WEEKLY: _____

DATES OF EMPLOYMENT:

FROM: _____ TO: _____
MONTH/DAY/YEAR MONTH/DAY/YEAR

DATES OF EMPLOYMENT:

FROM: _____ TO: _____
MONTH/DAY/YEAR MONTH/DAY/YEAR

TOTAL # OF HOURS WORKED IN THIS POSITION: _____

TOTAL # OF HOURS WORKED SPECIFICALLY IN PREVENTION IN THIS POSITION: _____

OF THE FOLLOWING PREVENTION DOMAINS, CHECK AS MANY AS DIRECTLY RELATE TO THIS POSITION:

- | | |
|---|--|
| <input type="checkbox"/> PLANNING & EVALUATION | <input type="checkbox"/> PREVENTION EDUCATION & SERVICE DELIVERY |
| <input type="checkbox"/> COMMUNITY ORGANIZATION | <input type="checkbox"/> PUBLIC POLICY & ENVIRONMENTAL CHANGE |
| <input type="checkbox"/> COMMUNICATION | <input type="checkbox"/> PROFESSIONAL GROWTH & RESPONSIBILITY |

In this space, please provide a description of your **primary** job responsibilities in this position:

EDUCATION RESUME

PHOTOCOPY THIS PAGE BEFORE MAKING ANY ENTRIES IF YOU WILL REQUIRE ADDITIONAL SPACE IN WHICH TO LIST YOUR EDUCATION.

FOR SPECIFIC CATEGORY REQUIREMENTS REFER TO THE EDUCATION SECTION OF THE **CPS INFORMATION AND REQUIREMENTS** PACKET

TITLE OF COURSE OR PROGRAM	DATE	INSTITUTION OR INDIVIDUAL OFFERING THE TRAINING	NUMBER OF TRAINING HOURS/CREDITS	TRAINING CATEGORY
				<i>Prevention</i> ___ hrs. <i>ATOD</i> ___ hrs. <i>Ethics</i> ___ hrs

Briefly describe the content of this training –

TITLE OF COURSE OR PROGRAM	DATE	INSTITUTION OR INDIVIDUAL OFFERING THE TRAINING	NUMBER OF TRAINING HOURS/CREDITS	TRAINING CATEGORY
				<i>Prevention</i> ___ hrs. <i>ATOD</i> ___ hrs. <i>Ethics</i> ___ hrs

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