



RECIPROCAL CERTIFICATE APPLICATION

The LCDC II, LCDC III, LICDC, and LICDC-CS have the potential to qualify for reciprocity within ICRC jurisdictions. Reciprocity allows individuals to transfer a license to other ICRC jurisdictions. In order to qualify, applicants must demonstrate that they have met ICRC education, work and testing requirements.

PLEASE TYPE OR PRINT LEGIBLY.

License Held: _____ LCDC II _____ LCDC III _____ LICDC _____ LICDC - CS

License Number _____

Name (first, middle and last) _____

Maiden Name (if applicable) _____

Date of Birth _____ SS # _____ - _____ - _____

Current Home Address

Current Work Address

(Please provide street number, street name, city, state and zip.)

_____	_____
_____	_____
_____	_____

County _____

Preferred Mailing Address Home Work

Home Phone _____ / _____ - _____ Work Phone _____ / _____ - _____

Mobile Phone _____ / _____ - _____ FAX # _____ / _____ - _____

E-Mail Address _____

Would you like to receive correspondences regarding your renewal application via email? ____ Yes ____ No

I. PERSONAL HISTORY INFORMATION

Have you ever had a professional license/certificate reprimanded, suspended, revoked, surrendered or in any other way sanctioned since obtaining your license? if yes, please attach a written explanation. ____ Yes ____ No

Have you been convicted of a misdemeanor or felony since obtaining your license? If yes, please complete the misdemeanor/felony questionnaire. ____ Yes ____ No

Do you currently live or work at least 51% of the time in Ohio? ____ Yes ____ No

II. ELIGIBILITY INSTRUCTIONS AND CHECKLIST

Individuals must fulfill all eligibility requirements for the level for which they are applying.

To obtain ADC Reciprocity:

- _____ Apply for or hold an LCDC II, LCDC III or LICDC.
- _____ Submit a Supervisor Reference Form documenting 4,000 hours of chemical dependency counseling work experience. These 4,000 hours are in addition to the 2,000 hours required for licensure. An Associate's degree in a behavioral science may substitute for 1,000 hours; or a Bachelor's degree in a behavioral science may substitute for 2,000 hours; or a Master's degree in a behavioral science may substitute for 4,000 hours.
- _____ Submit a Practical Experience Verification Form documenting 80 hours of practical experience. These 80 hours are in addition to the 220 hours required for licensure and may be divided among any of the 12 core areas.
- _____ Submit a Chemical Dependency Education Grid documenting 90 hours of education. These 90 hours must be in addition to the 180 hours required for licensure and may be divided among any of the content areas.
- _____ Pass the ADC Exam.

To obtain CCS Reciprocity:

- _____ Apply for or hold LICDC – CS.
- _____ Submit a Clinical Supervision: Supervisor Reference Form documenting 2,000 hours of work experience as a clinical supervisor of chemical dependency counseling services. This is in addition to the 2,000 hours required for licensure.
- _____ Submit a Clinical Supervision Education Grid documenting 30 hours of education specific to clinical supervision.
- _____ Pass the ADC and CCS exam.

III. APPLICANT STATEMENT FOR NOTARIZATION

I hereby affirm that I am of good moral character and that all information given herein is true and complete to the best of my knowledge and belief. I authorize any necessary investigations and/or release of personal information to the Chemical Dependency Professionals Board and its agents. I understand that falsification of any portion of this application may result in my being denied certification/licensure or in revocation of the same.

I hereby affirm that I have read the Chemical Dependency Code of Ethics, and I agree to abide by this code. (The Chemical Dependency Code of Ethics may be accessed at www.ocdp.ohio.gov or may be sent to an applicant upon request.)

I further agree to hold the Chemical Dependency Professionals Board free from any civil liability for damages or complaints related to any action within the scope and/or arising out of the performance of its duties, which it or any of its employees may take in connection with this application and/or failure to issue me said license.

I understand that the \$50 fee submitted herewith represents the non-refundable application fee. (A non-refundable \$20 fee will be charged for any check not accepted for deposit by the bank.)

Applicant Signature _____
Date

Subscribed and sworn before me this _____ day of _____, 20_____

Notary Signature _____
Date Commission Expires

If paying via check or money order: make payable to “**Treasurer, State of Ohio.**”

If paying via credit card: complete the CREDIT CARD AUTHORIZATION form.

Please return completed application, including required documentation and fee, to:

**Ohio Chemical Dependency Professionals Board
77 South High Street, 16th Floor Columbus, Ohio 43215
614/387-1110 (phone) 614/387-1109 (fax) www.ocdp.ohio.gov
Email: credentialing@ocdp.state.oh.us**

FOR OFFICE USE ONLY		
Date Received:	Fee Paid:	Check/M.O./C.C. #:



RECIPROCAL CERTIFICATE PRACTICAL EXPERIENCE VERIFICATION FORM

Applicant Name: _____

This form is provided to document the 80 hours of practical experience completed during an applicant's chemical dependency counseling work experience. These 80 hours are in addition to the 220 hours required for licensure. This form must be completed and returned with the Reciprocal Certificate Application.

This is actual experience in each core function. If an applicant cannot obtain any of the required practical experience at his/her employment, arrangements may need to be made in order to accomplish this requirement.

CORE FUNCTION	HOURS COMPLETED
Screening	
Intake	
Orientation	
Assessment	
Treatment Planning	
Counseling: Individual	
Group	
Family	
Case Management	
Crisis Intervention	
Client Education	
Referral	
Consultation	
Reports & Recordkeeping	

TOTAL HOURS COMPLETED (must be at least 80 hours) _____

These hours were completed: From _____ to _____
mo/yr mo/yr

Employer Name: _____

Supervisor Name: _____

Supervisor Phone Number: _____

The supervisor signature verifies that the above named individual has completed the 80 hours of practical experience.

Supervisor Signature: _____ Date _____



RECIPROCAL CERTIFICATE CHEMICAL DEPENDENCY SPECIFIC EDUCATION GRID

Please list, in chronological order, the 90 hours of education/training received in the required chemical dependency specific content areas. These 90 hours of education are in addition to the 180 hours required for licensure. Arrange the attached attendance verification in the same order as listed unless the verification is a college transcript.

All education hours must be verified and included with the application. Acceptable forms of verification include: official transcripts, copies of certificates of attendance, form letters or lists of workshops signed by agency official or supervisor.

Indicate the number of hours in each content area for which the education/training applies. The content areas are as follows:

- | | |
|---|--|
| 1 - Theories of addiction | 6 - Pharmacology |
| 2 - Counselling procedures & strategies with addicted populations | 7 - Prevention strategies |
| 3 - Group process & techniques working with addicted populations | 8 - Treatment planning |
| 4 - Assessment & diagnosis of addiction | 9 - Legal & ethical issues pertaining to chemical dependency |
| 5 - Relationship counselling with addicted populations | |

Date of training	Title of training	Total clock hours	1	2	3	4	5	6	7	8	9
TOTAL HOURS THIS PAGE											

One semester hour = 15 clock hours One quarter hour = 10 clock hours

DUPLICATE THIS PAGE AS NEEDED AND INCLUDE WITH THE FORMAL APPLICATION

**CHEMICAL DEPENDENCY COUNSELORS
SUPERVISOR REFERENCE FORM**

INSTRUCTIONS TO SUPERVISOR:

- Review Part A of this form.
- Complete Part B ONLY if the waiver of liability has been signed by the applicant.
- After completing this form, please return to the applicant.

PART B: TO BE COMPLETED BY SUPERVISOR

1. Name: _____ Title: _____

2. Professional credentials and/or licenses you hold: _____

3. Name of Applicant supervised: _____

4. Dates you have supervised this applicant: From _____ to _____
mo/yr mo/yr

Total hours of applicant work at this setting: _____

Average number of hours per week worked at this setting: _____

Percentage of time at this setting that was spent in chemical dependency counseling functions: _____ %

5. Are you aware of any unethical professional behavior by this applicant?

_____ Yes, please attach an explanation.

_____ No

6. Do you recommend the applicant for certification?

_____ Yes, without reservation

_____ No. (comments/explanation) _____

I verify the above named individual has completed chemical dependency counseling work experience under my supervision.

Supervisor's Signature

Date

CHEMICAL DEPENDENCY CLINICAL SUPERVISORS SUPERVISOR REFERENCE FORM

INSTRUCTIONS TO SUPERVISOR:

- Review Part A of this form.
- Complete Part B ONLY if the waiver of liability has been signed by the applicant.
- After completing this form, please return to the applicant.

PART B: TO BE COMPLETED BY SUPERVISOR

1. Name: _____ Title: _____

2. Professional credentials
and/or licenses you hold: _____

3. Name of Applicant supervised: _____

4. Dates you have supervised this
applicant: From _____ to _____
mo/yr mo/yr

Total hours of applicant supervisory work at this setting: _____

Average number of hours per week worked at this setting: _____

Total # of contact hours of face to face clinical supervision:
(must at a minimum document 200 hours) _____

5. Are you aware of any unethical professional behavior by this applicant?

_____ Yes, please attach explanation.

_____ No

6. Do you recommend the applicant for certification?

_____ Yes, without reservation

_____ No. (comments/explanation) _____

I verify the above named individual has completed work experience as a clinical supervisor of chemical dependency counseling services under my supervision.

Supervisor's Signature

Date



CLINICAL SUPERVISION EDUCATION GRID

Please list in chronological order the 30 hours of education received in the required clinical supervision specific content areas. The minimum number of hours in each area is identified. These total 20 hours. The remaining 10 hours may be distributed among the areas at the applicant's discretion. Arrange the attached attendance verification in the same order as listed unless the verification is a college transcript.

All education hours must be verified and included with the application. Acceptable forms of verification include: copy of transcripts, copies of certificates of attendance, form letters of lists of workshops signed by agency official or supervisor.

Indicate the number of hours in each content area for which the education applies. The content areas are as follows:

- | | |
|--|-------------------------------------|
| 1- Counselor Development (4 hours) | 4- Performance Evaluation (4 hours) |
| 2- Professional & Ethical Standards (4 hours) | 5- Administration (4 hours) |
| 3- Program Development & Quality Assurance (4 hours) | |

Date of training	Title of training	Total clock hours	1	2	3	4	5
TOTAL HOURS THIS PAGE							

One semester hour = 15 clock hours

One quarter hour = 10 clock hours

DUPLICATE THIS PAGE AS NEEDED AND INCLUDE WITH THE FORMAL APPLICATION