PREVENTION PRECEPTOR REGISTRATION FORM

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

This application must be fully completed and notarized before your preceptor registration will be recorded by the Board. Applicants must complete ALL the requirements for certification within the twenty-four months of registering their preceptorship. Applicants may file their Formal Application anytime in this two-year period if they have completed both their education/work experience and preceptor requirements. If you are unable to complete all the requirements in the two year period, you should not register a preceptor at this time. For further questions regarding the preceptorship process please contact the OCDP Board office.

Please type or print legibly.

Applicant Name (first, middle and last) _____

Maiden Name (if applicable) _____ **SSN** _____

Preferred Mailing Address (please provide street number, street name, city, state and zip)

_____

_____

_____

County _____ **Is this a change of address? ___Yes ___ No**

Phone Number _____ **Fax Number** _____

Work Phone Number _____

Email Address _____

I am registering for _____ **OCPS I** _____ **OCPS II**

Are you certified with CCDC credentials or an applicant pursuing these credentials?
Yes ___ No ___ If yes, what is your applicant or certification number? _____

Have you ever been convicted of a felony? Yes _____ No _____

I. FORMAL APPLICATION OVERVIEW

Please review the following requirements for certification. If you will not be able to meet the requirements listed below by the end of the preceptorship, it is advised that you delay registering a preceptor. A preceptorship is a maximum of 24 months.

Work Experience:	OCPS I	Three years with a minimum of 20% devoted to AOD prevention services. An associate's degree in a behavioral science may be substituted for one year of work experience, a bachelor's or higher in a behavioral science may substitute for two years.
	OCPS II	A bachelor's degree in a behavioral science and three years of work experience with a minimum of 50% devoted to AOD prevention services OR a master's degree or higher in a behavioral science and two years of work experience.

Required Educational Hours:	OCPS I	180 hours* of education in the prevention foundations and domains
	OCPS II	270 hours* of education in the prevention foundations and domains

*One half of the education must be in the five year period immediately preceeding the filing of the formal application.

II. PRECEPTOR VERIFICATION

The following OCPS I or OCPS II has agreed to serve as my Preceptor. Please note: Ohio Certified Prevention Specialist I (OCPS I) may precept applicants pursuing OCPS I certification. Ohio Certified Prevention Specialist II (OCPS II) may preceptor both OCPS I and OCPS II applicants.

Name: _____ **Certification Number:** _____

Agency/School Name:_____

Mailing Address (Street or Box): _____

City/State/Zip : _____

Business Phone: _____ **Home Phone:** _____

III. PRECEPTOR STATEMENT

I have discussed the preceptor requirements with this applicant and believe he/she is an appropriate candidate for preceptorship. I, in turn, have agreed to serve as the applicant's preceptor and verify that I have completed an approved preceptor training.

By entering into this preceptorship relationship, I understand that I have accepted the responsibility of completing all tasks relevant to preceptorship as outlined in the Board's rules. This includes maintaining a log of the preceptor relationship and completing a detailed evaluation of the applicant's skills and knowledge regarding prevention. I further verify that I will not charge a fee for my preceptorship services.

If for any reason I am unable to fulfill my preceptor responsibilities, I will notify, in writing, both the applicant and the OCDP Board.

Preceptor Name: _____ **Certification #:** _____

Signature: _____ **Date:** _____

IV. APPLICANT STATEMENT FOR NOTARIZATION

I understand that the designated date for the commencement of my preceptorship will be the date upon which this completed form is received by the Board. I verify that I will complete all eligibility requirements within twenty-four months of the registration of my preceptorship.

I further understand that the acceptance of this registration by the Board shall not be interpreted as an indication of my successful completion of the eligibility requirements for prevention certification. These areas will be addressed in detail during the Formal Application phase of certification.

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 Prevention Code of Ethics, and I agree to abide by this code. (The Prevention Code of Ethics may be accessed at www.ocdp.ohio.gov or may be sent to an individual 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 $25.00 check or money order submitted herewith represents the non-refundable Preceptor 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

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

Chemical Dependency Professionals Board
37 W. Broad St, Suite 785
Columbus, OH 43215

(614) 387-1110 phone **(614) 387-1109 fax** **www.ocdp.ohio.gov**

All checks and money orders should be made payable to Treasurer, State of Ohio.

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