Addiction Professionals Certification Board, Inc.
East Brunswick, NJ 08816
www.certbd.org fax: 732-249-1559

Certified Co Occurring Disorder Professional- NJ

_____

Applicant Name

***Scope of Service**: The CCDP-NJ is a non-reciprocal credential only recognized in New Jersey. There is no degree requirement and no exam requirement for the CCDP-NJ. The CCDP-NJ treats clients who have a primary diagnosis of co-occurring disorder that includes both mental illness and addiction problems. The CCDP is not a clinical practice credential and should only be used for work within behavioral health care settings. Private practice counselors must have a license approved by the Division of Consumer Affairs to provide independent counseling.*

Training:

- ☐ 200 hours Education/Training:
  - 140 hours must be in COD specific training (addiction and mental disorders combined)
  - 30 hours must be related to mental illness and recovery.
  - 30 hours must be related to addiction and recovery.
  - Of the 200 hours, 6 hours must be in ethics specific.
  - See education options within Education Section of this application.

EXPERIENCE:

- ☐ Co-Occurring Disorder Professional work experience requires a minimum of 1,000 hours in a Certification Board approved setting that includes treatment for Co- Occurring Consumers.
- ☐ 200 hour Practicum in a COD specific job description completed within the last year

❑ Initial review and certification fee: $200

Recertification required every 2 years.
40 Hours of continuing education hours must be in CCDP related topics from an approved provider every 2 years (topics include but are not limited to Mental Health and Alcohol and Drug related coursework).
$200 Non-refundable recertification fee.

Applications must be submitted via certbd.org website or by sending complete with check to:
The Certification Board of New Jersey, 1200 Tices Lane Suite 206, East Brunswick, NJ 08816.
___Please check here if you paid online and are mailing in your application.
The Board will **NOT** respond to inquiries regarding receipt of documents. Send all critical documentation to the Certification Board "Return Receipt" (the green post card from the Post Office or via FedEx, UPS or other common carrier with delivery verification).

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APPLICANT INFORMATION SHEET

NAME _____
(Please Print Your Name as it should appear on your Certificate)

EMAIL _____

HOME ADDRESS_____ **ZIP** _____

COUNTY_____

HOME PHONE #_____

HIGHEST DEGREE OF EDUCATION_____

AGENCY EMPLOYED AT_____

Education/ Training:

200 hours COD coursework. Attach all training certificates, transcripts, and course descriptions for the coursework submitted for review. No minimum per area.

I. College/University degree COD related coursework: :_____ hrs.

and/or

II. Board Approved COD Educational Manual coursework:_____ hrs.

and/or

III. Distance Learning: COD Pre-Approved :_____ hrs .

Maximum: 50 hours

Must Total 200 contact hours:_____

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Work Experience and Supervised Practicum Form

You may use additional copies of this section if necessary

I, _____ *attest that* _____ *has completed*
Supervisor Applicant

1000 hours of co-occurring specific work experience completed at _____
Agency

From: _____ To: _____ _____
Supervisor Signature

**Attach official job and program descriptions signed by your supervisor*

200 hour Supervised Practical Training

- Applicant's name_____
- Supervisor(s) name_____
- Agency where practicum was completed_____

Practicum hours must be completed within the two years immediately prior to the date of this application.
Practicum requires supervisor's signature for month/year each domain is completed.

Initial &Date:_____ 30 hours – COD Screening and Assessment

Initial &Date:_____ 30 hours - Crisis Prevention and Management

Initial &Date:_____ 30 hours -COD Treatment and Recovery planning

Initial &Date:_____ 30 hours – COD Counseling

Initial & Date:_____20 hours - Management & coordination of care

Initial & Date:_____20 hours - Professional Responsibility

Initial & Date:_____20 hours - Education of the person, support system & community

Initial & Date:_____20 hours - COD Systems and the Community

Initial & Date _____ Total: 200 hours completed

Supervisor's Signature: _____Date:_____

Applicant's Signature: _____ Date:_____

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AUTHORIZATION AND RELEASE FORM

I hereby authorize the Addiction Professionals Certification Board, Inc. to make any inquiry of any agency, facility, organization or individual for any and all additional information which might be necessary to fully and properly evaluate my application for the Certified Clinical Supervisor).
I hereby release and hold harmless the Addiction Professionals Certification Board, Inc., its Board of Directors, its Officers, its employees, servants, and agents 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 acknowledge, understand, and agree that any falsification or misrepresentation of information by myself or others regarding experience and/or qualifications will be sufficient reason for disapproval of my application or for withdrawal of the credential at a later date.
I understand that evaluations on me which are submitted by supervisors and/or colleagues are confidential. I hereby relinquish my right to review these evaluations.
I also affirm that I conform to the Ethical Standards as described in the requirements for credentialing (on following pages).

APPLICANT SIGNATURE _____

DATE _____WITNESS_____

STATEMENT OF UNDERSTANDING

I hereby apply for certification to the Addiction Professionals Certification Board, Inc. I understand that approval of my application depends upon my successfully completing the assessment of competency as established by the Board, including submission of all required references and successful completion of a 300 hour practicum in an approved treatment facility. I also understand that for research and statistical purposes only, the data from this application may be used in a non-identifying manner. I also understand this credential is designed to recognize individuals working with chemically dependent clients and is not restricted to primary alcohol/drug counselors.

APPLICANT SIGNATURE _____

DATE _____WITNESS_____

I have read and agree to abide by the ETHICAL STANDARDS FOR CERTIFIED PROFESSIONALS (CPs) standards on http://certbd.org/ethical-standards-for-certified-professionals-cps/:

APPLICANT SIGNATURE _____

DATE _____WITNESS_____