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

Certified Tobacco Treatment Specialist

____
Applicant Name

The CERTIFIED TOBACCO TREATMENT SPECIALIST is not an independent clinical practice credential and should only be used for work within health care or counseling settings. Private practice counselors must have a license approved by the Division of Consumer Affairs to provide independent counseling.

Training:

Must complete UMDNJ's Tobacco Dependency Program of 42 hours and submit the original certificate for review.

Experience:

- Masters or above in Human Services field with one year of full time counseling or health care experience. (1 year = 2000 hours)

- Bachelors in Human Services with two years of full time counseling or health care experience.

CADC/LCADC/ nursing or other recognized health related qualification, with four years of full time counseling or health care experience.(2 years = 4000 hours, 4 years = 8000 hours)

APPLICANT MUST via certbd.org website or by sending complete with check to:
THE FOLLOWING must be submitted with or attached to the 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).

- $225 non-refundable Initial review fee.
- Job Description signed by supervisor and program director.
- Program Description signed by program director.
- Applicant Resume.

The following forms are included in this application and must be completed:

References:

- 1 Supervisor from within your facility
- Signed and witnessed authorization and release form
- Signed Statement of Understanding
- Signed Ethical Standards (send signature page. Keep standards for your records)

- The following forms must also be submitted with this application:
- A job description, signed by both your immediate supervisor and your program director
- A program description, signed by your program director
- A resume covering at least the past five (5) years of your experience

Educational Record Form

You must complete the Certification Board approved tobacco training held by **The Tobacco Dependence Program of UMDNJ and must accompany your CTTS application.**

TOTAL 42 hours

1. Basic Tobacco and Health Knowledge 6 hours
2. Counseling Theory and Practice, Assessment Tools and Key Strategies 6 hours
3. Tobacco Caused Diseases, Environmental Tobacco Smoke, Pharmacological Treatments 6 hours
4. Tobacco Dependence Treatment Methods 6 hours
5. Treatment Planning 6 hours
6. Program Development and Evaluation (On-Line or Special In-Person Course) 6 hours
7. Tobacco Treatment Case Study 6 hours

Recertification Requirements (required every 2 years):

- Eighteen (18) hours of continuing education on tobacco dependence treatment every two (2) years
- $225 non-refundable recertification fee
- Submission of recertification application

APPLICANT INFORMATION SHEET

NAME ____

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

EMAIL ____

HOME ADDRESS____

COUNTY____

HOME PHONE #____

HIGHEST DEGREE OF EDUCATION____

AGENCY EMPLOYED AT____

___Please check here if you paid online and are mailing in your application.

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Work Experience Form

Please list the most current position first. Use one sheet for each position. Additional copies of this page may be reproduced. Attach a copy of your job description signed by your immediate supervisor. Also attach a program description signed by your supervisor and program director as well as your resume.

Applicant Name: ____

Name of Employer: ____

Address of Employer:____

Immediate Supervisor: _______________________________________

Program Director: ____

Applicant's Job Title: ____

Dates of Employment: ____
From (month/year) To (month/year)

How many hours of experience are you documenting?:__________________
(Please Note: 1 year of Full Time Experience = 2,000 hours.
Hours Completed: ______________________________________

If your work experience was as a private practitioner, please have a licensed professional case consultant sign here: ________________ Please be sure to include their resume.

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REFERENCES

On this page, identify the name of the individual whom you have requested to complete the reference included with this application. If you have accumulated your clinical supervisory experience from more than one (1) agency, additional references are required from each agency.
Additional copies of the reference forms may be reproduced.

CTTS SUPERVISOR REFERENCE FORM

(Please have this form typewritten or printed legibly)

Applicant Name :____

Supervisor's Name: ____

Agency:____

TITLE/POSITION: ____

How long have you known applicant: ____________________________________

Please read the description of the various knowledge and skills outlined below. Using the three point (0-2) scale shown below, determine the number which most nearly describes the applicant's ability in each category and enter this number in the blank provided to the right of the statement in the column marked "Score". If you have no basis for evaluating the applicant in a particular area, please enter "0" in the scoring column. Please comment briefly on the basis for each given score.

SCORING SCALE

0 - No basis for judgment 1 - Inadequate 2 - Acceptable

1. An advanced knowledge on how tobacco use is related to other physical, behavioral, and mental disorders.

Comments: ____

Score: _____

2. A demonstrated familiarity with the assessment and therapeutic modalities that are supported by the scientific evidence for effectiveness in the treatment of tobacco use and dependence.

Comments:

Score: ____

3. An operational experience with evidence-based assessment and treatment approaches used in the field of tobacco dependence.

Comments: ____

Score: ____

4. Ability to deal effectively and appropriately with clients and professional colleagues.

Comments: ____

Score: ____

5. Awareness of limits to professional competence and the need for ongoing supervision and professional development.
Comments: ____

Score: ____
6. Behaves in an ethical manner with clients and demonstrates an awareness of appropriate conduct with clients, their families and professional colleagues.
Comments: ____

Score: ____
SIGNATURE OF SUPERVISOR ____

Date: ____

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 ____

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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 PROFESIONSALS (CPs) standards on the following pages:

APPLICANT SIGNATURE ____

DATE __________________WITNESS____

Application Check-off Sheet

Please use this as a final self-reminder regarding all the necessary documents and have fully completed all the requirements of the application. This will help you, as well as us, with a quicker review of your application.

- ❑ Fee (check or money order)
- ❑ Late Fee (if applicable)
- ❑ Applicant Information Sheet (included email address?)
- ❑ Verification of Appropriate Experience
- ❑ Coursework Completion Page (Initial or Continuing Education)

Signatures

- ❑ Authorization and Release
- ❑ Applicant Recognition Statement
- ❑ Ethics Statement
- ❑ Statement of Understanding

I have checked and have completed any other requirements for this Application, and have included those items as well.

____

Signature Date