

Board of Addiction and Prevention Professionals (BAPP)  
3101 West 41<sup>st</sup> Street, Suite 205, Sioux Falls, SD 57105  
Phone: 605.332.2645 | Fax: 605.332.6778  
Email: [bapp@midconetwork.com](mailto:bapp@midconetwork.com) | Web: [www.dss.sd.gov/bapp](http://www.dss.sd.gov/bapp)



## APPLICATION FOR STATUS UPGRADE TO LICENSED ADDICTION COUSELOR (LAC)

Attached please find the Application for Status Upgrade from Certified Addiction Counselor (CAC) to Licensed Addiction Counselor (LAC). Please complete the application in its entirety. Do not leave information blank or attach separate sheets indicating ‘see attached’, even if you have previously documented the information.

Applications for status upgrade can be submitted at any time. **All requirements must be completed prior to making application for the status upgrade.** Extensions will not be granted to complete courses or work experience requirements. Applications will be denied if there are any incomplete items in the application portfolio.

Your supervisor(s) must complete the ‘Supervisor Evaluation and Recommendation’ form and send it directly to the Board of Addiction and Prevention Professionals (BAPP). Also, please mail or give the ‘Professional Recommendation’ form to three professional colleagues and have them send it directly to the BAPP. If you have completed work experience at more than one agency, please make a copy of the ‘Work Experience Verification’ form and send it to each agency for verification of all work experience hours.

Applicants applying for upgrade must have successfully passed the national written examination. Documentation of such must be on file with the Board of Addiction and Prevention Professionals and/or documentation provided with the application.

Applicants shall be denied status if convicted of, pled guilty or no contest to, and/or received a suspended imposition of sentence for a felony offense within 5 years of the date of application. All sentencing requirements must be completed or satisfied prior to the date of application.

The BAPP is required to comply with SDCL 25-7A-56 which is a prohibition against the issuance of professional license, registration, certification, or permit of application in the event of child support arrearage. Applicants listed on the State Registry will not be granted recognition, certification, licensure, or renewal until arrangements have been made with the Department of Social Services, Office of Child Support Enforcement and the individual’s name is cleared via monthly written reports from that office.

If you have any questions concerning this application or need assistance, please contact the BAPP Administrative Office.

SEND COMPLETED APPLICATION, TRANSCRIPT(S), CURRENT JOB DESCRIPTION, AND FEE TO:

BAPP  
3101 West 41<sup>st</sup> Street, Suite 205  
Sioux Falls, SD 57105

# Application for Status Upgrade to LAC

A \$150.00 check or money order must accompany this application.  
Submit to: BAPP, 3101 West 41<sup>st</sup> Street, Suite 205, Sioux Falls, SD 57105

## PERSONAL DATA:

Name: \_\_\_\_\_  
                    First                                    Middle                                    Last                                    Maiden

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Email: \_\_\_\_\_ Work Email: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Fax: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth date: \_\_\_\_\_

## CURRENT EMPLOYMENT:

**YOU ARE REQUIRED TO SUBMIT A COPY OF YOUR CURRENT JOB DESCRIPTION**

Agency Name: \_\_\_\_\_

Agency Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Job Title: \_\_\_\_\_

Name of Clinical Supervisor: \_\_\_\_\_

# Educational and Academic Data

## HIGH SCHOOL:

High School Attended: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Date of Graduation: \_\_\_\_\_

--OR--

## GENERAL EDUCATION DIPLOMA (GED):

Issued by: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Date: \_\_\_\_\_

## COLLEGE/UNIVERSITY (List ALL post secondary institutions you have attended):

Name of Institution	City, State	Degree(s) Earned or Pursuing (AA, BA, MA, etc.)	Date or Expected Date Conferred	Major Course of Study

**Official transcripts must be submitted from EVERY post-secondary institution you attended, and must be sent directly from the college/university to the BAPP.**

# Educational and Academic Data (Continued)

## **SPECIALIZED EDUCATION DOCUMENTATION:**

List all completed specialized educational courses.

A minimum of five courses must be at the graduate level.

All courses must equal 3 or more semester credits and earn a “C” grade or higher.

<b>Requirement</b>	<b>Name of College or University</b>	<b>Prefix - Course Number</b>	<b>Name of Course</b>	<b>Credit Hours</b>	<b>Term Taken</b>	<b>Grade</b>
Addiction Counseling Theories & Techniques						
Psychopharmacology <b>OR</b>						
Psychopathology						
Legal, Ethical & Professional Standards						
Case Management & Assessment of Co-Occurring Disorders						
Treatment Planning						
Clinical Supervision						
Multicultural Competency						

# Work Experience Documentation

**All experience must be specific to addiction counseling. List all relevant experience, beginning with your current place of employment. Verification must be received for all experience.**

**Applicant's Name:** \_\_\_\_\_

Agency Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Job Title: \_\_\_\_\_

Dates of Employment: From \_\_\_\_\_ To \_\_\_\_\_

Was the experience Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_ Volunteer: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Job Title: \_\_\_\_\_

Dates of Employment: From \_\_\_\_\_ To \_\_\_\_\_

Was the experience Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_ Volunteer: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Job Title: \_\_\_\_\_

Dates of Employment: From \_\_\_\_\_ To \_\_\_\_\_

Was the experience Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_ Volunteer: \_\_\_\_\_

(Duplicate page, if necessary)

# Work Experience Verification

**Applicant: All experience must be verified. Make a copy of this form for each agency where you completed work experience. Complete the top section and submit the form to each agency that is verifying your work experience hours.**

Applicant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Job Title: \_\_\_\_\_

Dates of Employment: From \_\_\_\_\_ To \_\_\_\_\_

Was the experience Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_ Volunteer: \_\_\_\_\_

Clinical Supervisor's Name \_\_\_\_\_  CAC  LAC

APPLICANT STOP HERE

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## THE FOLLOWING MUST BE COMPLETED BY THE AGENCY

The applicant listed above is applying for Licensed Addiction Counselor (LAC). Please verify the work experience for this individual and return this form directly to the Board for Addiction and Prevention Professionals (BAPP), 3101 West 41<sup>st</sup> Street, Suite 205, Sioux Falls, SD 57105.

- I hereby attest that the above information is true and correct. (If the above information is not correct, please make changes and place your initials beside the changes.) This person was involved in direct service with clients who have a diagnosis of alcohol or other drug abuse or dependence. This experience included both direct and indirect activities related specific to the alcohol and drug counselor domains to include the Twelve Core Functions.
- I verify that the applicant was supervised by a qualified Certified Addiction Counselor (CAC) or Licensed Addiction counselor (LAC) whose name is listed above; and, the required hours of ongoing supervision have been met (i.e. a minimum of eight contact hours each month, with a minimum of one hour of supervision for every ten hours of client contact). (If the supervisor is not credentialed through the BAPP, you must provide proof that he/she is credentialed as an addiction professional at a reciprocal level.)

Applicant's total **hours** of qualifying work experience: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name / Title / Credential: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Agency Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Agency Phone: \_\_\_\_\_ Date: \_\_\_\_\_

**CONFIDENTIAL – DO NOT RETURN THIS FORM TO THE APPLICANT**

# Professional Code of Ethics

**The Code of Ethics and Standards of Practice can be viewed and/or printed at: [www.dss.sd.gov/bapp](http://www.dss.sd.gov/bapp)**

The Professional Code of Ethics applies equally to all Certified Addiction Counselors, Licensed Addiction Counselors, Certified Prevention Specialists, Trainees, and individuals in the process of applying for certification, licensure, or trainee recognition. The Board of Addiction and Prevention Professionals (BAPP) believes that all people have rights and responsibilities through every stage of human development. The goal of the BAPP is for addiction and prevention professionals to treat everyone with the dignity, honor, and reverence that is fitting to them.

The Professional Code of Ethical Conduct entitles human beings to the physical, social, psychological, spiritual, and emotional care necessary to meet their individual needs. The BAPP's ethical codes and standards identify the ethical responsibilities of the profession. The Code details and establishes, although not exhaustive, those principles that form the standards of ethical behavior of any individual certified, licensed, or recognized by the Board.

The Code will set the basis for the reception of and processing of those allegations related to breeches of acceptable standards, practice, and behavior.

Private conduct is a personal matter, except when such conduct compromises the fulfillment of professional responsibilities or may endanger the health or safety of clients who are or may be under your care. When there is evidence that another professional is violating an ethical standard, whether obvious or perceived, you have a responsibility to report the unethical conduct to the BAPP.

I understand and subscribe to the professional Code of Ethics and understand that any violation of the principles will be grounds for disciplinary action and sanctions.

**By checking this box, I hereby attest that I have read and will comply with the Code of Ethics and Standards of Practice of the Board of Addiction and Prevention Professionals.**

This application will not be processed if you fail to read the Code of Ethics and have not checked the box above.

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Signature of Applicant

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Date

# Authorization and Release of Information

I hereby understand that being convicted of, pleading guilty to, or pleading no contest to, any felony, or to any crime involving moral turpitude or like offense, in any state, federal, foreign jurisdiction, tribal, or military court or tribunal, must be disclosed to the Board of Addiction and Prevention Professionals (Board). This information, or failure to fully disclose this information, may, standing alone, provide sufficient grounds to deny, revoke, suspend, or refuse trainee recognition, certification, licensure, or renewal. This includes any crimes of offenses where imposition of sentence was suspended.

I hereby understand that it is my obligation to disclose, on the 'Statement of Felony Charges' form, whether I have been convicted of, plead guilty to, or plead no contest to, any felony or crime of moral turpitude in any state, federal, foreign jurisdiction, tribal, or military court or tribunal, including any crimes or offenses where imposition of sentence was suspended. (*'Statement of Felony Charges' Form is included with this application.*)

I hereby attest that I am not required to register as a sex offender.

I confirm that I have never had an application denied, had my professional certificate or license revoked or suspended, or been sanctioned or disciplined by this or any other certifying or licensing professional board or authority, public or private. If I have had an application denied, had my professional certificate/license revoked or suspended, or been sanctioned or disciplined by this or any other certifying or licensing professional board or authority, public or private, I understand that I am required to provide that information to the Board, in writing.

I hereby authorize the Board to release to any agency, facility, organization, or individual any and all information necessary for verification of credentials.

I hereby authorize any agency, facility, organization, or individual contacted by the Board to release any and all information and documents requested and waive any and all confidentiality or privilege provided by state, federal, foreign jurisdictions, tribal, or military statute, law, or rule. I understand that the Board reserves the right to request further information or documentation to evaluate and verify my application, qualifications, education, training, moral character, and professional competence.

I hereby release and hold harmless the Board of Addiction and Prevention Professionals; its Board Members- past, present and future; its attorneys- past, present, and future; its agents, representatives and employees- past, present and future; as well as and any agency, facility, organization, or individual providing information or documents to the Board pursuant to my application.

I hereby understand that failing to provide accurate, full, and complete responses to the questions and requests for information in my application may, in the Board's discretion and judgment, cause it to deny, suspend, or revoke trainee recognition, certification, or licensure status, and may result in administrative, civil, or criminal legal action.

**By checking this box, I hereby attest that I have read and completely understand the Authorization and Release of Information. If for any reason, you are unable to certify that the information contained herein is correct and true, you will need to provide the Board with a written explanation.**

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Signature of Applicant

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Date

**Please print your name below as you would like it to appear on your certificate.**

Printed name: \_\_\_\_\_



# Statement of Felony Charges

All felony charges must be disclosed to the Board of Addiction and Prevention Professionals (BAPP). Felony charges include being convicted of, pleading guilty to, or pleading no contest to, any felony or crime of moral turpitude in any state, federal, foreign jurisdiction, tribal, or military court or tribunal and includes any crimes or offenses where imposition of sentence was suspended. Failure to fully disclose this information, may, standing alone, provide sufficient grounds to deny, revoke, suspend, or refuse trainee recognition, certification, licensure, or renewal.

I have had felony charges filed against me. Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered 'yes', please provide the requested information below and attach copies of court files and records showing a thorough explanation of the facts and circumstances surrounding the charges and specific information regarding what charges were filed, including exact dates, terms and conditions of the sentence/conviction, and when all terms and conditions were met.

Date charges were filed: \_\_\_\_\_

The Disposition (provide a thorough explanation of the facts and circumstances surrounding the charges):

The Sentence/Conviction and Fine (also include terms and conditions of the sentence, probation, etc. and when all terms and conditions were met):

Date all sentencing requirements were completed: \_\_\_\_\_

State why you feel this felony charge does not affect your ability to effectively work in the addiction counseling or prevention services field:

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

If you answered 'no', you are still required to sign and date this page.

# SUPERVISOR EVALUATION AND RECOMMENDATION

**INSTRUCTIONS FOR THE APPLICANT:** Give or mail this form directly to your supervisor(s) after you have filled in the bottom portion of this page. If your present supervisor has been supervising you for less than six (6) months, make a copy of this form and provide it to your immediate and past supervisors.

## CONFIDENTIAL

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Dear Supervisor:

The individual listed below is applying to the Board of Addiction and Prevention Professionals (BAPP) for status upgrade to Licensed Addiction Counselor (LAC). The information requested here is an essential part of the Board's evaluation of the competence of the applicant and must be on file before the application for upgrade can be processed.

The BAPP believes that your observation will provide a more complete and accurate impression of the knowledge and skills of the applicant than is available from other sources. Your evaluation and recommendation, plus recommendations from other professionals, and the data furnished by the applicant, will be used in determining eligibility for certification upgrade. The process can only be as good as you and the others make it, by careful and truthful reporting.

Please return the completed evaluation **DIRECTLY TO:**

**BAPP**  
3101 West 41<sup>st</sup> Street, Suite 205  
Sioux Falls, SD 57105

APPLICANT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SUPERVISOR'S NAME: \_\_\_\_\_

SUPERVISOR'S TITLE & CREDENTIALS\*: \_\_\_\_\_

AGENCY NAME: \_\_\_\_\_

AGENCY ADDRESS: \_\_\_\_\_

AGENCY PHONE: \_\_\_\_\_

\*If you are not credentialed through the BAPP, you must provide proof that you are credentialed as an addition professional at a reciprocal level.

## SUPERVISOR EVALUATION AND RECOMMENDATION (Continued)

**APPLICANT'S NAME:** \_\_\_\_\_

The following items represent the skills needed by an Addiction Counselor. Evaluate the applicant for their abilities in each area. Mark the rating most descriptive of the individual's demonstrated skills. Use N/O (not observed) ONLY if you have never observed nor have any knowledge of the applicant's skill in that area. Please use the following rating scale:

**1 – POOR                      2 – NEEDS IMPROVEMENT                      3 – ACCEPATBLE**  
**4 – GOOD                      5 – EXCELLENT**

COUNSELOR SKILL AREAS	RATING	N/O
SCREENING: Determining appropriate and timely services for clients with knowledge of his/her problems and their intensity.	1 2 3 4 5	
CLIENT INTAKE: The process of collecting client information for assessment purposes.	1 2 3 4 5	
CLIENT ORIENTATION: Providing clients with general goals, rules, services, rights, etc. of program services.	1 2 3 4 5	
CLIENT ASSESSMENT: Identification and evaluation of information to determine appropriate treatment services.	1 2 3 4 5	
CHEMICAL DEPENDENCY EVALUATION: Knowledge and application of the major theories and stages of addiction and the symptomatology of chemical dependency for assessment of clients.	1 2 3 4 5	
TREATMENT PLANNING: Defining problems and needs, establishing long- and short-term goals and developing a treatment process and the resources to be used.	1 2 3 4 5	
COUNSELING SKILLS: (Individual, Group, Family) The utilization of special skills to assist in assessing client's problems and facilitating appropriate changes.	1 2 3 4 5	
CASE MANAGEMENT: The coordination of services, agencies, resources or people within a planned framework of action for the achievement of established goals.	1 2 3 4 5	
CRISIS INTERVENTION: Assessing, defining and responding to the needs during acute, emotional, and/or physical distress.	1 2 3 4 5	
CLIENT EDUCATION: Provision of information concerning alcohol and other drug abuse implications, available services, and resources.	1 2 3 4 5	
REFERRAL: Identifying and limiting of appropriate services, familiarization of community and state resources available with demonstration of the referral process, including confidentiality requirements.	1 2 3 4 5	
REPORT AND RECORD KEEPING: Charting the results of the assessment and treatment plan, writing reports, progress notes, discharge summaries, and other client-related data.	1 2 3 4 5	
CONSULTATION: Relating with agency staff and other professionals to assure comprehensive, quality care for clients.	1 2 3 4 5	
PROFESSIONAL & ETHICAL RESPONSIBILITIES: A counselor's ability to adhere to generally accepted ethical and behavioral standards of conduct and continuing professional development.	1 2 3 4 5	

**SUPERVISOR EVALUATION AND RECOMMENDATION (Continued)**

Are you involved in the administration/management of the program where you are employed?

- No
- Yes, limited to clinical aspects (i.e., supervision of counselors).
- Yes, limited to administrative responsibilities.
- Yes, both \_\_\_\_\_% clinical and \_\_\_\_\_ % administrative.

How long have you supervised this applicant? \_\_\_\_\_

For what period of time, while under your supervision, was chemical dependency counseling the major part of this applicant's responsibilities?

From: \_\_\_\_\_ To: \_\_\_\_\_

Describe those activities: \_\_\_\_\_

\_\_\_\_\_

Comments and/or additional information you feel may be pertinent: \_\_\_\_\_

\_\_\_\_\_

I hereby certify that I have been in a position to observe and have first-hand knowledge of the applicant's work at: \_\_\_\_\_

(Name of work setting)

I recommend this applicant for status upgrade to LAC

I do not recommend this applicant for status upgrade to LAC.

I hereby certify that all of the above information is, to the best of my knowledge, true.

\_\_\_\_\_  
Signature of Supervisor

\_\_\_\_\_  
Date

**CONFIDENTIAL – DO NOT RETURN THIS FORM TO THE APPLICANT**

# Professional Recommendation Form

**Provide this form to a professional and/or academic colleague who is acquainted with your addiction counseling experience. Provide a pre-addressed, stamped envelope so the form can be mailed directly to the BAPP Administrative Office.**

**NOTE:** ANY INDIVIDUAL WHO HAS COMPLETED THE 'SUPERVISOR EVALUATION AND RECOMMENDATION' FORM FOR THIS APPLICANT MAY NOT SUBMIT A 'PROFESSIONAL RECOMMENDATION' FORM.

## **PART I - TO BE COMPLETED BY THE APPLICANT**

Complete the information below. Give this form to a professional who is acquainted with your work performance and abilities. Be sure to provide the individual with a pre-addressed, stamped envelope so the form can be mailed directly to the BAPP.

Name of Applicant: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I understand that this recommendation will be used in determining my eligibility to upgrade to LAC and is a character reference. Therefore, I agree and understand that I will not be entitled to this information under any circumstance.

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Date

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## **PART II - TO BE COMPLETED BY A PROFESSIONAL OR ACADEMIC ACQUAINTANCE**

The person listed above has applied for a status upgrade to Licensed Addiction Counselor (LAC). The signature above authorizes you to complete this form. Your assessment will assist the BAPP in determining the applicant's appropriateness for this upgrade. A fair and candid report is essential. Therefore, we ask for careful ratings and comments about character and ability. All information submitted will be viewed as confidential and will not be available to the applicant.

YOUR NAME: \_\_\_\_\_

POSITION/TITLE: \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

DAYTIME TELEPHONE #: \_\_\_\_\_

HOW LONG HAVE YOU KNOWN THE APPLICANT: \_\_\_\_\_

IN WHAT CAPACITY: \_\_\_\_\_

## Professional Recommendation Form (Continued)

Please rate the candidate by circling the most accurate response. Use “Don’t Know” ONLY if you have never observed or have absolutely no knowledge of the respective variable.

COUNSELOR SKILL AREAS	Poor-Excellent	Don’t Know
Breadth of knowledge in alcohol and other drug abuse	1 2 3 4 5	
Breadth of knowledge in the twelve core functions	1 2 3 4 5	
Relationship ability	1 2 3 4 5	
Communication skills	1 2 3 4 5	
Sense of responsibility & adherence to state & federal confidentiality regulations	1 2 3 4 5	
Empathy / understanding	1 2 3 4 5	
Openness / genuineness	1 2 3 4 5	
Honesty / integrity	1 2 3 4 5	
Cooperation with others	1 2 3 4 5	
Ability to recognize and set appropriate limits with clients	1 2 3 4 5	
Self-assessment / insight	1 2 3 4 5	
Ability to be objective	1 2 3 4 5	
Flexibility / adaptability	1 2 3 4 5	
Emotional stability	1 2 3 4 5	
Crisis problem solving	1 2 3 4 5	
Counseling abilities & competencies	1 2 3 4 5	

**Please provide a written overall assessment of the candidate as a Counselor. Comment on the intellectual and personal assets and/or liabilities that would affect the person’s professional practice in the diagnosis of alcohol or other drug abuse or dependence.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**CONFIDENTIAL – DO NOT RETURN THIS FORM TO THE APPLICANT**

# Professional Recommendation Form

**Provide this form to a professional and/or academic colleague who is acquainted with your addiction counseling experience. Provide a pre-addressed, stamped envelope so the form can be mailed directly to the BAPP Administrative Office.**

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## **PART I - TO BE COMPLETED BY THE APPLICANT**

Complete the information below. Give this form to a professional who is acquainted with your work performance and abilities. Be sure to provide the individual with a pre-addressed, stamped envelope so the form can be mailed directly to the BAPP.

Name of Applicant: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I understand that this recommendation will be used in determining my eligibility to upgrade to LAC and is a character reference. Therefore, I agree and understand that I will not be entitled to this information under any circumstance.

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Date

---

## **PART II - TO BE COMPLETED BY A PROFESSIONAL OR ACADEMIC ACQUAINTANCE**

The person listed above has applied for a status upgrade to Licensed Addiction Counselor (LAC). The signature above authorizes you to complete this form. Your assessment will assist the BAPP in determining the applicant's appropriateness for this certification upgrade. A fair and candid report is essential. Therefore, we ask for careful ratings and comments about character and ability. All information submitted will be viewed as confidential and will not be available to the applicant.

YOUR NAME: \_\_\_\_\_

POSITION/TITLE: \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

DAYTIME TELEPHONE #: \_\_\_\_\_

HOW LONG HAVE YOU KNOWN THE APPLICANT: \_\_\_\_\_

IN WHAT CAPACITY: \_\_\_\_\_

## Professional Recommendation Form (Continued)

Please rate the candidate by circling the most accurate response. Use “Don’t Know” ONLY if you have never observed or have absolutely no knowledge of the respective variable.

COUNSELOR SKILL AREAS	Poor-Excellent	Don’t Know
Breadth of knowledge in alcohol and other drug abuse	1 2 3 4 5	
Breadth of knowledge in the twelve core functions	1 2 3 4 5	
Relationship ability	1 2 3 4 5	
Communication skills	1 2 3 4 5	
Sense of responsibility & adherence to state & federal confidentiality regulations	1 2 3 4 5	
Empathy / understanding	1 2 3 4 5	
Openness / genuineness	1 2 3 4 5	
Honesty / integrity	1 2 3 4 5	
Cooperation with others	1 2 3 4 5	
Ability to recognize and set appropriate limits with clients	1 2 3 4 5	
Self-assessment / insight	1 2 3 4 5	
Ability to be objective	1 2 3 4 5	
Flexibility / adaptability	1 2 3 4 5	
Emotional stability	1 2 3 4 5	
Crisis problem solving	1 2 3 4 5	
Counseling abilities & competencies	1 2 3 4 5	

**Please provide a written overall assessment of the candidate as a Counselor. Comment on the intellectual and personal assets and/or liabilities that would affect the person’s professional practice in the diagnosis of alcohol or other drug abuse or dependence.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**CONFIDENTIAL – DO NOT RETURN THIS FORM TO THE APPLICANT**



# Professional Recommendation Form

**Provide this form to a professional and/or academic colleague who is acquainted with your chemical dependency counseling experience. Provide a pre-addressed, stamped envelope so the form can be mailed directly to the BAPP Administrative Office.**

**NOTE:** ANY INDIVIDUAL WHO HAS COMPLETED THE 'SUPERVISOR EVALUATION AND RECOMMENDATION' FORM FOR THIS APPLICANT MAY NOT SUBMIT A 'PROFESSIONAL RECOMMENDATION' FORM.

## **PART I - TO BE COMPLETED BY THE APPLICANT**

Complete the information below. Give this form to a professional who is acquainted with your work performance and abilities. Be sure to provide the individual with a pre-addressed, stamped envelope so the form can be mailed directly to the BAPP.

Name of Applicant: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I understand that this recommendation will be used in determining my eligibility to upgrade to LAC and is a character reference. Therefore, I agree and understand that I will not be entitled to this information under any circumstance.

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Date

---

## **PART II - TO BE COMPLETED BY A PROFESSIONAL OR ACADEMIC ACQUAINTANCE**

The person listed above has applied for a status upgrade to Licensed Addiction Counselor (LAC). The signature above authorizes you to complete this form. Your assessment will assist the BAPP in determining the applicant's appropriateness for this certification upgrade. A fair and candid report is essential. Therefore, we ask for careful ratings and comments about character and ability. All information submitted will be viewed as confidential and will not be available to the applicant.

YOUR NAME: \_\_\_\_\_

POSITION/TITLE: \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

DAYTIME TELEPHONE #: \_\_\_\_\_

HOW LONG HAVE YOU KNOWN THE APPLICANT: \_\_\_\_\_

IN WHAT CAPACITY: \_\_\_\_\_

## Professional Recommendation Form (Continued)

Please rate the candidate by circling the most accurate response. Use “Don’t Know” ONLY if you have never observed or have absolutely no knowledge of the respective variable.

COUNSELOR SKILL AREAS	Poor-Excellent	Don’t Know
Breadth of knowledge in alcohol and other drug abuse	1 2 3 4 5	
Breadth of knowledge in the twelve core functions	1 2 3 4 5	
Relationship ability	1 2 3 4 5	
Communication skills	1 2 3 4 5	
Sense of responsibility & adherence to state & federal confidentiality regulations	1 2 3 4 5	
Empathy / understanding	1 2 3 4 5	
Openness / genuineness	1 2 3 4 5	
Honesty / integrity	1 2 3 4 5	
Cooperation with others	1 2 3 4 5	
Ability to recognize and set appropriate limits with clients	1 2 3 4 5	
Self-assessment / insight	1 2 3 4 5	
Ability to be objective	1 2 3 4 5	
Flexibility / adaptability	1 2 3 4 5	
Emotional stability	1 2 3 4 5	
Crisis problem solving	1 2 3 4 5	
Counseling abilities & competencies	1 2 3 4 5	

**Please provide a written overall assessment of the candidate as a Counselor. Comment on the intellectual and personal assets and/or liabilities that would affect the person’s professional practice in the diagnosis of alcohol or other drug abuse or dependence.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**CONFIDENTIAL – DO NOT RETURN THIS FORM TO THE APPLICANT**