



**American Academy
of Health Care Providers**

I N T H E

Addictive Disorders

**Certified Addiction Specialist
APPLICATION PACKET**

American Academy of Health Care Providers in the Addictive Disorders
314 West Superior Street | Suite 508
Duluth, MN 55802

info@americanacademy.org AmericanAcademy.org 888.429.3701

MINIMUM ELIGIBILITY REQUIREMENTS - CAS



American Academy
of Health Care Providers
I N T H E
Addictive Disorders

CERTIFIED ADDICTION SPECIALIST (CAS)

The American Academy of Health Care Providers in the Addictive Disorders offers the Certified Addiction Specialist (CAS) certification to health care professionals in the field of addictive disorders that includes specializations in one or more areas:

Professionals with a masters or doctorate degree* in mental health-related fields:

Three years of supervised experience providing direct addictive disorder health care services.

Professionals with a bachelor's degree* or non-degreed must have:

Five years of supervised experience providing direct addictive disorder health care services.

Documentation of Education

1. Counseling Competencies (120 hours)
2. Choose one or more areas of specialization.

Applicant must have 60-hours of education for each area selected:

Alcohol, Other Drugs, Disordered Gambling, Sex Addiction, and/or Eating Disorders
Only one area of specialization is required when applying.

3. 30 hours of education/training from one or more of the following: Services to special populations, co-occurring disorders, PTSD, disabilities, diverse populations, probation/parole, ethics, communicable diseases, or sexual harassment.

Letters of Recommendation

Three professional recommendations from professionals familiar with the Applicant's work; at least one must be a clinical supervisor who can document the applicant's health care experience.

Fees

\$195 non-refundable application fee - includes a background check.

An 89-page study guide is available for purchase. \$40 for an electronic copy or \$99 for printed copy to be mailed to you.

Exam fee \$295 + additional fees for proctoring services are the responsibility of the application.

* Accredited university/college/institution of higher learning.

CERTIFICATION EXAMINATION



American Academy
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CERTIFIED ADDICTION SPECIALIST (CAS)

The Academy has developed a comprehensive examination designed to test the applicant's knowledge in the essential core domains of addiction treatment. The online proctored examination consists of 150 multiple choice questions representing the Academy's job/practice analysis and performance domains that include:

Counseling

- Marriage and family therapy
- Screening instruments and techniques
- Treating special populations
- Treatment techniques
- Detoxification
- Intervention skills
- Interpersonal skills

Treatment Planning

- Assessment and diagnostic skills
- Developing a diagnostic and treatment formulation
- Relationship between addictions and other problems
- Referral skills

Professional and Ethical Responsibilities

- Legal and ethical issues
- Training activities that lead to credentials
- Documentation
 - Administrative skills
 - Treatment process skill

Foundations (Transdisciplinary)

- Dual diagnosis
- Theoretical models of addiction
- Addiction concepts

Client, Family, and Community Education

- Signs and symptoms of addiction and withdrawal
- Therapy organization and movement skills

Web-based Examination & Administration

The examination is a web-based proctored examination. Candidates are allowed three hours to complete the 150-question exam and the results are available within two business days. The exam is pass/fail based on raw score.

The exam must be proctored at an official testing site that include but are not limited to:

- Official testing center at an accredited college/university or institute of higher learning
- Certified librarians at a library, college or university
- Professional learning or testing centers such as Sylvan Learning Centers
- Educational officers of a military installation

Once your application has been approved, you will be sent contact information for the approved proctor in your area to schedule the exam day/time directly with their office.

CAS Study Guide:

Applicants approved to take the examination will receive the CAS exam study guide. This 90-page study guide was prepared to review the domains covered in the exam.

Digital Format: \$40

Printed Format: \$99 (includes shipping)

Examination Fee: \$295 Re-Testing Fee: \$100 + proctoring fee

Once applications are reviewed and accepted, the examination fee will be due. Please contact the Academy to pay the fee by credit card. Candidates who do not successfully complete the exam will be contacted and given the opportunity to re-test for the certification.

CERTIFIED ADDICTION SPECIALIST CERTIFICATION APPLICATION FORM



**American Academy
of Health Care Providers**
I N T H E
Addictive Disorders

OFFICE USE ONLY:
Date Received: _____ 20____
App #: _____
Fee enclosed: _____
Accept _____ Deny _____
Exam Date: _____
CAS No.: _____

Name _____

Home Address _____

City _____ State ____ Country _____ Postal Code _____

Phone (home) _____ (office) _____ (cell) _____ fax _____

Email Address _____

Employer _____

Address _____

City _____ State ____ Country _____ Postal Code _____

SEND CORRESPONDANCE TO: Home address _____ or Professional address: _____

SPECIALIZATION: Check each addiction specialization for which you are applying. 60 hours of training is required for each specialization you wish to apply for.

Alcohol _____ Other Drugs _____ Eating Disorders _____ Sex Addiction _____ Gambling Addiction _____

Current Certification/Licensure:

License _____ Number _____ Date first issued _____ State _____

Certification _____ Number _____ Date first issued _____

Certifying body _____

Education:

Highest degree earned _____ Institution _____

Graduation date _____ Department _____

Major field or program _____

Other degrees earned _____ Institution _____

Graduation date _____ Department _____

Major field or program _____

Supervised Health Care Experience in the Addictive Disorders:

Please list the most recent first.

1. Name of facility: _____

Address _____

City _____ State ____ Country _____ Postal Code _____

Dates: From Month/Year _____ to Month/Year _____ Part-time ___ Full-time ___ Hours per week _____

Your title or position _____

Describe the nature of duties including primary clinical population served:

Please specify the percentage of your caseload identified with specific addictive disorders (Example: 30% eating disordered, 40% drug addicted, 30% gambling addiction)

Please list separately each supervisor and period of supervision:

1. Name of supervisor _____
Supervisor's degree _____ Title _____
Dates of supervised health care experience from month/year _____ to month/year _____ = _____ months

2. Name of supervisor _____
Degree _____ Title _____
Dates of supervised health care experience from month/year _____ to month/year _____ = _____ months

2. Name of facility: _____
Address _____
City _____ State ____ Country _____ Postal Code _____
Dates: From Month/Year _____ to Month/Year _____ Part-time ___ Full-time ___ Hours per week _____
Your title or position _____

Describe the nature of duties including primary clinical population served:

Please specify the percentage of your caseload identified with specific addictive disorders (e.g. 30% eating disordered, 40% drug addicted, 30% gambling addiction)

Please list separately each supervisor and period of supervision:

1. Name of supervisor _____
Degree _____ Title _____
Dates of supervised health care experience from month/year _____ to month/year _____ = _____ months

2. Name of supervisor _____
Degree _____ Title _____
Dates of supervised health care experience from month/year _____ to month/year _____ = _____ months

3. Name of facility _____

Address _____

City _____ State ____ Country _____ Postal Code _____

Dates: From Month/Year _____ to Month/Year _____ Part-time __ Full-time _____ Hours per week _____

Your title or position: _____

Describe the nature of duties including primary clinical population served:

Please specify the percentage of your caseload identified with specific addictive disorders (e.g. 30% eating disordered, 40% drug addicted, 30% gambling addiction)

Please list separately each supervisor and period of supervision:

1. Name of supervisor _____
Degree _____ Title _____
Dates of supervised health care experience from month/year _____ to month/year _____ = _____ months
2. Name of supervisor _____
Degree _____ Title _____
Dates of supervised health care experience: from month/year _____ to month/year _____ = _____ months

Internship Training Experience:

1. Name of facility: _____

Address _____

City _____ State ____ Country _____ Postal Code _____

Dates: From Month/Year _____ to Month/Year _____ Part-time __ Full-time _____ Hours per week _____

Your title or position: _____

Describe the nature of duties including primary clinical population served:

Please specify the percentage of your caseload identified with specific addictive disorders: (e.g. 30% eating disordered, 40% drug addicted, 30% gambling addiction)

Your title during training _____

Name of supervisor _____

Degree _____ Title _____

Total Months of Supervised Experience Time = _____ months

Please note any other training/experience relevant to this application that will assist the Academy Certification Staff review of your application.

Have you previously applied to the American Academy? ____ Yes ____ No

I hereby attest that all of the above information is true and correct to the best of my knowledge. I acknowledge that the certification program of the Academy is entirely voluntary and agree to be bound by its policies and procedures, as they now exist or as they may be amended in the future. I agree to make no claim against the Academy for action taken by it in accordance with those policies and procedures. I authorize the Academy to contact any of the supervisors listed in my application and request that each of the supervisors so contacted fully and frankly respond to all inquiries made of him or her by the Academy regarding my application.

Signature of Applicant

Date

Application Payment Options:

Call the Academy office to pay by phone, request an electronic invoice, mail a check with your application.

Applications and supporting documentation should be **mailed** to:

American Academy of Health Care Providers in the Addictive Disorders
314 West Superior Street, Suite 508
Duluth, MN 55802

Toll free phone: 888-429-3701 Fax 218-722-0346 Email: info@americanacademy.org

The American Academy of Health Care Providers in the Addictive Disorders is committed to adherence and compliance to all applicable laws as set forth and in regard to equal opportunities for all individuals in accordance with Title VI of the Civil Rights Act of 1964, as amended by the Civil Rights Restoration Act of 1991 (42 USC §1981, 2000e et seq), Section 504 of the Rehabilitation Act of 1973, as amended (29 USC §794), the Age Discrimination Act of 1975, as amended (42 USC §6101 et seq), Title II of the Americans with Disabilities Act of 1990 (42 USC §12101 et seq), and Title IX of the Education Amendments of 1972. Neither the American Academy of Health Care Providers in the Addictive Disorders (AAHCPAD), nor the AAHCPAD officers or employees shall discriminate against applicants, registrants, members, employees or other professionals or individuals on the basis of sex, race, color, national origin, sexual orientation, economic condition, disability or age in the certification, membership, or registration process, or in its programs and activities.



Applicant Background Screening Consent Form

Personal Information

Full Name (no nicknames):		
Maiden Name/Other Names Used:		Date last used:
Maiden Name/Other Names Used:		Date last used:
Social Security Number: - -	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Drivers License Number:	State:	

Have you been convicted of any violations (or is action pending by any law enforcement agency) in the last seven (7) years? Include court martial's, but do not include juvenile convictions or traffic violations resulting in a fine of \$100 or less.

Yes No If yes, list all violations below, include dates and arresting agency. Attach additional pages if necessary. (A conviction will not necessarily bar an applicant from employment)

All addresses for the last SEVEN years: (attach additional pages if necessary)

1.	_____	_____	_____	_____	_____	_____
	Street	City	County	State	Zip	Years From – To
2.	_____	_____	_____	_____	_____	_____
	Street	City	County	State	Zip	Years From – To
3.	_____	_____	_____	_____	_____	_____
	Street	City	County	State	Zip	Years From – To
4.	_____	_____	_____	_____	_____	_____
	Street	City	County	State	Zip	Years From – To
5.	_____	_____	_____	_____	_____	_____
	Street	City	County	State	Zip	Years From – To
6.	_____	_____	_____	_____	_____	_____
	Street	City	County	State	Zip	Years From – To
7.	_____	_____	_____	_____	_____	_____
	Street	City	County	State	Zip	Years From – To

5-Year Employment History (Show every employment – begin with last or present employer.)

Show all employments, beginning with last or present employer. If self-employed, list at least 2 business and 2 credit references including account numbers and/or contact names, checking the appropriate boxes.

May your current employer(s) be interviewed? Yes No

Dates (month/year) From: _____ To: _____	Check one: <input type="checkbox"/> Employer <input type="checkbox"/> If self-employed, business reference <input type="checkbox"/> Credit Reference (Acct. #: _____)
	Name: _____ Phone: _____
	Address: _____ City: _____ State: _____ Zip: _____
	Job Title(s): _____
	Name of Supervisor or Contact: _____ Dept: _____ Reason for Leaving: _____
Dates (month/year) From: _____ To: _____	Check one: <input type="checkbox"/> Employer <input type="checkbox"/> If self-employed, business reference <input type="checkbox"/> Credit Reference (Acct. #: _____)
	Name: _____ Phone: _____
	Address: _____ City: _____ State: _____ Zip: _____
	Job Title(s): _____
	Name of Supervisor or Contact: _____ Dept: _____ Reason for Leaving: _____
Dates (month/year) From: _____ To: _____	Check one: <input type="checkbox"/> Employer <input type="checkbox"/> If self-employed, business reference <input type="checkbox"/> Credit Reference (Acct. #: _____)
	Name: _____ Phone: _____
	Address: _____ City: _____ State: _____ Zip: _____
	Job Title(s): _____
	Name of Supervisor or Contact: _____ Dept: _____

	Reason for Leaving: _____
Dates (month/year)	Check one: <input type="checkbox"/> Employer <input type="checkbox"/> If self-employed, business reference <input type="checkbox"/> Credit Reference (Acct. #: _____)
From: _____	Name: _____ Phone: _____
To: _____	Address: _____ City: _____ State: _____ Zip: _____
	Job Title(s): _____
	Name of Supervisor or Contact: _____ Dept: _____
	Reason for Leaving: _____
Dates (month/year)	Check one: <input type="checkbox"/> Employer <input type="checkbox"/> If self-employed, business reference <input type="checkbox"/> Credit Reference (Acct. #: _____)
From: _____	Name: _____ Phone: _____
To: _____	Address: _____ City: _____ State: _____ Zip: _____
	Job Title(s): _____
	Name of Supervisor or Contact: _____ Dept: _____
	Reason for Leaving: _____

Education

Institution Name and Address	From (mo/yr)	To (mo/yr)	GPA/ Class Standing	Major	Minor	Type of Degree	Date Degree Obtained or to Be Obtained

Authorization to Release Information and Records

I, _____, hereby authorize the **American Academy of Health Care Providers in the Addictive Disorders** and/or their agent to conduct an appropriate background investigation of my former employment, education, and criminal records for determination of my eligibility for certification. I authorize all persons who may have information relevant to this investigation to disclose it to **Choice Screening** and/or their agent. I release and agree to hold harmless all persons providing such information and **Choice Screening**, its officers, directors, employees and agents from liability on account of such disclosure. I hereby further authorize that a photocopy of this authorization may be considered as valid as the original.

These investigations might include, but are not limited to, searches of educational institutions attended; records of previous employment, including work history, efficiency ratings, complaints and grievances filed by or against me; records and recollections of attorney-at-law or of other counsel, whether representing me or any other person (in either a civil or criminal case in which I have been involved); records from the U.S. Veterans' Administration; criminal history information or files in local, state or federal agencies; and motor vehicle records. I also authorize the National Personnel Records Center, or other custodian of my military service record, to release to **Choice Screening**, the following information and/or copies of documents from my military service record: 00214, service record, and any disciplinary records.

I understand that these searches may be used to determine certification eligibility. Therefore, I authorize and consent for full release of records (either orally or in writing) to the authorized representatives of the company. In addition, I release and discharge the company and its agent and associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs expenses or any other charge or complaint filed with any agency arising from retrieving and reporting this information. I understand that I may request a copy of the report from **Choice Screening** 600 Grant Street, Suite 700, Denver, CO 80203 at telephone number (720) 974-7882. After reading this document, I fully understand its contents and authorize the background verification.

New York Applicants: By signing below, you acknowledge receipt of Article 23-A of the New York Correction Law.

Are you applying for certification in California, Minnesota or Oklahoma? Yes ___ No ___

I hereby certify that all information provided in this authorization is true, correct and complete.

Signed this _____ day of _____, 20__

Applicant Signature: _____



CHOICE SCREENING

600 Grant Street, Suite 700, Denver CO 80203

APPLICATION INSTRUCTIONS & CHECKLIST



American Academy
of Health Care Providers
I N T H E
Addictive Disorders

CERTIFIED ADDICTION SPECIALIST (CAS)

Checklist for Completing the Certified Addiction Specialist Application

- ___ Application forms must be originals with original signatures. Please keep a copy for your records.
- ___ Copy of an official photo ID.
- ___ Applicant's current resume or curriculum vitae.
- ___ Transcript of bachelor's, master's or doctoral degrees from accredited institute of higher learning
- ___ Copies of diplomas, licenses, and certifications.
- ___ Documentation of 270 hours of education that must include the following:
 - ___ 120 hours of training or education in counseling competencies
 - ___ 60 hours of training or education for *each* specialization requested
 - ___ 30 hour of training or education in special populations, ethics, communicable disease, sexual harassment prevention.
- ___ Code of Ethics & Conduct form – signed by applicant.
- ___ Applicant Background Screening Consent Form completed and signed.
- ___ Non-refundable application fee: \$195
- ___ Payment for optional CAS Exam Study Guide (\$40 Digital Copy or \$99 Printed Copy)

REFERENCES:

- ___ Submit three letters of professional recommendation from individuals who are familiar with the applicant's clinical work. At least one letter must be provided from a clinical supervisor. All reference letters need to be on professional letterhead. List references below:
 1. _____
 2. _____
 3. _____

CLINICAL SUPERVISION RECOMMENDATIONS:

Clinical supervisors must be licensed or certified in their respective fields. The experience and credentials of the supervisor must be appropriate to the supervision provided.

Clinical Supervision Verification Forms (**CONFIDENTIAL**):

- ___ A self-addressed stamped envelope for returning the completed form must be provided by the applicant to the clinical supervisor who will attest to applicant's supervision.
- ___ Clinical supervisor must complete the form and sign. It is then to be placed in the envelope provided by the applicant, together with the supervisor resume or curriculum vitae, or letter outlining his/her training and experience specifically in the treatment of addictive disorders.
- ___ Supervisor must seal the envelope, sign their name across the seal, and return it to the applicant.
- ___ Applicant will submit the sealed envelopes with the application and portfolio.

OTHER:

Incomplete applications that do not meet the requirements will be returned. The application and review fees are non-refundable. The Academy will notify the applicant of certification status within two weeks of receiving the completed application.

DEFINITIONS:

Accredited health care training program: Programs accepted for certification requirements are those degree-granting educational institutions that are accredited by the appropriate regional accreditation board and those that receive such accreditation within six years of the date of the applicant's awarded degree.

Direct health care services: The applicant must have provided supervised direct health care services to those identified with addictive disorders in a licensed clinical setting. Health care services include, but are not limited to, assessment, diagnosis, and approved therapeutic (medical or psychological) interventions.

Certifiable internship program: An internship program is comprised of a minimum of 1,500 working hours and must be completed within 24 consecutive months. Internship experience considered certifiable are those whose training programs and supervision are approved by the American Psychological Association, the American Medical Association, the American Psychiatric Association, the American Psychoanalytical Association, the National League of Nursing, the National Association of Social Workers, and those licensed or certified by local state agencies. These programs generally require the applicant's status to be considered as an intern, trainee, or fellow.

Clinical Supervisors: Clinical supervisors must be licensed or certified in their respective fields. The experience, credentials, and activities of the supervisor must be appropriate to the supervision provided.

Clinical Training in Specialization – trainings must be specific to alcohol addiction, other drugs (methamphetamine, tobacco, HIV, etc.), eating disorders, sexual addiction and/or gambling addiction. Co-occurring and dual diagnosis trainings do not apply towards specializations.

***Current Clinical Education** – education must be current and not to exceed five years.

Supervision is broadly defined in the Center for Substance Abuse Treatment (CSAT) / Substance Abuse and Mental Health Services Administration's (SAMHSA) *Technical Assistance Publication (Tap #21)*, as the administrative, clinical, and evaluative process of monitoring, assessing and enhancing counselor performance.



Since Hippocrates wrote his oath more than 2000 years ago, health care providers have sought to establish standards for ethical and competent medical and psychological treatment. The American Academy itself was created to establish such a standard in the field of addiction treatment, which it succeeded in doing with the creation of the Certified Addiction Specialist (C.A.S.) credential.

The Academy's membership is comprised of clinicians from a variety of disciplines and treatment modalities who include nurses, physicians, psychologists, psychiatrists, social workers, forensic counselors and counselors, unified in their commitment to providing the highest quality of health care to individuals suffering from addiction. Our diverse membership is also unified in their recognition of the ethical standards and considerations that are specific to this field.

This code is meant to provide only a very general outline of the principles for those health care providers specifically treating the addictions and is **in no way** exhaustive of the ethical responsibilities of our membership. Since our members come from a variety of disciplines and may carry multiple credentials, the principles set forth here should not be viewed in any way as supervening or abrogating other ethical codes to which our members might be bound. On the contrary, the Academy's code is meant to supplement or compliment other standards, both legal and ethical, while setting forth a code of conduct that addresses the issues that are unique to working with individuals with addictions. This code is also meant to serve notice to the public as to the standards of health care and treatment that they can expect from Academy members.

Academy members are bound by the Academy's ethical code and will be held to the letter and spirit of this code. The membership of those violating this code will be subject to inquiry and review, resulting in possible suspension or revocation of the credential. By signing this Code of Ethics/Code of Conduct you agree to cooperate with any complaint and/or disciplinary investigation unless such disclosure of information would violate the confidentiality requirements of Subpart 2, Title 42, Code of Federal Regulations.

PRINCIPLES OF CONDUCT

I. Competence

Academy members must recognize both the strengths and limitations in their ability to treat addictions. They continually seek to stay abreast of innovations in the understanding and treatment of addiction. They also only treat addictions about which they are knowledgeable and capable of treating. As a corollary to this, they only offer treatment services which are within their realm of competence and said competence is determined on the basis of their education, clinical supervision, and experience.

II. Maintenance of Competence

Because of the continual changes in the field of addiction treatment, Academy members maintain awareness of research findings and changes in treatment techniques and approaches, which is necessary to maintain their competence in this field.

III. Nondiscrimination

In their work in the addictions, members of the Academy do not discriminate against their clients or co-workers on the basis of race, gender, religion, sexual orientation, age, disability, ethnicity, socio-economic status, or national origin. They also do not unfairly discriminate on the basis of addiction or the medical complications of addiction. While alcoholism and drug addiction are recognized by the federal government to be disabilities and individuals suffering from such addictions are protected from discrimination under the Federal Rehabilitation Act, Academy members do not restrict their nondiscrimination practices to these individuals, but extend them to all people suffering from addiction, recognizing that all such addictions are debilitating.

a) Academy members are knowledgeable about the unique or special issues that face the individuals that they are treating both on the basis of their individual situations and on the basis of the addiction from which they suffer.

b) Academy members are able to recognize instances in which individual differences between themselves and their client affect their ability to provide the highest quality health care. In such cases, Academy members take the necessary steps to become competent in these areas or they make referrals to agencies or individuals who can best address their client's needs.

c) Academy members recognize those personal issues and conflicts that might affect their ability to provide their clients with the best possible health care. In such instances, they will refer the patient to someone better able to deal with him/her, or will refrain from treating the patient until the Academy member has adequately resolved these issues.

d) Academy members recognize that there are individuals who suffer from multiple addictions. In such cases, Academy members will only treat the addictions that they are competent to treat. With regard to the other addictions, they will either take the steps necessary to become competent in these areas or will make referrals to agencies or individuals who can best address them.

e) Academy members recognize that many clients suffering from an addiction suffer from other mental disorders as well. Academy members treat only the problems that they are competent to treat. In complicated cases in which several disorders must be treated simultaneously, Academy members will seek the requisite support and consultation and, if this is not available, will refer the client to the appropriate agency or clinician.

f) Academy members recognize that many clients seeking treatment for addiction may also suffer from medical complications and/or viral infections, e.g., HIV, TB or hepatitis, that eventuate from their addiction. In such cases, Academy members will treat only the aspects of the illness that they are competent to treat. If they are not competent to work with such clients, they will either take the necessary steps to become competent, or they will consult with others and make referrals to the agencies or individuals that can best address the client's needs.

IV. Harassment

Academy members do not engage in any type of harassment, sexual or otherwise, in the workplace.

a) The Academy considers sexual harassment to be any activity that demeans or creates a hostile environment for an individual through sexual behavior or language. This includes unwelcome or unwanted advances of a sexual nature, verbal and nonverbal behavior of a sexual nature that would be deemed inappropriate by a reasonable person, and soliciting sex within the context of one's professional responsibilities.

b) Academy members do not engage in any other forms of harassment in the workplace. This includes verbal abuse, physical abuse, sexual harassment, threats, or any other activities that involve the exploitation or denigration of others, or, otherwise create a hostile work environment for others.

c) Academy members do not engage in sexual conduct with clients, their family members, or other persons who are significant to them.

V. Conflicts of Interest

Academy members are familiar and adhere to the laws concerning their responsibilities and they are able to anticipate those responsibilities that might potentially conflict with their role as health care provider. Members will not engage in social or business relationships for personal gain with clients, their family members, or other persons who are significant to them.

VI. Confidentiality

Academy members respect the patient-client confidentiality agreement. Because of the potential limitations on confidentiality (as suggested in Principle V), Academy members are careful to apprise their clients of the limits of confidentiality. All Academy members will protect client rights to confidentiality in accordance with Part 2, Title 42, Code of Federal Regulations.

VII. Clients Receiving Services Elsewhere

Individuals being treated for an addiction often receive health services from other sites. In considering whether to treat such individuals, Academy members consult these other services to determine whether the client is best served in this manner. Academy members also anticipate and attempt to resolve potential conflicts that might arise from this arrangement.

VIII. Making Referrals

In making referrals, Academy members consider the best possible placement for their clients. Such referrals are always based on the best interests of the client and **never** on the financial interests of the clinician. Academy members attempt to familiarize themselves with a particular treatment site before making a referral to that site.

IX. Assessment Tools

Academy members are careful to use current assessment tools which are compatible with contemporary theories of addiction.

X. Relapse

Academy members include relapse prevention as part of their treatment approach.

XI. Impaired Professionals

As a corollary to Principle I, Academy members who develop their own addiction difficulties will refrain from providing treatment until such time as they are able to provide competent treatment. Members are prohibited from providing counseling services, attending any program services or activities, or being present on program premises while under the influence of any amount of alcohol or illicit drugs (with the exception of the legitimate use of prescription drugs and over-the-counter drugs used in the dosage described in the packaging).

I agree to be bound by and to comply with the Code of Ethics and Conduct as set forth by the American Academy of Health Care Providers in the Addictive Disorders.

Signature

Name (printed)

Date: _____

CLINICAL SUPERVISOR VERIFICATION - CAS



American Academy
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I N T H E
Addictive Disorders

CERTIFIED ADDICTION SPECIALIST (CAS)

CONFIDENTIAL

Applicant Name: _____

Specialties applied for:

Alcohol ___ Other Drugs ___ Eating Disorders ___ Sexual Addiction ___ Disordered Gambling ___

Supervision is broadly defined in the Center for Substance Abuse Treatment (CSAT) / Substance Abuse and Mental Health Services Administration's (SAMHSA) *Technical Assistance Publication (Tap #21)*, as the administrative, clinical, and evaluative process of monitoring, assessing and enhancing counselor performance.

To the Clinical Supervisor:

The applicant named above is applying for a Certified Addiction Specialist certification from the American Academy of Health Care Providers in the Addictive Disorders. To qualify for the CAS credential, applicants must have supervised clinical experience, specialized addiction training, and must demonstrate a critical understanding of the central tenets of addictions treatment. You have been identified by the applicant as having been his/her clinical supervisor.

MINIMUM ELIGIBILITY REQUIREMENTS FOR A CERTIFIED ADDICTION SPECIALIST:

Professionals with master's or doctorate degrees must have:

1. A masters or doctorate degree from an accredited institute of higher learning in the field of mental health;
2. Three years (6,000 hours) of supervised experience providing direct addictive disorder health care services. Pre-doctoral or pre-master's internships may be applied towards one year of clinical supervision;
3. A minimum of 270 hours of formal education in counseling and related addiction fields;
4. Three professional recommendations from those who are professionally familiar with the applicant's work and can document his or her health care experience.

Professionals with other degrees or without a degree must have:

1. Five years (10,000 hours) of supervised experience providing direct health care services to those identified with an addictive disorder;
2. A minimum of 270 hours of formal education in counseling and related addiction fields;
3. Three professional recommendations from those who are professionally familiar with the applicant's work and can document his or her health care experience.

Please complete this Clinical Supervisor Verification Form, sign and please include a copy of your curriculum vitae or resume with the completed form. This form must be sealed in an envelope with your name signed across the seal. Forms should be returned to the applicant. The applicant may not submit his/her applicant without this form.

To be completed by the supervisor (form is confidential):

Supervisor's Information:

Name _____ Title/Position _____

Organization/Company _____

Address _____

City _____ State _____ Country _____ Postal Code _____

Clinical Supervisor's Specialty Field (Check all that apply)

Alcohol _____ Other Drugs _____ Eating Disorders _____ Sex Addiction _____ Gambling Addiction _____

Your Degree _____

Your Licenses/Certifications _____

Specialty Boards _____

Are you a Member of the American Academy of Health Care Providers? ___ Yes ___ No

Dates of supervision with the above named applicant: Month/Year _____ to Month/Year _____

Total Months of Clinical Supervision: _____ months. Total hours applicant worked per week: _____ hrs

Number of direct (face to face) supervision **hours each month** for the period listed above _____

Name of facility where supervision was conducted _____

Your position at the time of supervision _____

Applicant's position at the time of supervision _____

Comments about the applicant (**form is confidential**):

This signed form represents verification of the applicant's supervised experience providing direct health care service to those individuals identified with an addictive disorder. By signing this form, you are recommending that this applicant be designated as a Certified Addiction Specialist for the specialties applied for. Your recommendation represents an endorsement of the applicant's training, experience, and competence as a health care provider in the addictive disorders.

Signature: _____ Title: _____

Telephone: _____ E-mail: _____

Date: _____

Please return to the applicant in a sealed envelope with your signature across the seal.

CERTIFICATION BOARD



American Academy
of Health Care Providers
I N T H E
Addictive Disorders

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I N T H E
Addictive Disorders

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