Upper Midwest Indian Council on Addictive Disorders (UMICAD)
PO Box 1130
Bemidji, MN 56619
Ph. (218) 230-2622 Fax: (218) 319-8468

I am applying for

____ Alcohol/Drug Counselor I (ADC I)

____Alcohol/Drug Counselor II (ADC II) ____Prevention Specialist I

____Alcohol/Drug Counselor III (ADC III) ____Prevention Specialist II

I have enclosed a copy of my International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse IC&RC ADC Certification examination test results.

I have enclosed a copy of my UMICAD Written Examination test results.

Also

I have enclosed the application fee of $150.00 (please make check payable to UMICAD)

Please Print or Type

First Name:	**Last Name:**	**MI:**
Home Address:		**SS #**
City:	**State:**	**Zip:**
Home Number:	**Cell Number:**	

List all the following information regarding your current clinical practice site/agency location. (note: if you have an additional clinical practice site(s), copy this page, provide the requested information, and attach it to this General Information Sheet)

Site Name:	**Phone#:**		
Address:	**Fax#:**		
City:	**State:**	**Zip:**	**County:**
Job Title:	**Number of hours work per week**		
Email:	**Email:**		

I have asked the certified counselor or certified clinical supervisor (ADC II, ADC III, CCS I, or CCS II) who supervised my substance use disorder counseling experience to complete the COUNSELOR EVALUATION FORM:

Supervisor's Name:	Credential(s)	Phone Number:

I have asked the following persons to complete and forward counselor professional reference forms to The Upper Midwest Indian Council On Addictive Disorders (UMICAD). (Please list three people, other than your supervisor, who know you professionally and can assess your AODA work, knowledge and skills.).

Name of Reference:	Credential(s)	Telephone Number:

ASSURANCES

I. I certify that all the enclosed application materials were prepared by me; and are true and correct

II. I hereby acknowledge receipt of the Upper Midwest Indian Council on Addictive Disorder, Inc. (UMICAD) counselor ***CODE OF CONDUCT*** and do agree to its terms.

III. I understand that the UMICAD credential certificate remains the property of the UMICAD.

IV. I understand that if my counselor certification is suspended or revoked as a result of my breaching the UMICAD counselor ***CODE OF CONDUCT,*** I will return my credential certificate to the UMICAD Office immediately.

Name: _____
(please print or type)

Signature: _____

Date: _____

Note: The remaining questions and responses are optional. Your responses will be held confidential; and **will not affect** the decisions made concerning your application for a UMICAD counselor classification. Your responses continue to provide valuable information which allows the UMICAD to evaluate current trends in the AODA profession. The UMICAD would appreciate your responding to the following questions.

What is your date of birth? _____

What is your Gender? _____ Male _____ Female

What is your ethnic background?

_____ African American _____ Asian American _____ Caucasian

_____ Multiracial _____ Hispanic/Latino _____ Native American

_____ Other: (please specify)

Professional Experience: *see certification handbook for requirements and directions on completing this form*

First Name:	**Last Name:**	**MI:**

Present Position

Employment Date: Start:	End:

Total hours Worked:	Hours in SUD counseling	Hours in other counseling:

Site Name:	Phone#:		
Address:	Fax#:		
City:	State:	Zip:	County:
Job Title:	Number of hours work per week		
Email:	Email:		
Supervisors Name:			
Supervisors Title/ Credentials:			

1. In this position, I have spent _____hours performing direct client counseling in one-to-one, family, and groups.
2. Of the hours listed above in blank 1, how many hours were spent counseling the **substance use disorder client** in one-to-one, family, and groups?
3. Of the hours listed above in blank 2, how many hours were spent counseling the **substance use disorder client** using an individual modality (one-to-one)?

Describe all duties and function in this position below (attach copy of agency job description)-

_____
_____
_____
_____

Previous Position # 2

Employment Date: Start:	End:

Total hours Worked:	Hours in SUD counseling	Hours in other counseling:

Site Name:	Phone#:		
Address:	Fax#:		
City:	State:	Zip:	County:
Job Title:	Number of hours work per week		
Email:	Email:		
Supervisors Name:			
Supervisors Title/ Credentials:			

1. In this position, I have spent _____hours performing direct client counseling in one-to-one, family, and groups.
2. Of the hours listed above in blank 1, how many hours were spent counseling the **substance use disorder client** in one-to-one, family, and groups?
3. Of the hours listed above in blank 2, how many hours were spent counseling the **substance use disorder client** using an individual modality (one-to-one)?

Describe all duties and function in this position below (attach copy of agency job description)-

_____
_____
_____
_____

Professional Experience: *see certification handbook for requirements and directions on completing this form*

First Name:	**Last Name:**	**MI:**

Previous Position # 3

Employment Date: Start:	End:

Total hours Worked:	Hours in SUD counseling	Hours in other counseling:

Site Name:	Phone#:		
Address:	Fax#:		
City:	State:	Zip:	County:
Job Title:	Number of hours work per week		
Email:	Email:		
Supervisors Name:			
Supervisors Title/ Credentials:			

1. In this position, I have spent _____hours performing direct client counseling in one-to-one, family, and groups.
2. Of the hours listed above in blank 1, how many hours were spent counseling the **substance use disorder client** in one-to-one, family, and groups?
3. Of the hours listed above in blank 2, how many hours were spent counseling the **substance use disorder client** using an individual modality (one-to-one)?

Describe all duties and function in this position below (attach copy of agency job description)-

_____
_____
_____
_____

Previous Position # 4

Employment Date: Start:	End:

Total hours Worked:	Hours in SUD counseling	Hours in other counseling:

Site Name:	Phone#:		
Address:	Fax#:		
City:	State:	Zip:	County:
Job Title:	Number of hours work per week		
Email:	Email:		
Supervisors Name:			
Supervisors Title/ Credentials:			

1. In this position, I have spent _____hours performing direct client counseling in one-to-one, family, and groups.
2. Of the hours listed above in blank 1, how many hours were spent counseling the **substance use disorder client** in one-to-one, family, and groups?
3. Of the hours listed above in blank 2, how many hours were spent counseling the **substance use disorder client** using an individual modality (one-to-one)?

Describe all duties and function in this position below (attach copy of agency job description)-

_____
_____
_____
_____

First Name:	Last Name:	MI:

EDUCATION & TRAINING RESUME

COURSE/CLASSROOMINFORMATION

Complete a copy of this form for each course/seminar attended. ****USE ONE PAGE PER COURSE**** (See certification handbook pages for requirements and directions on completing this form) Education requirements: 270 hours specific to the domains, and 6 hours of counselor specific ethics

Training Offered By: _____

Trainer's Name: _____

Trainer's Agency: _____

Title of Course, Seminar, Conference track, etc.: _____

Number of CEU's _____

Description of Content: _____

This Course, Seminar, Conference track, etc. was endorsed by: _____

EXPERIENCE FOR EDUCATION OPTION

First Name:	Last Name:	MI:

* *appropriate non UMICAD accredited Master's Doctorate Degree: A clinically focused Master's, Doctorate degree from an accredited school of higher education with a course of study in human services (i.e. community counseling, mental health, social work, rehabilitation counseling, or psychology) UMICAD reserves the right to disqualify any course of study it deems does not meet standard.*

I have completed: (check only one)

___ a master's or doctorate degree from an accredited academic based institution. I am counting my degree for 4000 hours of work experience and 500 hours direct substance use disorder (S.U.D.) counseling experience and 125 hours of S.U.D. counseling one-to-one

___ a master's or doctorate degree from a non-accredited academic based institution. I am asking for approval to count my degree for 4000 hours of work experience and 500 hours direct substance use disorder (S.U.D.) counseling experience and 125 hours of S.U.D. counseling one-to-one

___ a baccalaureate degree from an accredited academic based institution. I am counting my degree for 2000 hours of work experience and 250 hours direct substance use disorder (S.U.D.) counseling experience and 67 hours of S.U.D. counseling one-to-one

___ an associate degree from an accredited academic based institution. I am counting my degree for 1000 hours of work experience and 125 hours direct substance use disorder (S.U.D.) counseling experience and 33 hours of S.U.D. counseling one-to-one

I have enclosed documentation of my degree (an official university transcript indicating completion of the course of study and the award of a degree). Do not send originals

College/University: _____

Location (City, State): _____

Human Services area: _____

Academic Degree awarded: _____

Date Degree awarded: _____

Your full name(s) during the time you attended above institution (if different than name appearing throughout this application): _____

First Name:	Last Name:	MI:

CORE FUNCTION TRAINING

CORE FUNCTION TRAINING REQUIREMENT; 300 HOURS (see certification handbook)

Name of Supervisor/Trainer: _____

Supervisor's Credentials:
- ____ADC II* Certification Number: _____
- ____ADC III* Certification Number: _____
- ____CCS I Certification Number: _____
- ____LADC License Number: _____
- ____CSW**
- ____Licensed Physician**
- ____Licensed Psychologist**
- ____Other/Specify _____

Supervisor's Title: _____

Agency Name: _____ Agency Address: _____

_____ : _____ Zip: _____

Agency Phone # _____

Please indicate number of hours spent in each core function:

(see minimum hours required in each core function area in the certification handbook)

Screening (25)		Case Management (15)	
Intake (10)		Crisis Intervention (15)	
Orientation (10		Client Education (30)	
Assessment (40)		Referrals (10)	
Treatment Planning (20)		Reports and Record Keeping (30)	
Counseling (85)		Consultations (10)	
		Total:	

If you received core function training in more than one agency or from more than one trainer, please duplicate this form using one copy for each agency and/or trainer.

COUNSELOR EVALUATION FORMFOR: _____

(print applicant's name)

*****CONFIDENTIAL*****

Dear Certified Clinical Supervisor or Certified Counselor,

Your employee listed above is applying to the Upper Midwest Indian Council on Addictive Disorders (UMICAD) for certification as a Certified Alcohol and Drug Counselor. The information requested is an essential part of the Board's evaluation of the competence of the applicant and must be on file before the application can be processed.

The UMICAD believes that your observation will have developed a more complete and accurate impression of the knowledge and skills of the applicant than is available from other sources. Your evaluation plus that received from the other references and the data furnished by the applicant will be used in determining eligibility for certification. The process is only as good as you and the others make it be careful and truthful reporting.

Please complete all information and return the evaluation form within one week. Your cooperation is very much appreciated

Supervisor's Name: Title & Credentials: _____ Agency: Agency Address: _____ City/State/Zip Agency phone #	SUPERVISOR, PLEASE NOTE: In the scale listed below, a rating of: 1 is equivalent to Poor 2 is equivalent to Fair 3 is equivalent to Acceptable 4 Is equivalent to Good 5 is equivalent to Excellent On the basis of your knowledge of the above named counselor, rate his/her skill in each area listed below. Circle the appropriate number or check the other box.

Areas of Skill	Poor Excellent	Don't Know	Not Applicable
1. Exhibits skill in active listening (attending, paraphrasing)	1 2 3 4 5		
2. Exhibits skill in probing	1 2 3 4 5		
3. Exhibits skill in summarizing	1 2 3 4 5		
4. Exhibits skill in reflection	1 2 3 4 5		
5. Exhibits skill in interpretation	1 2 3 4 5		
6. Exhibits skill in confrontation	1 2 3 4 5		
7. Exhibits skill in self-disclosure	1 2 3 4 5		
8. Exhibits warmth	1 2 3 4 5		
9. Exhibits respect	1 2 3 4 5		
10. Exhibits empathy	1 2 3 4 5		
11. exhibits concreteness	1 2 3 4 5		

Areas of Skill	Poor				Excellent	Don't Know	Not Applicable
12. Exhibits empathy	1	2	3	4	5		
13. Skill in recognizing and clarifying dysfunctional behavior and its ramifications for the individual client	1	2	3	4	5		
14. Skill in motivation the client to actively participate in treatment.	1	2	3	4	5		
15. Skill in the practical use of three counseling approaches other than self-help groups, which are appropriate for treatment of the individual alcohol/drug abusing/dependent client	1	2	3	4	5		
16. Skill in the practical use of group counseling techniques	1	2	3	4	5		
17. Skill in the appropriate selection of individual, group and/or family counseling approaches according to individualized client needs.	1	2	3	4	5		
18. Skill in assessing and intervening in crisis, including assessment of dangerousness to self or others.	1	2	3	4	5		
19. Skill in developing and implementing individualized treatment plans according to identified client needs.	1	2	3	4	5		
20. Skill in problem-solving techniques, goal setting and decision making in conjunction with clients.	1	2	3	4	5		
21. Skill in termination of counseling.	1	2	3	4	5		
22. Skill in client intake process.	1	2	3	4	5		
23. Skill in initial and on-going client evaluation process.	1	2	3	4	5		
24. Skill in interpretation and assessment of case records.	1	2	3	4	5		
25. Skill in evaluating and periodically updating or modifying the treatment plan and its strategies.	1	2	3	4	5		
26. Skill in identifying the additional resources and services best suited for the individual client.	1	2	3	4	5		
27. Skill in directing the client to additional resources and services	1	2	3	4	5		
28. Skill in maintaining follow-up with the client and with service providers to assure that the client's needs are met	1	2	3	4	5		
29. Skill in the efficient productive handling and coordination of, and involvement with, clients throughout the treatment process, from initial intervention or intake through disposition, termination and follow-up.	1	2	3	4	5		
30. Skill in the maintenance of up-to-date, accurate and understandable case files and records, including history, intake, treatment plan, progress notes, reports and correspondence, referral dispositions and termination or discharge summary.	1	2	3	4	5		
31. Skill in treating client files and records in accordance with the client's best interest and with all federal, state, local and agency regulations, especially those regulations governing confidentiality. This includes disclosures that occur in the discussion of confidential material as part of intra-or-inter-agency stuffing's, consultation, referral or client advocacy.	1	2	3	4	5		
32. Skill in verbal and written communication with professional colleagues and clients.	1	2	3	4	5		

First Name:	Last Name:	MI:

SUPERVISOR'S STATEMENT

I hereby certify that I have been in a position to observe and have first-hand knowledge of _____

work at _____

I have observed the applicant's work from _____ to _____
(mm/dd/yy) (mm/dd/yy)

Describe the procedures you have used to supervise and evaluate the applicant below (attach additional sheets if necessary):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I HEREBY CERTIFY THAT THIS RATING IS, TO THE BEST OF MY KNOWLEDGE, TRUTHFUL AND REFLECTS AS ACCURATELY AS POSSIBLE MY KNOWLEDGE OF THEAPPLICANT.

_____ _____
Signature Date

THE UMICAD CERTIFICATION BOARD, INC. RESERVES THE RIGHT TO REQUEST FURTHER INFORMATION FROM YOU CONCERNING THISAPPLICANT.

PLEASE NOTE DO NOT RETURN TO APPLICANT! PLEASE RETURN DIRECTLY TO UMICAD:

UMICAD
PO BOX 1130
BEMIDJI, MN 56619
PHONE: 218-230-2622
FAX: 218-319-8468

COUNSELOR PROFESSIONAL REFERENCE FORMFOR: _____

(print applicant's name)

The applicant listed above is applying to the Upper Midwest Indian Council on Addictive Disorders (UMICAD) for certification as a Certified alcohol and Drug Counselor. References must be included as part of the application. We ask that you please **complete both sides** of this reference form and forward it to the Certification Board as soon as possible.

the UMICAD believes that certification should be based on input from a variety of sources including the observations of persons who have known the applicant **professionally.** For this reason, all applicants are required to list three persons who will complete this reference form. Your evaluation plus those received from others and the data furnished by the applicant will be used in determining eligibility for certification. The process is only as good as you and the others make it by careful and truthful reporting.

Please complete all information and return the evaluation form within one week. Your cooperation is very much appreciated

(Person completing reference form) please print or type Name:	PLEASE NOTE: In the scale listed below, a rating of: 1 is equivalent to Poor 2 is equivalent to Fair 3 is equivalent to Acceptable 4 Is equivalent to Good 5 is equivalent to Excellent
Title & Credentials: _____ Agency:	
Agency Address: _____	On the basis of your knowledge of the above named counselor, rate his/her skill in each area listed below.
City/State/Zip	Circle the appropriate number or check the other box.
Agency phone #	

Areas of Skill	Poor				Excellent	Don't Know	Not Applicable
1. Common Sense	1	2	3	4	5		
2. Poise	1	2	3	4	5		
3. Enthusiasm	1	2	3	4	5		
4. Reliability	1	2	3	4	5		
5. Personal and Professional Honesty	1	2	3	4	5		
6. Empathy	1	2	3	4	5		
7. Ability to Work with Others	1	2	3	4	5		
8. Ethics	1	2	3	4	5		
9. Knowledge of AODA field	1	2	3	4	5		
10. Effectiveness of Counseling Approach and Techniques	1	2	3	4	5		
11. Appropriateness of Counselor - Counselee Relationships	1	2	3	4	5		
12. Communication Skills	1	2	3	4	5		

GENERAL REMARKS: _____

I HEREBY CERTIFY THAT THIS RATING IS, TO THE BEST OF MY KNOWLEDGE, TRUTHFUL AND REFLECTS AS ACCURATELY AS POSSIBLE MY KNOWLEDGE OF THEAPPLICANT.

I have known the applicant listed on the other side for _____ years. My relationship with applicant was/is

_____

(indicate nature of relationship such as co-worker, colleague, etc.)

_____

Signature

_____

Date Signed

THE UMICAD CERTIFICATION BOARD, INC. RESERVES THE RIGHT TO REQUEST FURTHER INFORMATION FROM YOU CONCERNING THIS APPLICANT.

DO NOT RETURN THIS FORM TO THE APPLICANT! Return this form directly to:

UMICAD
PO BOX 1130
Bemidji, MN 56619
Ph. (218) 230-2622
FAX: (218) 319-8468

COUNSELOR PROFESSIONAL REFERENCE FORMFOR: _____

(print applicant's name)

The applicant listed above is applying to the Upper Midwest Indian Council on Addictive Disorders (UMICAD) for certification as a Certified alcohol and Drug Counselor. References must be included as part of the application. We ask that you please **complete both sides** of this reference form and forward it to the Certification Board as soon as possible.

the UMICAD believes that certification should be based on input from a variety of sources including the observations of persons who have known the applicant **professionally.** For this reason, all applicants are required to list three persons who will complete this reference form. Your evaluation plus those received from others and the data furnished by the applicant will be used in determining eligibility for certification. The process is only as good as you and the others make it by careful and truthful reporting.

Please complete all information and return the evaluation form within one week. Your cooperation is very much appreciated

(Person completing reference form) please print or type Name:	PLEASE NOTE: In the scale listed below, a rating of: 1 is equivalent to Poor 2 is equivalent to Fair 3 is equivalent to Acceptable 4 Is equivalent to Good 5 is equivalent to Excellent
Title & Credentials: _____ Agency:	
Agency Address: _____	On the basis of your knowledge of the above named counselor, rate his/her skill in each area listed below.
City/State/Zip	Circle the appropriate number or check the other box.
Agency phone #	

Areas of Skill	Poor				Excellent	Don't Know	Not Applicable
1. Common Sense	1	2	3	4	5		
2. Poise	1	2	3	4	5		
3. Enthusiasm	1	2	3	4	5		
4. Reliability	1	2	3	4	5		
5. Personal and Professional Honesty	1	2	3	4	5		
6. Empathy	1	2	3	4	5		
7. Ability to Work with Others	1	2	3	4	5		
8. Ethics	1	2	3	4	5		
9. Knowledge of AODA field	1	2	3	4	5		
10. Effectiveness of Counseling Approach and Techniques	1	2	3	4	5		
11. Appropriateness of Counselor - Counselee Relationships	1	2	3	4	5		
12. Communication Skills	1	2	3	4	5		

GENERAL REMARKS: _____

I HEREBY CERTIFY THAT THIS RATING IS, TO THE BEST OF MY KNOWLEDGE, TRUTHFUL AND REFLECTS AS ACCURATELY AS POSSIBLE MY KNOWLEDGE OF THEAPPLICANT.

I have known the applicant listed on the other side for _____ years. My relationship with applicant was/is

_____

(indicate nature of relationship such as co-worker, colleague, etc.)

_____

Signature

_____

Date Signed

THE UMICAD CERTIFICATION BOARD, INC. RESERVES THE RIGHT TO REQUEST FURTHER INFORMATION FROM YOU CONCERNING THIS APPLICANT.

DO NOT RETURN THIS FORM TO THE APPLICANT! Return this form directly to:

UMICAD

PO BOX 1130
Bemidji, MN 56619
Ph. (218) 230-2622
FAX: (218) 319-8468

COUNSELOR PROFESSIONAL REFERENCE FORMFOR: _____

(print applicant's name)

The applicant listed above is applying to the Upper Midwest Indian Council on Addictive Disorders (UMICAD) for certification as a Certified alcohol and Drug Counselor. References must be included as part of the application. We ask that you please **complete both sides** of this reference form and forward it to the Certification Board as soon as possible.

the UMICAD believes that certification should be based on input from a variety of sources including the observations of persons who have known the applicant **professionally.** For this reason, all applicants are required to list three persons who will complete this reference form. Your evaluation plus those received from others and the data furnished by the applicant will be used in determining eligibility for certification. The process is only as good as you and the others make it by careful and truthful reporting.

Please complete all information and return the evaluation form within one week. Your cooperation is very much appreciated

(Person completing reference form) please print or type Name:	PLEASE NOTE: In the scale listed below, a rating of: 1 is equivalent to Poor 2 is equivalent to Fair 3 is equivalent to Acceptable 4 Is equivalent to Good 5 is equivalent to Excellent
Title & Credentials: _____ Agency:	
Agency Address: _____	On the basis of your knowledge of the above named counselor, rate his/her skill in each area listed below.
City/State/Zip	Circle the appropriate number or check the other box.
Agency phone #	

Areas of Skill	Poor				Excellent	Don't Know	Not Applicable
1. Common Sense	1	2	3	4	5		
2. Poise	1	2	3	4	5		
3. Enthusiasm	1	2	3	4	5		
4. Reliability	1	2	3	4	5		
5. Personal and Professional Honesty	1	2	3	4	5		
6. Empathy	1	2	3	4	5		
7. Ability to Work with Others	1	2	3	4	5		
8. Ethics	1	2	3	4	5		
9. Knowledge of AODA field	1	2	3	4	5		
10. Effectiveness of Counseling Approach and Techniques	1	2	3	4	5		
11. Appropriateness of Counselor - Counselee Relationships	1	2	3	4	5		
12. Communication Skills	1	2	3	4	5		

GENERAL REMARKS: _____

I HEREBY CERTIFY THAT THIS RATING IS, TO THE BEST OF MY KNOWLEDGE, TRUTHFUL AND REFLECTS AS ACCURATELY AS POSSIBLE MY KNOWLEDGE OF THEAPPLICANT.

I have known the applicant listed on the other side for _____ years. My relationship with applicant was/is

_____

(indicate nature of relationship such as co-worker, colleague, etc.)

_____

Signature

_____

Date Signed

THE UMICAD CERTIFICATION BOARD, INC. RESERVES THE RIGHT TO REQUEST FURTHER INFORMATION FROM YOU CONCERNING THIS APPLICANT.

DO NOT RETURN THIS FORM TO THE APPLICANT! Return this form directly to:

UMICAD
PO BOX 1130
Bemidji, MN 56619
Ph. (218) 230-2622
FAX: (218) 319-8468

First Name:	Last Name:	MI:

Continuing Education Form

List each training course, seminar, workshop, etc., date(s), contact hours, substance abuse specific or related using this format.

DO NOT ATTACH DOCUMENTATION (make copies of this form if additional space is required.)

Title of Training — Contact Hours — Specific/Related

Endorsed by — Date(s) of training

Title of Training — Contact Hours — Specific/Related

Endorsed by — Date(s) of training

Title of Training — Contact Hours — Specific/Related

Endorsed by — Date(s) of training

Title of Training — Contact Hours — Specific/Related

Endorsed by — Date(s) of training

Title of Training — Contact Hours — Specific/Related

Endorsed by — Date(s) of training

Title of Training — Contact Hours — Specific/Related

Endorsed by — Date(s) of training

Title of Training — Contact Hours — Specific/Related

Endorsed by — Date(s) of training

Title of Training — Contact Hours — Specific/Related

Endorsed by — Date(s) of training

Title of Training — Contact Hours — Specific/Related

Endorsed by — Date(s) of training

First Name:	Last Name:	MI:

Continuing Education Form

List each training course, seminar, workshop, etc., date(s), contact hours, substance abuse specific or related using this format.

DO NOT ATTACH DOCUMENTATION (make copies of this form if additional space is required.)

Title of Training | Contact Hours | Specific/Related

Endorsed by | Date(s) of training

Title of Training | Contact Hours | Specific/Related

Endorsed by | Date(s) of training

Title of Training | Contact Hours | Specific/Related

Endorsed by | Date(s) of training

Title of Training | Contact Hours | Specific/Related

Endorsed by | Date(s) of training

Title of Training | Contact Hours | Specific/Related

Endorsed by | Date(s) of training

Title of Training | Contact Hours | Specific/Related

Endorsed by | Date(s) of training

Title of Training | Contact Hours | Specific/Related

Endorsed by | Date(s) of training

Title of Training | Contact Hours | Specific/Related

Endorsed by | Date(s) of training

Title of Training | Contact Hours | Specific/Related

Endorsed by | Date(s) of training

This application was updated on 12/29/2021 by Ashley McKenzie