Criteria for Certified Reciprocal Alcohol & Drug Counselor (CRADC)

I. Criteria for those with an applicable Masters Degree
   ➢ Applicable Masters Degree
   ➢ 2000 hours of applicable work experience within the last 10 years
   ➢ 300 hours of a Supervised Practicum in the Performance Domains
   ➢ Signed Competency Rating Form from MCB qualified supervisor
   ➢ 300 Contact Hours of Education to include the following:
     • 6 live ethics hours (not from online or home study)
     • 20 of the 300 hours obtained within the prior 12 months of applying
   ➢ Pass IC&RC International ADC Examination if not upgrading from CADC

II. Criteria for those with an applicable Bachelors Degree
   ➢ Applicable Bachelors Degree
   ➢ 4000 hours of applicable work experience within the last 10 years
   ➢ 300 hours of a Supervised Practicum in the Performance Domains
   ➢ Signed Competency Rating Form from MCB qualified supervisor
   ➢ 300 Contact Hours of Education to include the following:
     • 6 live ethics hours (not from online or home study)
     • 20 of the 300 hours obtained within the prior 12 months of applying
   ➢ Pass IC&RC International ADC Examination if not upgrading from CADC

III. Criteria for those with an applicable Associates Degree
    ➢ Applicable Associates Degree
    ➢ 5000 hours of applicable work experience within the last 10 years
    ➢ 300 hours of a Supervised Practicum in the Performance Domains
    ➢ Signed Competency Rating Form from MCB qualified supervisor
    ➢ 300 Contact Hours of Education to include the following:
      • 6 live ethics hours (not from online or home study)
      • 20 of the 300 hours obtained within the prior 12 months of applying
    ➢ Pass IC&RC International ADC Examination if not upgrading from CADC

Criteria continued on next page
IV. Criteria for those with a High School Diploma/HSE

- High School Diploma/HSE
- 6000 hours of applicable work experience within the last 10 years
- 300 hours of a Supervised Practicum in the Performance Domains
- Signed Competency Rating Form from MCB qualified supervisor
- 300 Contact Hours of Education to include the following:
  - 6 live ethics hours (not from online or home study)
  - 20 of the 300 hours obtained within the prior 12 months of applying
- Pass IC&RC International ADC Examination if not upgrading from CADC

APPLICABLE DEGREES

(A degree must be from a college or university found in the US Dept. of Education’s database of accredited schools. The database can be found at [http://ope.ed.gov/accreditation](http://ope.ed.gov/accreditation).)

1. Psychology
2. Social Work
3. Criminal Justice
4. Family Studies
5. Sociology
6. Chemical Dependency
7. Counseling
8. Nursing
9. Human Services
10. Art Therapy
11. Applied Behavioral Science
12. Education

*If your Related Field Degree (Major) is in one of the above areas but has a different transcript title, please contact the MCB office at 573-616-2300 to verify it will be accepted as an applicable degree.*
DEFINITIONS

A. CONTACT HOURS of EDUCATION/TRAINING is defined as workshops, seminars, institutes, accredited college/university courses, MCB approved home study or on-line courses and in-services. One (1) contact hour of education is equal to sixty (60) minutes of continuous instruction. 15 contact hours are given for each college credit. Therefore, a college course of three (3) credits is equal to 45 contact hours.

In order to be considered a valid training experience for the purpose of credentialing, education/trainings must be related to the knowledge and skill base associated with the performance domains of a substance use disorders counselor.

All education taking place outside the applicant's place of employment must be documented through proof of attendance including transcripts from an accredited college, letters and/or certificates of completion. Supporting documentation in the form of brochures, flyers, syllabus, course description, etc. may also be required to review content for acceptability.

All education taking place within the applicant's place of employment must be documented by title, date and length of presentation, as well as the name and title of presenter. The training must be verified by the employee's supervisor who attests the training took place and the employee was a participant in the entire training.

B. APPLICABLE WORK EXPERIENCE is defined as supervised work experience in a position with job duties that assist clients in the recovery process by performing the substance use disorder counselor performance domains. Experience as a volunteer, intern and/or payment of a stipend qualifies as work experience if the same work is performed that a paid employee would perform.

All qualifying work experience must have been accrued during the ten (10) years immediately prior to application being made.

Work experience must be verified by an employment verification form from the agency(s) in which the applicant has been employed.

C. SUPERVISED PRACTICUM IN THE PERFORMANCE DOMAINS is defined as performance of the performance domains while under supervision.

Supervision must be provided by someone who holds a CRADC, CRAADC, CCJP, CCDP, CCDP-D, RADC, RADC-P, LPC, LCSW, or Licensed Psychologist and who has attended the MCB Clinical Supervision Training.

The supervision of the performance domains may take place within an academic setting and/or within a supervised work setting. The goal is to receive supervised experience in all of the domains. Applicants must complete a minimum of 10 hours performing each of the domains with a total supervised practicum of 300 hours.

D. PERFORMANCE DOMAINS DEFINITIONS: Refer to the ADC Candidate Guide on the MCB web site at www.missouricb.com under the Candidate Guide link.
CHECK LIST FOR CRADC APPLICATION

1. You have submitted the $400.00 with this application if you are a new applicant, $325.00 if you are upgrading from a MAADC I/II, or $125.00 if you are upgrading from a CADC.

2. You have paid by check or money order, or have provided your credit/debit card information on page 8 of this application packet. **Applications will not be reviewed until payment is received.**

3. You have completely filled out the application.

4. You have signed the Code of Ethical Practice and Professional Conduct.

5. You have filled out the Family Care Safety Registry Worker Registration Form and included the form with your packet. If your agency has conducted a FCSR background check on you within the last 30 days, you may submit the results to help expedite the application process.

6. You have submitted proof of 300 total hours of education/training with 20 of those hours being obtained within the 12 months prior to application.

7. The appropriate person has completed and signed the Counselor Employment Verification Form(s) and mailed directly to the MCB.

8. If necessary, the Supervised Practicum Form was filled out by a MCB qualified supervisor and mailed to the MCB.

9. The Competency Rating Form was filled out by a MCB qualified supervisor and mailed to the MCB.

10. The appropriate High School/HSE or College transcripts were sent.

11. Typically, applications are reviewed within two weeks of receipt in the MCB office. If you have not received written correspondence from the MCB 3 weeks **after** mailing your application to the MCB, call the MCB.

12. If you took and passed the examination and you have not received correspondence from the MCB, check the Professional Search on the MCB web site homepage at www.missouricb.com. Type in your last name. If your application is complete, your credential information will be displayed and your certificates will be mailed soon.
Application Instructions:

1. Requirements to receive this credential are subject to change without notice. Please make sure you are submitting the most recent application packet. If you are unsure, contact the MCB office.
2. The application must be typed or neatly printed.
3. Please keep a copy of all materials submitted for your records.
4. FEES: The total CRADC Fee for a new applicant is $400.00. The total CRADC Fee for someone upgrading from a MAADC I/II is $325.00. The total CRADC Fee for someone upgrading from a CADC is $125.00. You may pay by check, money order, or by providing credit card information on page 8 of this application packet. Applications will not be reviewed until payment is received.
5. Please be advised that should your application be reviewed and additional information is requested, you will have 90 days to provide the requested information. Failure to do so will result in your application expiring without being approved.
6. All fees are non refundable. If your application is denied or expires, fees will not be refunded.
7. If your application is denied, you may contact the MCB office staff for instructions on how to appeal the denial of your application.
8. All materials submitted to the MCB office become property of the MCB.
9. The applicant must currently reside and/or be employed in the State of Missouri at least 51% of the time. The only exception to this is applicants living and working in a state that is not a member of the International Certification and Reciprocity Consortium.
10. Please remember that it is your responsibility to keep the MCB office informed of any personal informational changes such as address and phone number changes. If you fail to notify us of changes, you will be responsible for any material that is mailed to the wrong address and will have to pay a fee to have the material sent again.
11. Please mail your application to the MCB. Please do not fax your application.

Special Instructions For Those Applicants Upgrading

1. Your application is a continuation from your previous application(s). Therefore, you do not need to submit duplicate information from previous applications such as transcripts, training certificates sent with previous applications, etc. However, you must completely fill out the application packet.
Useful Information:

1. If at any time during the application process, a question arises about an applicant’s moral character, reputation for honesty, integrity, or professionalism, the Board may either deny the application at that time or place the application on hold until an investigation has been done and a decision made regarding the question brought up.

2. Once your application has been accepted and has final approval, you will receive an e-mail and/or letter from our office with further instructions on how to continue the application/testing process. With this letter, you will also receive information on obtaining a free Candidate Guide. This guide provides you sample questions for the exam. In addition, additional study materials can be purchased. The companies that sell study guides are listed on our web site www.missouricb.com under the “Study Guide Information” link. The exam you are taking is called the ADC Exam.

3. The CRADC credential is a reciprocal credential with other IC&RC member boards that offer this credential. You can contact the MCB office for more information on reciprocity.
Important Notice To Applicants

According to Missouri Credentialing Board (MCB) Policies and Procedures, the following rules apply to those seeking a MCB credential.

1. No individual currently under any type of court supervision can apply for a MCB credential. Please wait until you are completely free from court supervision before applying.

2. The following items disqualify an individual from ever being credentialed with the MCB:
   A. Is listed on the Department of Mental Health disqualification registry
   B. Is listed on the employee disqualification list of the Dept. Health and Senior Services or Dept. of Social Services
   C. Any crime against a minor
   D. A person who has been convicted of, found guilty to, plead guilty to or nolo contendere to any of the Disqualifying Crime(s) Pursuant to Section 630.170, RSMo. The crime(s) will only disqualify an applicant if the crime(s) were a felony. Please view information about Section 630.170, RSMo on the MCB web site www.missouricb.com under the Disqualifying Crimes Link.

3. If an individual has applied for and been given an exception from the Department of Mental Health, the individual may apply for a MCB credential. Please send in proof of exception with your application.
APPLICATION

FOR

Certified Reciprocal Alcohol & Drug Counselor (CRADC)

Appropriate fee must be submitted with application.

MISSOURI CREDENTIALING BOARD
428 E. Capitol, 2nd Floor
JEFFERSON CITY, MISSOURI 65101

TELEPHONE: (573) 616-2300
WEB SITE: www.missouricb.com
EMAIL: help@missouricb.com

Please Mark Credit Card Type:
1. Visa
2. MC
3. Discover

CC Expiration Date: _____/_____

Credit Card #: ___________-__________-__________-__________

Credit Card 3 Digit Verification Code: ____________________________
THIS APPLICATION MUST BE TYPED OR PRINTED NEATLY
All Applications Become the Property of MCB

Please check if you are: _____ New Applicant _____ Upgrade Applicant

Applicant’s Name: __________________________________________________________________________

First     Middle     Last     Name Suffix (Jr., II)

Maiden     Other Names Used

Current Home Address: _______________________________________________________________________

Street/PO Box     Apt. #

City     State     Zip     County

Home Telephone: _____/_________________     SSN: __________-______-__________

Work Telephone: _____/_______________, Ext. _______     Cell Number: _____/_______________

E-mail Address: __________________________________________________________________________

SEX: _____M     _____F     BIRTH DATE:_____/_____/__________

Are you currently or have you been credentialed or licensed as a Substance Use Disorder Professional by the MCB or any other state or organization? _____Yes  _____No

If yes, which state/organization and when? ______________________________________________________

What is the type of credential/license held with the other state/organization?

________________________________________________________________________________________

Have you ever been ARRESTED and/or CONVICTED of a felony? _____Yes  _____No

If yes, please go to the www.missouricb.com website, print off the “Felony Offense Form”, fill out the form and submit with your application. If you were convicted of a felony listed in Section 630.170 RSMo (view www.missouricb.com; Disqualifying Crimes link), you may not apply for this credential without an exception from the Department of Mental Health.

Have you ever knowingly been contacted by a Division of Family Services employee regarding a CHILD ABUSE and/or CHILD NEGLECT incident involving you? _____Yes  _____No

If yes, please go to the www.missouricb.com website, print off the “Child Abuse/Neglect Statement”, fill out the form and submit with your application. In addition, please contact the Division of Family Services at 573-751-2330 and request a report of the incident to include with this application.

Revised December 2016 CRADC (ADC) Application
**Education/Degree Information**

Please mark your highest level of education completed:

1. High School Diploma/HSE: _____
3. Associate Degree: _____  Degree Program: ________________________
4. Bachelor Degree: _____  Degree Program: ________________________
5. Master Degree/Higher: _____  Degree Program: ________________________

An applicant may document High School Diploma or HSE or College/University degree by:

1. Submitting copy of High School Diploma/HSE
2. Submitting official College/University transcripts directly to MCB
3. Submitting copy of College/University transcripts to MCB and having a MCB Qualified Supervisor sign/date the following:

   *(I attest that the applicant’s degree listed above has been verified & the applicant has submitted unofficial transcripts with the application)*

   **MCB Qualified Supervisor: ________________________________**
   **MCB Supervision Number: ________________________________**

**Where Does the Applicant Currently Work?**

<table>
<thead>
<tr>
<th>Name of Employer</th>
<th>Mailing Address of Employer</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

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<tr>
<th>Name &amp; Title of Immediate Supervisor:</th>
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</table>

<table>
<thead>
<tr>
<th>Your Business Phone: Area Code/Telephone Number</th>
<th>Extension</th>
<th>Fax #</th>
<th>Area Code/Telephone Number</th>
</tr>
</thead>
</table>

**TRAININGS/EDUCATIONAL HOURS**

The number of educational hours needed for the CRADC is as follows:

1. 300 Hours Total
   - 6 contact hours of live ethics training (not online or home study)
   - 20 of the 300 hours obtained within the prior 12 months of applying

All training hours must be documented by transcripts, certificates, in-service logs or other means of qualifying documentation.

Revised December 2016 CRADC (ADC) Application
Applicant’s Agreement to the Code of Ethical Practice and Professional Conduct

I have read the Current Treatment Code of Ethical Practice and Professional Conduct as listed on the MCB web site www.missouricb.com, MCB Ethics Code Link and agree to abide by this code:

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Signature</td>
<td>Date</td>
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</table>

**AUTHORIZATION AND RELEASE**

I hereby certify all of the information given herein is true and complete to the best of my knowledge and belief. I also authorize any relevant investigations, or the release of personal information to the Missouri Credentialing Board, its agents, or contractors pursuant to this application/renewal procedure. I understand falsification of any portion of this application/renewal will result in my being denied credentialing, or revocation of same upon discovery.

I further agree to hold the Missouri Credentialing Board and its Board Members, officers, agents, staff, peer evaluators and examiners, free from any civil liability for damages or complaints by reason of any action that is within the scope and arise out of the performance of their duties which they, or any of them, may take in connection with this application/renewal, any examination, the grades with respect to any examination, and/or the failure of the MCB to issue me said credential or renewal.

This Authorization and Release shall also apply to personal information requested by the Board at any time following credentialing in connection with any investigation concerning allegations that could lead to disciplinary action against me.

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Date</th>
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<tbody>
<tr>
<td>Signature</td>
<td>Date</td>
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</table>
MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
FAMILY CARE SAFETY REGISTRY  
WORKER REGISTRATION

PLEASE TYPE OR PRINT CLEARLY

SECTION A: WORKER TYPE (CHECK ONE BOX ONLY)

- CHILD CARE WORKER ($9.00)  PERSONAL CARE WORKER ($9.00)  XX VOLUNTARY REGISTRANT
- ELDER CARE WORKER ($9.00)  RECIPIENT OF STATE OR FEDERAL FUNDS ($0.00)  FOSTER PARENT (NO FEE)

SECTION B: IDENTIFYING DATA FOR BACKGROUND SCREENING

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MIDDLE NAME</th>
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MAIDEN AND PRIOR NAMES USED

SOCIAL SECURITY NUMBER (ATTACH COPY OF SOCIAL SECURITY CARD)

<table>
<thead>
<tr>
<th>DATE OF BIRTH</th>
<th>GENDER</th>
<th>TELEPHONE NO.</th>
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MAILING ADDRESS

<table>
<thead>
<tr>
<th>STREET ADDRESS OR POST OFFICE BOX</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
<th>COUNTY</th>
</tr>
</thead>
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HOME ADDRESS (if different than mailing address)

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<thead>
<tr>
<th>STREET ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
<th>COUNTY</th>
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SECTION C: CURRENT EMPLOYER INFORMATION (IF APPLICABLE)

<table>
<thead>
<tr>
<th>EMPLOYER NAME</th>
<th>CONTACT PERSON</th>
<th>PHONE NUMBER</th>
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<th>ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
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</table>

SECTION D: AUTHORIZATION TO RELEASE BACKGROUND SCREENING INFORMATION

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorized the Missouri Department of Health and Senior Services to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) for employment purposes only, as provided in 210.921, subsection 1 subdivision (1) and (2), RSMo. For purposes of the FCSR, “employment purposes” includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy in the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening determination.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to your designated bank account. I understand that my signature below authorized my Financial Institution to deduct this payment from my account. In the event that DHSS or its subcontractor, is unable to secure funds from your account or you provide insufficient or inaccurate information regarding your account, your obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT (REQUIRED IN INK)  

DATE / /  

IMPORTANT: Individuals are required to register one time only.  

Submit this form with your application and a copy of your SS card. If your agency has run a FCSR check within the last 30 days, you can submit the results with this form which may speed up the application process. By doing so, you give permission for your agency to share their FCSR results.

Revised December 2016 CRADC (ADC) Application
COUNSELER EMPLOYMENT VERIFICATION FORM
An applicant is applying to the MCB for a Certified Reciprocal Alcohol Drug Counselor (CRADC) credential. Please **mail** this completed form within one week of receipt directly to the Board at the address listed below. Please give a copy of this form to the applicant for their records and future reference.

Employee's Name: ________________________________________________________________

Supervisor’s Name (Print): _________________________________________________________

Agency: _________________________________________________________________________

Address: _________________________________________________________________________

____________________________________________________________________________________

Telephone: _________________________________________________________________________

Today’s Date: _______________________________________________________________________

Within the last 10 years from the date listed above, please list the **composite total** number of hours the applicant spent working with substance use disorder clients in the following domains: **(Please list all hours worked as this form replaces any previous employment forms submitted with prior applications)**

Screening, Assessment & Engagement: _________

Counseling: _________

Treatment Planning, Collaboration & Referral: _________

Professional & Ethical Responsibilities: _________

Supervisor’s Name (Printed): _______________________________________________________

Supervisor’s Signature: _______________________________________________________________________

Date: _____________________________________________________________________________

Please return this form directly to MCB, 428 E. Capitol, 2nd Floor, Jefferson City, MO 65101. Provide a copy of this form to the applicant.
SUPERVISED PRACTICUM OF THE PERFORMANCE DOMAINS FORM

INSTRUCTIONS: On this form document the number of supervised hours performed in each domain. **The applicant must have completed a total of 300 hours. The applicant must perform a minimum of 10 hours in each domain.** The remaining number of hours needed for credentialing can be in any of the domains.

**Supervised hours must be provided by a MCB qualified supervisor only.**
(MCB qualified supervisor includes an individual who holds a CRADC, CRAADC, CCJP, CDP, CCDP-D, RADC, RADC-P, LPC, LCSW, or Licensed Psychologist and who has completed the MCB Clinical Supervision Training. This cannot be an immediate family member)

Applicant's Name (Print): ______________________________________________________________

MCB Qualified Supervisor (Print): __________________________________________________________

Agency: ______________________________________ Clinical Supervision Number: ______________

Total # Supervised Work Hours (Must be a minimum of 300 hours): __________________________

Please indicate on the domain lines below how many of the Total # Supervised Work Hours listed above were in each domain. The total listed on the line above should equal the sum total of the 4 domains (Must be a minimum of 10 hours listed for each domain):

Screening, Assessment & Engagement: _______ Hours

Counseling: _______ Hours

Treatment Planning, Collaboration & Referral: _______ Hours

Professional & Ethical Responsibility: _______ Hours

MCB Qualified Supervisor’s Signature: ____________________________ Today’s Date: __________

Please return this form directly to MCB, 428 E. Capitol, 2nd Floor, Jefferson City, MO 65101. Provide a copy of this form to the applicant.
COMPETENCY RATING FORM

1=Understands; 2=Developing; 3=Competent; 4=Skilled; 5=Master

INSTRUCTIONS FOR SUPERVISOR: On this form, a MCB qualified supervisor should rate the competency of the applicant in the 10 listed areas using the rating scale 1-5 given above. For help in determining a rating for a particular area use the competency rating forms found in your clinical supervision manual and/or the TAP 21.

(MCB qualified supervisor includes an individual who holds a CRADC, CRAADC, CCJP, CCDP, CCDP-D, RADC, RADC-P, LPC, LCSW, or Licensed Psychologist and who has completed the MCB Clinical Supervision Training. This cannot be an immediate family member)

Practice Dimension       Rating

Clinical Evaluation – Screening  _____
Clinical Evaluation – Assessment  _____
Treatment Planning  _____
Referral  _____
Individual Counseling  _____
Group Counseling  _____
Family Counseling  _____
Client, Family, and Community Education  _____
Documentation  _____
Professional/Ethical Responsibilities  _____

Total Rating Score  _____

(Please add the scores together for each of the above practice dimensions to get a total rating score)

Applicant's Name: ____________________________________________________________

Name of Supervisor (Print): __________________________________________________
Title:_______________________________________________________________________

Agency:__________________________________________________________Clinical Supervision Certificate#:________________________
Address:_____________________________________________________________________

Supervisor's Signature:_________________________________________Today's Date:____________________________

Please return this form directly to MCB, 428 E. Capitol, 2nd Floor, Jefferson City, MO 65101. Provide a copy of this form to the applicant.
DOCUMENTATION OF DISABILITY-RELATED NEEDS

Please have this section completed by an appropriate professional (physician, psychologist, psychiatrist) to ensure that your board is able to provide the required exam accommodations. Submitted documentation must follow ADA guidelines in that psychological or psychiatric evaluations must have been conducted within the last three years. All medical/physical conditions require documentation of the treating physician’s examination conducted within the previous three months.

Professional Documentation:

I have known ___________________________________________ since _____/_____/_____ in my capacity as a ______________________________________________.

Exam Candidate Date

Professional Title

The candidate discussed with me the nature of the exam to be administered. It is my professional opinion that, because of this candidate’s disability described below, he/she should be accommodated by providing the special arrangements listed below:

Description of Disability:

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Signed: ______________________________________________________ Title: ___________________________

Printed Name: _________________________________________________________________________________

Address: ______________________________________________________________________________________

City/State/Zip: ____________________________________________________

Telephone Number: _____________________________ Email: __________________________________________

License Number: _______________________________ Date: ___________________________________________
(if applicable)
REQUEST FOR SPECIAL ACCOMMODATIONS

If you have a disability that requires special testing accommodations, please complete this form and the Documentation of Disability-Related Needs and return it to your IC&RC member board for processing. The information you provide and any documentation regarding your disability and your need for accommodations in testing will be treated with strict confidentiality. Submitted documentation must follow ADA guidelines in that psychological or psychiatric evaluations must have been conducted within the last **three years**. All medical/physical conditions require documentation of the treating physician’s examination conducted within the previous **three months**.

Preferred Exam Date: ________________  Preferred Exam Location: __________________________

Name: ____________________________________________

Home Address: __________________________________________

City/State/Zip: __________________________________________

Daytime Telephone Number: __________________________

Email: __________________________________________

**Special Accommodations:**

I request special accommodations for the following IC&RC ADC examination

Please provide (check all that apply):

- [ ] Special seating or other physical accommodations
- [ ] Reader
- [ ] Large print exam
- [ ] Extended testing time (time and a half)
- [ ] Distraction-free room
- [ ] Other special accommodations (please specify)

Comments:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Print Name: __________________________

Signature: __________________________

Date: __________________________