STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
ALCOHOL AND DRUG COUNSELOR LICENSURE/CERTIFICATION
VERIFICATION OF EDUCATION

TO BE COMPLETED BY APPLICANT

Applicant: Please complete the top portion of this form and forward to the appropriate authority for official verification of completion of education in alcohol and drug counseling.

Name of Applicant: _____ **Year of Completion:** _____

Identification information (i.e. social security number) if required by verifying entity _____

INFORMATION BELOW TO BE COMPLETED BY VERIFYING AUTHORITY ONLY

Section 1. The applicant listed above is applying for licensure/certification as an alcohol and drug counselor in Connecticut. Please provide the following information regarding the course of study that such individual completed at your institution.

Title of training _____ Did this training pertain to alcohol and drug abuse? ☐ Yes ☐ No.

Where was such instruction completed? _____

Dates of attendance: from _____/_____/_____ to _____/_____/_____

Section 2. To qualify for licensure or certification this individual must have completed 360 hours of education, at least 240 of which pertained to alcohol and drug abuse, while the remaining hours must have been in the field of human behavior. Did this individual satisfy these hourly requirements? ☐ Yes ☐ No. If no, number of hours completed _____

Did this individual complete at least 90 hours in *counseling theories and techniques*? ☐ Yes ☐ No. If no, number of hours completed: _____

Did this individual complete the following areas and minimum hours related to alcohol and drug abuse:

	YES	NO	If No, number of hours completed
Pharmacology – 18 hours	☐	☐	_____
assessment and treatment planning – 30 hours	☐	☐	_____
cross-cultural, special population and ethnically diverse groups 12 hours	☐	☐	_____
ethics – 12 hours	☐	☐	_____
HIV – AIDS – 6 hours	☐	☐	_____

If any of the above areas were not satisfied, please elaborate:

_____

_____

_____

Note: In responding to this section, no more than 40 hours of inservice training may be credited toward satisfying the educational requirements.

Please indicate whether the following core counseling functions were represented in this applicant's education:

☐ *Screening* ☐ *intake* ☐ *orientation* ☐ *assessment*
☐ *counseling* ☐ *referral* ☐ *case management* ☐ *consultation*
☐ *treatment planning* ☐ *crisis intervention* ☐ *client education* ☐ *report and record keeping*

_____ _____
Name and Title of Person Completing Form *Institution*

_____ _____
Signature of Authorized Representative *Date*

Day Time Telephone Number _____

Thank you for your assistance. Please return this form directly to:

Department of Public Health
ADC Licensure/Certification
410 Capitol Ave., MS **#12APP**
P.O. Box 340308
Hartford, CT 06134-0308