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Return To:
PO Box 975
Bismarck,ND 58502

North Dakota Board of Addiction Counseling Examiners
INDIVIDUALIZED CLINICAL TRAINING PLAN REQUEST FORM

PRIOR TO STARTING CLINICAL TRAINING, THIS FORM MUST BE COMPLETED AND RETURNED TO THE BOARD OFFICE ALONG WITH AN OFFICIAL COPY OF THE TRAINEE'S TRANSCRIPT(S) SHOWING COMPLETION OF THE REQUIRED ACADEMIC COURSE WORK. TWO ACADEMIC COURSES MAY BE COMPLETED WHILE REGISTERED AS A CLINICAL TRAINEE.

Name _____
Last First MI (Maiden)

SSN _____ Email _____

Hm. Phone Number _____ Wk Phone _____

Home Address _____

City State Zip

Work Address _____

City State Zip

The above named trainee:

Has been accepted into the _____
Name of Clinical Training Program

and requests approval to participate in an individualized training plan involving the following facilities:

Facility _____ Clinical Supervisor _____

Type of training _____

Start and End date of training _____

(Continue on next page.)

Facility _____ Clinical Supervisor _____

Type of training _____

Start and End date of training _____

Facility _____ Clinical Supervisor _____

Type of training _____

Start and End date of training _____

Facility _____ Clinical Supervisor _____

Type of training _____

Start and End date of training _____

ALL CORE ACADEMIC COURSEWORK MUST BE COMPLETED, WITH THE EXCEPTION THAT TWO COURSES MAY BE COMPLETED WHILE REGISTERED AS A CLINICAL TRAINEE:

Academic Institution	Degree	Date Completed
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***AN OFFICIAL COPY OF THE TRAINEE'S TRANSCRIPT VERIFYING COMPLETION OF THE REQUIRED ACADEMIC COURSEWORK MUST BE SUBMITTED WITH THIS FORM.**

Signature of Clinical Training Program Director

Date

Print name of Clinical Training Program Director or Clinical Supervisor

Address

Phone

E-mail