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Return to:
NDBACE
PO Box 975
Bismarck, ND 58502

North Dakota Board of Addiction Counseling Examiners
TRAINEE COMPLETION FORM

Upon completion of a training program, this form is to be completed by the Clinical Training Program Director and returned to the Board office.

Trainee's Full Name _____

Name of Clinical Training Program _____

Completion date of training _____

***YOU MUST INCLUDE A COPY OF THE TRAINEE'S FINAL MONTHLY PERFORMANCE REVIEW AND VERIFICATION OF COMPLETION OF AN ORAL EXAMINATION WITH THIS FORM.**

I verify the above-named trainee has completed 1400 hours of clinical training which included 50 hours of supervision with a minimum of 30 hours of direct supervision in the required clinical areas (Screening, assessment, and treatment planning; counseling services; service coordination, case management, and referral services; documentation; multicultural counseling, education, and professional ethics):

Signature of Clinical Training Program Director or
Clinical Supervisor

Date

Print name of Clinical Training Program Director or Clinical Supervisor

Address

Phone

E-mail