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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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Clinical Training Program Director

\_\_\_\_\_  
Address

\_\_\_\_\_

\_\_\_\_\_  
Phone

\_\_\_\_\_  
E-mail