Notice: All NDBACE
files are subject
to the North Dakota
Open Records Law

Return To:
PO Box 975
Bismarck,ND 58502

North Dakota Board of Addiction Counseling Examiners

CLINICAL TRAINEE REGISTRATION 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

Start date of training ______________________________________

Continued on next page.

PLAN FOR COMPLETION OF 1400 HOURS OF CLINICAL TRAINING:

Addiction Training Site	Beginning Date (month/year)	Anticipated Ending Date (month/year)

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

***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

____

Address

____

____

Phone   E-mail

Rev. 03/09