NDBACE
NORTH DAKOTA BOARD OF ADDICTION COUNSELING EXAMINERS

NOTICE:
All NDBACE files are subject to the North Dakota Open Records Law
RETURN FORM TO:
North Dakota Board of Addiction Counseling Examiners
1601 N 12th St Suite 609
Bismarck, ND 58501

Clinical Trainee Registration Form

Prior to starting clinical training, you must complete this form and return it to the board office, along with a copy of the trainee's transcript(s) showing completion of the required academic coursework. Trainees may complete two academic courses while they are registered as clinical trainees. Please attach a completed LAC or LMAC Transcript Review From to this application.

This form may be completed by the consortium training director, university program/internship director, or agency program director.

Trainee Information

Last Name:_____ First Name:_____

Middle Name:_____ Maiden Name: _____

Home Address: _____

Work Address: _____

Home Phone:_____ Work Phone: _____

Email Address: _____

The above named trainee has been accepted into the_____program.

Anticipated start and end dates for training _____

Name/s and license/s of clinical supervisor/s:

_____

_____

_____

Note: LACs who are registered clinical supervisors are able to provide supervision until Dec. 31, 2023.

PLAN FOR COMPLETING CLINICAL TRAINING:

Number of hours required:

- 350hrs (if ND licensed LP, MD, LMFT, LPCC, LICSW, or advanced clinical practice nurse)
- 700hrs
- 960hrs

Where will the training take place?

- NDBACE approved consortium
- ND agency (through an individualized NDBACE approved training plan)

Note: Bachelor's level (LAC) applicants may only complete their training through a NDBACE approved consortium. Master's level (LMAC) applicants may complete their training through any of the above options.

Training Site Start Date (mo/yr) Anticipated End Date (mo/yr)

_____

_____

Note: Bachelor's level (LAC) applicants must complete their training at 2 or more sites. Master's level (LMAC) applicants may complete their training at 1 or more sites.

_____ _____

Clinical Training Program Director Signature Date

Email Address: _____