

Certificate of Proficiency

in the
Treatment of Alcohol and
Other Psychoactive
Substance Use Disorders



The College of Professional Psychology

The College of Professional Psychology awards proficiency certification on behalf of the American Psychological Association Practice Organization, the world's largest scientific and professional organization representing psychologists.

The ***Certificate of Proficiency*** in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders is offered to licensed psychologists who meet eligibility requirements, regardless of APA membership status. It is a uniform national credential offered exclusively to psychologists who treat alcohol and other psychoactive substance use disorders.

The ***Certificate of Proficiency*** in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders provides an effective mechanism for informing consumers, referral sources, and third-party payors that you possess the knowledge and experience associated with competent practice in the treatment of alcohol and other psychoactive substance use disorders.

Requirements for Certification

The requirements for the *Certificate of Proficiency* in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders include:

- ◆ current state or provincial license in good standing to engage in the independent practice of psychology;
- ◆ provision of health services in psychology;
- ◆ engagement as a licensed psychologist in the treatment of alcohol and other psychoactive substance use disorders for at least 1 year during the last 3 years; and
- ◆ successful completion of the College of Professional Psychology's examination in the treatment of alcohol and other psychoactive substance use disorders.

The Examination

The examination consists of 150 multiple-choice items, is administered by computer at more than 200 locations, and can be scheduled at your convenience by appointment. Results are provided immediately upon completion and are transmitted to the College of Professional Psychology. Confirmation of certification is issued within several weeks. The knowledge domain listed below serves as a content outline for the examination.

Candidates who are authorized to take the examination will receive a Candidate Guide that contains a detailed content outline, a list of suggested readings, and sample questions.

The knowledge domain is:

- ◆ Clinical Pharmacology and Clinical Epidemiology of Psychoactive Substances
- ◆ Etiology of Psychoactive Substance Use Disorders
- ◆ Initiation, Progression, and Maintenance of Psychoactive Substance Use Disorders
- ◆ Course/Natural History of Psychoactive Substance Use Disorders
- ◆ Prevention, Early Intervention, and Harm Reduction
- ◆ Screening and Assessment of Psychoactive Substance Use
- ◆ Diagnosis and Comorbidity
- ◆ Treatment I: Models and Approaches
- ◆ Treatment II: Planning, Implementing, and Managing Treatment and the Course of Recovery
- ◆ Issues in Specific Populations
- ◆ Research Knowledge
- ◆ Legal and Ethical Issues

Renewal of Certification

The College of Professional Psychology's *Certificate of Proficiency* provides certification for 3 years. Because of the importance of remaining current with regard to the treatment of alcohol and other psychoactive substance use disorders, certified psychologists will be required to renew certification every 3 years. This is accomplished through the College of Professional Psychology's recertification program.

The recertification program requires that you obtain a minimum of 18 hours of CE credit (contact hours) over the 3-year period of certification. Only continuing education that is provided by an APA-approved sponsor or a state or provincial psychological association will be accepted.

You will also be asked to submit verification that your state or provincial license continues in good standing.

Before You Proceed

- ◆ You must enclose all forms and letters to be submitted in application for the *Certificate of Proficiency* in one envelope. A pre-addressed envelope is provided for this purpose.
- ◆ Your application will not be processed without all forms and letters, including the appropriate payment.
- ◆ No staples or paper clips, please.

Work Setting Codes

Human Service Settings

- 31 Public general hospital
- 32 Private general hospital
- 33 City/county/state psychiatric hospital
- 34 Not for profit private psychiatric hospital
- 36 For profit, private psychiatric hospital
- 35 Veterans Administration (VA) hospital
- 37 Military hospital (e.g. Air Force)
- 41 Individual private practice
- 42 Group psychological practice
- 43 Medical/psychological group practice
- 44 Outpatient mental health clinic, freestanding
- 45 Community mental health center or clinic (CMHC)
- 46 Health Maintenance Organization (HMO)
- 47 Counseling or guidance center (not school or college)
- 40 Nursing home
- 48 Special health services (e.g. substance abuse or mental retardation)
- 38 Independent Practice Association (IPA)
- 39 Preferred provider organization (PPO)
- 70 Other managed care
- 49 Other human service setting

Other Employment Settings

- 51 Self-employed (not private practice or independent consultant)
- 52 Consulting firm
- 53 Private research organization or lab
- 54 Government research organization or lab
- 55 Business or industry (excluding consulting firm or research organization)
- 56 Independent consultant
- 61 Criminal justice system
- 62 Military service (other than above settings)
- 63 Federal government agency (other than above settings)
- 64 State govt. agency (other than above settings)
- 65 Local govt. agency (other than above settings)
- 66 Other non-profit organization
- 69 Other non-educational or non-service setting not listed above
- 06 Student counseling or services center (university)

Before You Proceed (Continued)

Fees

The fees for the *Certificate of Proficiency* in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders are listed in the table below. Use the **Application Fee Payment Form** (page 9) to pay your application fee.

Non-Refundable Application Fee:	
APA Member	\$325
Non-Member	\$395
Examination Fee:	\$200
<i>(paid at the time you schedule your examination)</i>	
Annual Maintenance Fee	\$ 50
Renewal Fee	\$125
<i>(paid at the time of 3-year renewal; includes Maintenance Fee for the renewal year)</i>	

Documenting Your Engagement in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders (Letters of Reference)

Using the **Reference Letter Cover Form** (pages 13 and 15), submit two (2) letters of reference which specifically address your recent (1 year within the last 3 years) engagement in the treatment of alcohol and other psychoactive substance use disorders. Both the Reference Letter Cover Form and the reference letter itself must be submitted.

Letters of reference may be written only by the following licensed professionals: psychologists, physicians, social workers, or nurses. Licensed professionals who write letters of reference are not required to be supervisors or co-workers, but may be colleagues (psychologists, physicians, social workers, or nurses) who have knowledge of your recent practice in this treatment area.

Special Accommodations for Testing

Most special needs for testing can be accommodated. If you require special accommodations, call the College of Professional Psychology at (202) 336-6128 at least **45 days in advance of your desired testing date**. Procedures for documenting your need for special accommodations will be provided.

If you have any questions concerning this application or the *Certificate of Proficiency*, feel free to contact the College of Professional Psychology directly at 202-336-6100, or at email address: apacollege@apa.org.

To write to us, address your inquiries to:

College of Professional Psychology
750 First Street, NE
Washington, D.C. 20002-4242

Application

Certificate of Proficiency in the

Treatment of Alcohol and Other Psychoactive Substance Use Disorders

(Please type or print)

1. Name: _____ Degree: _____

Mailing Address: _____

Day Time Phone Number: _____ Fax Number: _____

Email address _____

Social Security Number: _____

APA Member Number (if applicable): 0000 _____ - _____

2. Will you require special accommodations? Yes No

3. I hereby declare that I have been engaged in the treatment of alcohol and other psychoactive substance use disorders as a licensed psychologist for at least 1 year during the last 3 years.

Signature: _____ Date: _____

4A. Current Psychology License:

Licensing State or Province: _____ License Number: _____ Expiration Date: ____/____/____
Month Day Year

Be sure to enclose a photocopy of a document (or documents) that verifies your current licensure status including the date of expiration (i.e., wallet card, wall certificate, letter from the state or provincial licensing board).

Is this state or provincial license to practice psychology current and in good standing?

Yes No (If no, your licensure status does not meet the necessary eligibility requirements.)

Does this license confer upon you the right to engage in the independent practice of psychology without limitations or restrictions, such as the need for supervision or limitations on the services you may provide?

Yes No (If no, your licensure status does not meet the necessary eligibility requirements.)

4B. Original Psychology License:

I have been continuously licensed to engage in the independent practice of psychology without limitations or restrictions since ____/____. State or province granting original license: _____
Month Year

4C. Have you, at any time, been the subject of a finding of unethical, unprofessional (including malpractice), or illegal conduct made as a part of a final decision by a regulatory body (i.e., licensing board, professional ethics body, or other regulatory body) or by a court (civil or criminal)?

Yes No (If yes, attach an explanation and copies of official documents.)

5. Provision of Health Services

In order to be eligible for the *Certificate of Proficiency* you must be a psychologist who provides health services. For the purpose of certification by the College of Professional Psychology, *health services* is defined as follows:

Health services include the delivery or supervision of prevention, assessment, consultation and/or therapeutic intervention services in psychology directly to individuals whose growth, adjustment, or functioning is actually impaired or is at risk for impairment.

Select ONE of the following ways to document the fact that you are a psychologist who provides health services. Check ONLY One:

- Current Practice:** I hereby declare that I have been legally engaged in the provision of health services in psychology for at least 2 years during the last 5 years. Enclose **Verification of the Provision of Health Services** form (page 11).
- Listing in a Register:** Current listing in a nationally recognized register of psychologists who provide health services. Enclose a photocopy of your current listing in the published register, the title page of the register, and the copyright page.
- State or Provincial Recognition as a Health Service Provider:** Current recognition pursuant to state or provincial psychology licensing laws as a “Health Service Provider.” If your state or provincial licensing board grants a “Health Service Provider” title, it is typically reflected in the documentation submitted pursuant to Section 4 (above). If it is not, enclose additional appropriate documentation from the state or province. The following states grant a “Health Service Provider” designation: IA, IN, KY, MA, MO, NC, OK, TN, and TX.

6. The following optional demographic information is requested to enable the College of Professional Psychology to know more about its certificants. Information provided will have no bearing on your application for certification.

Where did you gain your knowledge of and experience in the treatment of alcohol and other psychoactive substance use disorders? Check ALL that apply:

- APA-approved continuing education
- Other coursework
- Other continuing education
- Training in the workplace after licensure
- Part of formal graduate training in psychology
- Other, specify: _____
- Part of formal post-doctoral training in psychology _____

What percent of your practice of psychology is devoted to the treatment of alcohol and other psychoactive substance use disorders?

- Less than 25%
- Between 51% and 75%
- Between 26% and 50%
- Between 76% and 100%

Enter ONE code that reflects your primary work setting: _____
(see **Before You Proceed**, page 4 for codes)

How did you become aware of this certification program?

- APA Monitor
- Workplace requirement or preference
- State association meeting or publication
- Other, specify: _____
- Colleague _____

Waiver and Acknowledgement

I have applied to the APA Practice Organization College of Professional Psychology for the *Certificate of Proficiency*. I hereby certify that the information provided in this application and its enclosures is accurate and complete to the best of my knowledge and belief. I hereby attest to the fact that my state or provincial license is current and in good standing. I authorize the College of Professional Psychology to contact any or all of the references provided in my application and/or the state or provincial licensing agency through which I am licensed. I understand that the College of Professional Psychology has the right to refuse or revoke certification if my application contains fraudulent information. I understand that the certification program of the College of Professional Psychology is voluntary and I agree to be bound by its policies and procedures as they now exist or as they may be amended in the future. I understand that renewal of the College of Professional Psychology *Certificate of Proficiency* through its recertification program is required for continued certification.

I acknowledge the authority of the College of Professional Psychology to establish and maintain standards for certification and to reject or accept applicants for certification. I agree to hold the American Psychological Association Practice Organization and the American Psychological Association free from any claim, damage, or complaint by reason of any action it may take in regard to this application, including, but not limited to, the establishment of certification criteria, including examination content and scoring, and the determination of whether I have met the requirements for certification.

I understand that my *Certificate of Proficiency* may be revoked if I am the subject of a finding of unethical, unprofessional, or illegal conduct made as a part of a final decision by a court or regulatory body (administrative, civil or criminal), including the American Psychological Association’s Code of Ethics enforcement entity. If I am granted certification, I agree to notify the College of Professional Psychology of such a finding within 45 days of the final decision.

I understand that my *Certificate of Proficiency* may be revoked if I fail to meet renewal criteria or to pay fees and that I may resign my certification at any time without refund of fees paid.

Signature: _____ Date: _____

NOTARY

On this _____ day of _____, 20____, _____
APPLICANT

personally appeared before me and signed his or her signature above, having satisfactorily proven to be the person whose signature appears above.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

Signature of Notary Public: _____

My commission expires: _____

Application Fee Payment Form

(Please type or print)

Name: _____

Address: _____

Daytime Phone Number: _____

APA Member Number (if applicable): 0000 _____ - _____

Please Note: Payment Must Be Made In U.S. Funds

Check the appropriate non-refundable application fee:

\$325 APA Members \$395 Non-Members

Form of Payment: Check (Payable to: APA) VISA MasterCard American Express

Card Number: _____ Expiration: _____

Name as it appears on credit card: _____

Signature: _____

I understand that an additional examination fee of \$200 must be paid at the time I schedule my examination.

PLEASE DETACH HERE
 FOR APPLICANT USE ONLY

To *Ensure* Your Application Is Complete

Enclose in the pre-addressed envelope provided with this Application:

- Completed *Certificate of Proficiency Application* (pp. 5-6);
- Signed and notarized **Waiver and Acknowledgement** (p. 7);
- Photocopy of licensure documentation (See p. 5 for details);
- Documentation of provision of health services (See p. 6 for options);
- Two (2) letters of reference AND cover forms (See p. 4 for information);
- Application Fee Payment Form** (above) and check or credit card authorization.

Mail to: APA Practice Organization
 College of Professional Psychology
 750 First Street, N.E.
 Washington, D.C. 20002-4242

Verification of the Provision of Health Services

Current Practice Method Only

Certificate of Proficiency in the

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The same reference may be used to verify applicant's engagement in the delivery of health services as is used to document engagement in the treatment of alcohol and other psychoactive substance use disorder.

Applicant's Name: _____

Applicant's Address: _____

To the Psychologist, Physician, Social Worker or Nurse: The above-named individual is applying to the College of Professional Psychology for the *Certificate of Proficiency* in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders. The applicant is required to document that he or she has been engaged in the provision of health services in psychology for at least 2 years during the last 5 years. You have been identified by the applicant as a licensed professional who has knowledge of the applicant's practice in psychology.

In this capacity we ask you to read the statement below and determine whether, based on your own knowledge, it applies to the applicant. **Return this completed form directly to the applicant who will submit it to the College of Professional Psychology with his or her application.**

Verification Statement

Based on my own knowledge, I hereby verify that _____ (*the applicant*) has been engaged for at least 2 of the last 5 years in the delivery or supervision of prevention, assessment, consultation and/or therapeutic intervention services in psychology directly to individuals whose growth, adjustment, or functioning is actually impaired or is at risk for impairment.

Check the box that indicates your licensed profession (ONLY these four are accepted):

Psychologist Social Worker Physician Nurse

Your Name: _____

Address: _____

Licensing State or Province: _____

State or Provincial License Number: _____ Expiration Date: _____

Signature: _____ Date: _____

Please return this form directly to the applicant.

Reference Letter Cover Form

Certificate of Proficiency
in the
Treatment of Alcohol and Other Psychoactive Substance Use Disorders

Applicant's Name: _____

Applicant's Address: _____

To the Psychologist, Physician, Social Worker or Nurse: The above-named individual is applying to the College of Professional Psychology for the *Certificate of Proficiency* in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders. The applicant is required to document that he or she has been engaged in the treatment of alcohol and other psychoactive substance use disorders for at least 1 year during the last 3 years. You have been identified by the applicant as a licensed professional who has knowledge of his or her practice in psychology for at least 1 year of the last 3 years.

In this capacity we ask you to write a letter of reference for the above-named applicant. You must describe your knowledge of his or her practice during the last 3 years in the treatment of alcohol and other psychoactive substance use disorders. Include information about how long you have known the applicant and specify your professional relationship. **Return both this completed cover form and your letter directly to the applicant who will submit them to the College of Professional Psychology with his or her application.** You may place your letter in a sealed envelope if you wish.

Check the box that indicates your licensed profession (**ONLY** these four are accepted):

Psychologist Social Worker Physician Nurse

Your Name: _____

Address: _____

Licensing State or Province: _____

State or Provincial License Number: _____ Expiration Date: _____

My knowledge of the applicant's practice of psychology in the treatment alcohol and other psychoactive substance use disorders covers the following period of time:

FROM / TO /
 Month Year Month Year

Signature: _____ Date: _____

We appreciate your time and thoughtful assistance. **Please return this cover form along with your letter of reference directly to the applicant.** You may place your letter of reference in a sealed envelope if you wish.

Reference Letter Cover Form

Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders

Applicant's Name: _____

Applicant's Address: _____

To the Psychologist, Physician, Social Worker or Nurse: The above-named individual is applying to the College of Professional Psychology for the *Certificate of Proficiency* in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders. The applicant is required to document that he or she has been engaged in the treatment of alcohol and other psychoactive substance use disorders for at least 1 year during the last 3 years. You have been identified by the applicant as a licensed professional who has knowledge of his or her practice in psychology for at least 1 year of the last 3 years.

In this capacity we ask you to write a letter of reference for the above-named applicant. You must describe your knowledge of his or her practice during the last 3 years in the treatment of alcohol and other psychoactive substance use disorders. Include information about how long you have known the applicant and specify your professional relationship. **Return both this completed cover form and your letter directly to the applicant who will submit them to the College of Professional Psychology with his or her application.** You may place your letter in a sealed envelope if you wish.

Check the box that indicates your licensed profession (ONLY these four are accepted):

Psychologist Social Worker Physician Nurse

Your Name: _____

Address: _____

Licensing State or Province: _____

State or Provincial License Number: _____ Expiration Date: _____

My knowledge of the applicant's practice of psychology in the treatment alcohol and other psychoactive substance use disorders covers the following period of time:

FROM / TO /
 Month Year Month Year

Signature: _____ Date: _____

We appreciate your time and thoughtful assistance. Please return this cover form along with your letter of reference directly to the applicant. You may place your letter of reference in a sealed envelope if you wish.

REQUIRES
EXTRA
POSTAGE

APA Practice Organization
College of Professional Psychology
750 First Street, N.E.
Washington, D.C. 20002-4242

To *Ensure Your Application* is Complete

Before you submit your application, be sure you have enclosed:

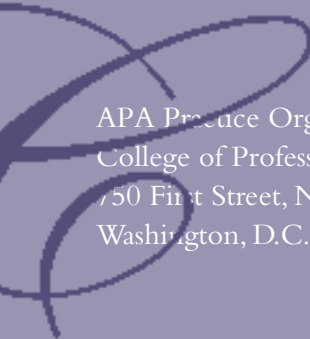
- Completed *Certificate of Proficiency Application* (pp. 5-6);
- Signed and Notarized **Waiver and Acknowledgement** (p. 7);
- Photocopy of licensure documentation (See p. 5 for details);
- Documentation of provision of health services (See p. 6 for options);
- Two (2) letters of reference AND cover forms (See p. 4 for information);
- Application Fee Payment Form** and check or credit card authorization (p. 9).

Please do not enclose additional materials or use paper clips or staples. Thanks.

Mail to:

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College of Professional Psychology
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Washington, D.C. 20002-4242





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