

## APPLICATION INSTRUCTIONS

The initial application is a brief sketch of the professional's qualifications. This is meant to be an assessment for review purposes. This application is a recording and compilation of documents demonstrating competency in the knowledge and skills specifically related to the domains of the adolescent treatment endorsement. This process includes validation from employers, supervisors, and instructors.

1. Application forms must be neatly printed or typewritten.
2. Clip your materials to keep them together. Do not place your application materials in binders, folders, report covers, etc.
3. Your check or money order should be made payable to ICB. All fees (where applicable) are non-refundable. (**No** refunds will be given.)
4. Make a photocopy of your entire completed application including all attachments for your records. Send the original copy of the application and copies of all other documents.  
**Emailed applications will not be accepted.**
5. Applications will not be approved until all sections are completed and signed where required. If there are problems with your application materials, you will receive notification via email.
6. It is the applicant's responsibility to notify ICB in writing of any changes to name, work/home address and work/home telephone numbers.
7. Applications not completed after one year will be closed, and the applicant will need to reapply.
8. ICB reserves the right to request further information from employers and other persons listed on the application forms.
9. Send completed application to:  
ICB, Inc.  
401 East Sangamon Avenue  
Springfield, IL 62702

# ADOLESCENT TREATMENT ENDORSEMENT APPLICATION

PLEASE PRINT OR TYPE

Name \_\_\_\_\_ / / \_\_\_\_\_  
                     Last                                      First                                      Middle                                      Date of Birth

Home Address \_\_\_\_\_  Male  Female

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

County \_\_\_\_\_ Telephone \_\_\_\_ / \_\_\_\_ - \_\_\_\_ Fax \_\_\_\_ / \_\_\_\_ - \_\_\_\_

Email address at home \_\_\_\_\_ @ \_\_\_\_\_

Current Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

County \_\_\_\_\_ Telephone \_\_\_\_ / \_\_\_\_ - \_\_\_\_

Email address at work \_\_\_\_\_ @ \_\_\_\_\_

I would like correspondence sent to:  Home Address  Work Address

**Please check one selection from each of the following areas:**

**Ethnic Origin**

- Caucasian
- Black/African-American
- Asian or Pacific Islander
- Other \_\_\_\_\_

**Highest Education Level Completed**

- High School Diploma or GED
- Vocational Certificate
- Associate of Arts/Sciences
- Bachelor of Arts/Sciences
- Master of Arts/Sciences
- Doctorate

**Primary Work Setting**

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Mental Health Disorders</li> <li><input type="checkbox"/> Substance Use Disorders</li> <li><input type="checkbox"/> Residential</li> <li><input type="checkbox"/> Intensive Outpatient</li> <li><input type="checkbox"/> Developmental Disabilities</li> <li><input type="checkbox"/> Co-Occurring</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Inpatient Treatment</li> <li><input type="checkbox"/> Private Practice</li> <li><input type="checkbox"/> Outpatient Treatment</li> <li><input type="checkbox"/> Case Management &amp; Referral</li> <li><input type="checkbox"/> Crisis Intervention</li> <li><input type="checkbox"/> Elementary/High School</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Department of Corrections</li> <li><input type="checkbox"/> College/University</li> <li><input type="checkbox"/> Domestic Violence</li> <li><input type="checkbox"/> HIV/AIDS</li> <li><input type="checkbox"/> Medical/Hospital</li> <li><input type="checkbox"/> Other _____</li> </ul> |
|---|--|---|

**Primary Population Served**

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Adults</li> <li><input type="checkbox"/> Adolescent</li> <li><input type="checkbox"/> Children</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Geriatrics</li> <li><input type="checkbox"/> Mixed</li> </ul> |
|---|---|

**Primary Profession**

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Social Work</li> <li><input type="checkbox"/> Counseling</li> <li><input type="checkbox"/> Nursing</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Psychology</li> <li><input type="checkbox"/> Occupational Therapy</li> </ul> |
|---|--|

Application Number \_\_\_\_\_

All answers are correct to the best of my knowledge. I authorize any educational institution, employer, or other body having knowledge of my professional or academic status, to release information to ICB.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**Please Note:** The Illinois Certification Board, Inc. may request further information with regards to the documentation presented in this application. This information is not available to others outside the credentialing process without the written consent of the applicant. This information will be used strictly to evaluate professional competence of the applicant and **WILL BE KEPT CONFIDENTIAL BY ICB.**

**WORK EXPERIENCE FORM**

I hereby attest that the applicant is working in a paid position where a minimum of 51% of his/her time is spent providing direct, primary alcohol and other drug (AOD) counseling services to adolescents.

The applicant minimally has primary responsibility for providing alcohol and drug counseling in individual and/or group settings, preparing treatment plans, documenting client progress notes and is clinically supervised by an individual who is knowledgeable in substance use disorder treatment.

\_\_\_\_\_  
Signature of Supervisor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

To obtain this seal of endorsement, the applicant must be a Certified Alcohol and Other Drug Counselor and/or Licensed Practitioners of the Healing Arts pursuant to Title 77, Part 2060.309 and can provide proof that they are certified or licensed in good standing.

\_\_\_\_\_ I am a Certified Alcohol and Other Drug Counselor.

(Attach a copy of your current certification)

\_\_\_\_\_ I am a Licensed Practitioner of the Healing Arts.

(Attach a copy of your current license)

**BE SURE TO ATTACH A JOB DESCRIPTION FOR YOUR CURRENT POSITION.** Job description must be on agency letterhead and dated and signed by applicant and supervisor. All relevant former employment must be verified by job descriptions from employers.

Position/title \_\_\_\_\_

Date Employed:

From \_\_\_\_\_ to \_\_\_\_\_ hrs. of work per week \_\_\_\_\_  
mo./day/yr. mo./day/yr.

Place of Employment: \_\_\_\_\_

Immediate Supervisor: \_\_\_\_\_

Title \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_

Application Number \_\_\_\_\_

Position/title \_\_\_\_\_

Date Employed:

From \_\_\_\_\_ to \_\_\_\_\_ hrs. of work per week \_\_\_\_\_  
mo./day/yr. mo./day/yr.

Place of Employment: \_\_\_\_\_

Immediate Supervisor Signature: \_\_\_\_\_

Title \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

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Position/title \_\_\_\_\_

Date Employed:

From \_\_\_\_\_ to \_\_\_\_\_ hrs. of work per week \_\_\_\_\_  
mo./day/yr. mo./day/yr.

Place of Employment: \_\_\_\_\_

Immediate Supervisor Signature: \_\_\_\_\_

Title \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

All answers are correct to the best of my knowledge. I authorize any educational institution or, other body having knowledge of my academic status, to release information to ICB regarding my status.

Signature of Applicant

Date



**EDUCATION FORM**

Please reproduce this form as needed to record all RELEVANT education specific to adolescent performance domains. Be sure to attach documentation (i.e. transcripts, certificates) that supports participation. Lack of documentation will result in the inability to apply these hours towards endorsement.

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**Record of Education**

**Dates Attended** \_\_\_\_\_ **Clock Hrs/Credit Hrs** \_\_\_\_\_

**Courses/Program Title** \_\_\_\_\_

**Sponsoring Organization** \_\_\_\_\_

**Briefly Describe the Content of Education** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Record of Education**

**Dates Attended** \_\_\_\_\_ **Clock Hrs/Credit Hrs** \_\_\_\_\_

**Courses/Program Title** \_\_\_\_\_

**Sponsoring Organization** \_\_\_\_\_

**Briefly Describe the Content of Education** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LETTER OF SUPPORT**

ICB believes that credentials should be based on input from a variety of sources, especially the observations of persons who have known the applicant professionally. For this reason, all applicants are required to provide this form as a letter of support from a professional who is credentialed through ICB and/or is a Licensed Independent Practitioner, and has worked with the applicant in a professional capacity.

**APPLICANT'S NAME:** \_\_\_\_\_

I have worked with this applicant and can attest that he/she has demonstrated the skills and abilities required for providing substance use disorder treatment specifically to adolescents.

I certify that this letter truthfully reflects my support of the applicant, and I hereby recommend this applicant for the Adolescent Treatment Endorsement.

**NAME:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**CREDENTIAL/LICENSE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**COMMENTS (Required):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**ASSURANCE AND RELEASE**

The Illinois Certification Board, Inc. (ICB) may request further information with regards to the documentation I have presented in this application. This information is not available to others outside the registration process without written consent of the applicant.

I give my permission for ICB and staff to investigate my background as it relates to information contained in this application for the Adolescent Treatment Endorsement. I understand that intentionally false or misleading statements, or intentional omissions, shall result in denial or revocation of registration.

I consent to the release of information contained in my application file, and other pertinent data submitted to, or collected by ICB, to officers, members, and staff of the afore mentioned board.

I further agree to hold ICB, its officers, board members, employees and examiners free from civil liability for damages or complaints by reason of any action that is within the scope of the performance of their duties which they may take in connection with this application and the subsequent examination, and/or the failure of ICB to issue the registration. In the event my certification and/or license is either sanctioned, terminated or suspended, I agree to surrender my Adolescent Treatment Endorsement.

I further certify that my Adolescent Treatment Endorsement and status is public knowledge.

I hereby affirm that the information provided on this form is correct and that I believe I am qualified for the endorsement for which I am applying.

<p>_____</p> <p><b>Signature of Applicant</b></p>	<p>____/____/____</p> <p><b>Date</b></p>
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# CODE OF ETHICS FOR ADOLESCENT TREATMENT ENDORSEMENT

## **Principle 1: Legal and Moral Standards**

Professionals with Adolescent Treatment Endorsement (ATE), in the practice of alcohol and other drug treatment services for adolescents, show respect and regard for the laws of the communities in which they work. They recognize that violations of legal standards may damage their own reputation and that of their profession.

- a. The welfare and dignity of the client are to be protected and valued above all else.
- b. Professionals with ATE shall not physically or verbally abuse their clients.
- c. Professionals with ATE shall not use alcohol.
- d. Professionals with ATE shall not financially exploit their clients.
- e. Professionals with ATE shall not use legal drugs.
- f. In some circumstances, Professionals with ATE may themselves use properly prescribed, mood-altering drugs for necessary and appropriate medical reasons. In such circumstances, they should weigh their ability to serve in counseling relationships.
- g. Professionals with ATE shall not possess or use any illegal drugs under any circumstances.
- h. Professionals with ATE who can legally prescribe controlled substances must exercise clinical discretion in prescribing controlled substances that are mind-altering and/or addictive.

## **Principle 2: Professionals with Adolescent Treatment Endorsement/Client Relationships**

In the provision of substance use disorder treatment services for adolescents, Professionals with Adolescent Treatment Endorsement shall establish and maintain counselor/client relationships characterized by professionalism, respect and objectivity.

- a. Professionals with ATE shall not enter into counseling relationships with members of their own family, close friends, persons closely connected to them or others whose welfare might be jeopardized by such a dual relationship.
- b. Professionals with ATE shall ensure that services are offered in a respectful manner in an appropriate environment.
- c. Professionals with ATE shall not charge or collect a private fee or other form of compensation for services to a client who is charged for those same services through the counselor's agency. They shall not engage in fee-splitting.
- d. Professionals with ATE in clinical or counseling practice must not use their relationship with clients to promote personal gain or the profit of an agency or commercial enterprise of any kind.
- e. Professionals with ATE shall avoid continuing a counseling relationship for personal gain or satisfaction beyond the point where it is clear that the client is not benefiting from the relationship.
- f. Professionals with ATE shall not give or receive a fee, commission, rebate or any other form of compensation for the referral of clients.
- g. Professionals with ATE shall not abandon or neglect clients in treatment and shall assist in making appropriate arrangements for the continuation of treatment, if appropriate, following termination, of treatment.

- h. If Professionals with ATE determine an inability to be of professional assistance to clients, they shall either avoid initiating the counseling relationship or immediately terminate that relationship. In either event, they shall be knowledgeable about referral resources and suggest appropriate alternatives. If clients decline the suggested referral, Professionals with ATE are not obligated to continue the relationship.
- i. Professionals with ATE shall terminate a counseling relationship, securing client agreement when possible, when it is reasonably clear that the client is no longer benefiting, when services are no longer required, when counseling no longer serves the client's needs or interests, or when clients do not pay their fees.
- j. In promotional and marketing activities for services, Professionals with ATE shall respect the dignity and confidentiality of their clients.
- k. Professionals with ATE shall not engage in any sexual relationship, conduct or contact with clients during the time of the counseling relationship or for at least one year thereafter, or if the client or former client becomes or remains "emotionally dependent" on the counselor [as defined under Illinois Law at 740 ILCS 140/1(a)]. Professionals with ATE in all instances shall not engage in any sexual relationship, conduct or contact through means of any therapeutic deception.

### **Principle 3: Non Discrimination**

Professionals with ATE must not discriminate against clients or other professionals based on race, religion, age, sex, disability, ethnicity, national ancestry, sexual orientation or economic condition.

### **Principle 4: Competence**

Professionals with ATE have the responsibility to provide competent professional services.

- a. Professionals with ATE shall not offer services outside the boundaries of their profession unless otherwise educated and trained.
- b. Professionals with ATE shall not offer services outside their range of competency.

### **Principle 5: Confidentiality**

Professionals with Adolescent Treatment Endorsement shall preserve, protect and respect their clients' right to confidentiality.

- a. Professionals with ATE shall comply with the federal and state laws, rules and regulations pertaining to client confidentiality.
- b. Professionals with ATE shall guard professional confidences and shall reveal such confidences only in compliance with the law or when there is a clear and imminent danger to an individual or society.
- c. Professionals with ATE must inform the client and obtain agreement in areas likely to affect the client's participation including the recording of an interview, the use of interview material for training purposes and observation of an interview by another person.
- d. Professionals with ATE must discuss information obtained in clinical or consulting relationships only in appropriate settings and only for professional purposes clearly concerned with the case. Written and oral reports must present only data germane to the purpose of the evaluation and every effort must be made to avoid undue invasion of privacy.
- e. Professionals with ATE must use clinical and other material in classroom teaching and writing only when the identities of the persons involved are adequately disguised.

- f. The general requirement that Professionals with ATE keep information confidential does not apply when the best interests of clients, welfare of others, obligations to society, or legal requirements demand that confidential information be revealed. Professionals with ATE shall consult with other professionals when they are unsure of whether an exception to confidentiality exists.
- g. Before confidential information is disclosed over the client's objection, because of legal requirements, Professionals with ATE shall request to the court that the disclosure not be required and explain why disclosures are harmful to clients. Steps are taken to limit the extent of the unwanted disclosure. A professional shall not, however, be obligated to violate any state or federal law, or the order of competent jurisdiction.
- h. When circumstances require the disclosure of confidential information, only information that is essential is to be revealed. To the extent possible, clients are to be informed before confidential information is disclosed.
- i. At the beginning of the counseling relationship, Professionals with ATE discuss with clients the relevant limitations of confidentiality and the foreseeable uses of information generated through counseling services. Professionals with ATE shall explain that confidentiality cannot be guaranteed in group counseling and communicate that clearly to group members.

**Principle 6: Inter-Professional Relationships**

Professionals with Adolescent Treatment Endorsement shall establish and maintain professional relationships characterized by respect and mutual support.

- a. Professionals with ATE shall establish and maintain professional relationships with their clients.
- b. Professionals with ATE shall respect the confidences shared by other colleagues/professionals with respect to clients.
- c. Professionals with ATE shall not knowingly solicit the clients of other colleagues/professionals.
- d. Professionals with ATE shall not knowingly withhold information that has been appropriately released by the client from colleagues/professionals that would enhance their treatment effectiveness.
- e. Professionals with ATE shall not knowingly accept for treatment a person who is receiving services from another professional except by agreement with that worker or after the termination of the case by that worker.
- f. When working within a treatment team, Professionals with ATE will not abdicate their responsibility to protect and promote the welfare and best interests of the client.
- g. When working within a treatment team, Professionals with ATE shall work to support, not damage or subvert, the decisions made by the team.

**Principle 7: Ethical Standards of Professionals with Adolescent Treatment Endorsement.**

**Principle 7.1: Professionals with Adolescent Treatment Endorsement shall establish and maintain an employer/employee relationship characterized by professionalism and respect for the agency's rules of operation.**

**Principle 7.2: Professionals with Adolescent Treatment Endorsement shall strive at all times to maintain high standards in the services they offer.**

- a. The maintenance of high standards of competency is a responsibility shared by all Professionals with ATE.

- b. In circumstances where Professionals with ATE violate ethical standards, it is the obligation of Professionals with ATE who know first hand of their activities to attempt to rectify the situation. If such attempts fail, Professionals with ATE shall promptly notify the ICB Executive Director.

**Principle 7.3: Professionals with Adolescent Treatment Endorsement respect their professional status and standing.**

Professionals with ATE shall not misrepresent their own or other professionals qualifications and affiliations.

**Principle 7.4: Professionals with Adolescent Treatment Endorsement have an obligation to see that alcohol and other drug treatment for adolescents is done by qualified, competent persons.**

Professionals with ATE shall submit accurate and honest information to ICB for the purpose of obtaining, maintaining and recommending someone for endorsement.

**Principle 8: Resolving Ethical Issues**

Professionals with Adolescent Treatment Endorsement shall take appropriate action when they possess information that raises doubts as to whether another alcohol and other drug treatment professional is acting in an ethical manner.

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**PERSONAL STATEMENT**

As a Professional with ATE, I shall strive at all times to maintain the highest standards in all services I provide, valuing competency and integrity over expediency or ability, providing services only in those areas where my training and experience meet established standards. I shall always recognize that I have assumed a heavy social and vocational responsibility due to the intimate nature of my work, which touches the lives of other human beings.

My signature below indicates my agreement with and willingness to abide by this Code of Ethics.

**Signature of Applicant** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Notary** \_\_\_\_\_ **Date** \_\_\_\_\_

**Notary Stamp** \_\_\_\_\_



## Adolescent Treatment Endorsement Checklist

The following should be in your Application for the Adolescent Treatment Endorsement

- \_\_\_\_\_ General Information Sheet.....page 2-3
- \_\_\_\_\_ Work Experience Form....page 4-5  
(Attach Job Description)
- \_\_\_\_\_ Supervised Practical Experience....page 6
- \_\_\_\_\_ Education Form....page 7  
(Attach documentation of completion)
- \_\_\_\_\_ Letter of Support from a credentialed professional.....page 8  
(Credentialed through ICB and/or Licensed Independent Practitioner)
- \_\_\_\_\_ Assurance and Release (Signed and dated).... page 9
- \_\_\_\_\_ Code of ethics (Signed and dated)..... page 13

Mail all application materials to:

Illinois Certification Board, Inc.  
401 East Sangamon Avenue  
Springfield, IL 62702

**Applications will not be accepted by email.**