



PLEASE READ CAREFULLY BEFORE COMPLETING APPLICATION

WORKSHOP APPLICATION

THIS APPLICATION IS USED WHEN THE PUBLIC IS INVITED.

The fee for application is \$30.00 and \$5.00 for each continuing education unit (CEU) that the Illinois Certification Board (ICB) awards. (The MAXIMUM CEUs fee is \$100). ICB will issue an invoice for CEUs awarded for the training program.

Requests for expedited processing of the application will require an additional fee of \$30.00 and applications will be processed within 2 business days of receipt of payment of this fee, with all necessary documents. Fees are non-refundable.

ICB will review applications to determine whether the information submitted meets AOD Counselor (CADC, CRADC, CSADC, CAADC), Preventionist (CPS, CSPS), Assessment and Referral Specialist (CARS), Problem and Compulsive Gambling Counselor (PCGC), Criminal Justice Addictions Professional (CCJP), Registered Dual Disorder Professional (RDDP), Associate Addictions Professional (CAAP), Recovery Support Specialist (CRSS), Medication Assisted Addictions Professional (MAATP), Co-Occurring Substance Use and Mental Health Disorder Professional I/II (CODP I/CODP II), Family Partnership Professional (CFPP), National Certified Recovery Specialist (NCRS), Veterans Support Specialist (CVSS), Peer Recovery Specialist (CPRS), Adolescent Treatment Endorsement (ATE), and Gender Competent Endorsement (GCE) criteria.

Please do not advertise which category your program is until you have received notification from ICB. You may indicate that you have applied for ICB CEUs for your training program.

PLEASE SUBMIT APPLICATIONS 60 TO 90 DAYS PRIOR TO THE DATE OF THE EVENT.

APPLICATIONS WILL NOT BE ACCEPTED BY EMAIL.

REPEAT OF PROGRAM: Once a program has been awarded CEUs, the program number is valid for two years. The program may be repeated any number of times within this two-year period without submitting another application. You will need to pay the fee for CEUs and submit a letter or program repeat form to ICB providing the date and any changes concerning the event.

Maintain all information concerning the program for at least two years.

WORKSHOP APPLICATION INSTRUCTIONS

Category 1, 2 and 3 continuing education units awarded by ICB.

CATEGORY 1: Education must be specific to alcohol and other drug for AOD Counselors, Preventionists, and Assessment and Referral Specialists, specific to gambling for Problem and Compulsive Gambling Counselors, specific to criminal justice for Criminal Justice Addiction Professionals, specific to alcohol and other drug abuse/dependency as related to the performance domains for Associate Addictions Professionals, specific to knowledge and skills related to mental health recovery and the role of peer support in the recovery process for Recovery Support Specialists, specific to alcohol and other drugs or MAAT for Medication Assisted Addiction Treatment Professionals, specific to knowledge and skills related to alcohol and other drug or mental health for CODP, specific to knowledge and skills related to the provision of services to children and families and the role of peer support to families for Family Partnership Professional, specific to residential extended care or recovery home services for National Certified Recovery Specialist, specific to knowledge and skills, as they relate to military culture; recovery and the role of the Veteran support specialist in the recovery process for Veteran Support Specialist, and specific to knowledge and skills related to recovery and the role of the peer support in the recovery process for Peer Recovery Specialist.

CATEGORY 2: Education must be specific to the knowledge and skills related to the core functions and domains, and/or knowledge areas of the credentials. For Associate Addictions Professionals, education must be specific to ethics and professional boundaries.

CATEGORY 3: Education must be specific to knowledge and skills related to the CODP Core Functions.

For Registered Dual Disorder Professionals, education must be alcohol and other drug abuse and co-morbidity specific.

For Adolescent Treatment Endorsement, education must be in adolescent specific alcohol and other drug addiction treatment performance domains.

For Gender Competent Endorsement, education must be in women specific alcohol and other drug addiction performance domains.

To complete the application form, refer to the following instructions that correspond to the numbers on the application.

1. Print the name, address, telephone number, and website of the organization offering the continuing education program.
2. Identify an individual who will assume primary responsibility for the continuing education program and serve as the contact person to ICB in this application process. Also list the contact person's email address.
- 3a. Print the name of the continuing education program.
- 3b. List the date(s) of the program.
4. Print the facility location and the address where the program is to be given.
5. Estimate the minimum and maximum number of persons expected to attend this program.
6. Give a brief description of your intended audience (AOD counselors, clinical directors, addictions nurses, etc.).
7. Submit a description of your continuing education program, to include:
 - Objectives of the program: list the learner objectives
 - Program content: a brief summary of the content of the program
 - Format of instruction: brief description of instruction format (lecture, discussion, videotape, film, role-play, etc.)
 - Time frame: project a schedule for this program indicating program start-up time, presentation time, all breaks, and scheduled time of completion/adjournment.
 - Faculty/Instructor qualifications: provide documentation of the qualifications of the program instructor. (resumes/vitas)
8. ICB requires programs awarded CEUs be evaluated by certified or board registered participants. Attach a copy of the evaluation form you will be using to evaluate your program.
9. ICB requires programs awarded CEUs provide certified or board registered participants with a form to document successful completion of the program. The proof of completion form MUST contain:
 - Name of the sponsoring agency
 - Title of the program
 - Date of the program
 - Name of participant/registrant (Names should be typed. Please do not provide blank certificates to attendees.)
 - Number of ICB continuing education units
 - Assigned categories
 - ICB assigned program number
10. Indicate if this program will be offered more than once by checking the appropriate space. If program is to be repeated, indicate the number of times program will be repeated, if known.
11. ICB maintains and provides a listing of educational events. Please indicate if you want your program listed. This service is free for listing in the ICB Continuing Education Bulletin (available in print format and on our website). If contact person for advertising is different than in sections 1 and 2, please complete advertising contact person section.
12. Indicate the fee you are charging for this program.
13. The application fee is \$30.00. Attach a check or money order for \$30.00 made out to ICB. If requesting expedited processing, indicate request and include additional fee of \$30, for a total application fee of \$60.00.
14. The contact person of the sponsoring agency should read, sign, and date the application.
15. The contact person of the sponsoring agency should read, sign, and date the release statement.

If you need assistance please call the ICB office at (217) 698-8110.



ALLOW 60-90 DAYS TO PROCESS THIS APPLICATION

APPLICATION FOR ICB CONTINUING EDUCATION UNITS WORKSHOP

This application form is to be used by sponsors of continuing education programs to request continuing education units from ICB for a workshop.

Please refer to the application instructions as you are completing this application form.

1. **Sponsor Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ **Extension:** _____ **Website:** _____

2. **Contact Person:** _____ **E-Mail Address:** _____

3a. **Title of Continuing Education Program:**

3b. **Date(s) of Program Presentation:**

From: _____ **To:** _____

4. **Location of Program:**

5. **Size of Audience:**

How many persons do you expect will attend this program? _____ (Minimum Number)

_____ (Maximum Number)

6. **Intended Audience:** (please describe your intended audience)

What percentage of your audience do you anticipate will be certified or board registered professionals?
(Check one)

- _____ Less than 10%
- _____ 10% to 25%
- _____ 25% to 50%
- _____ 50% to 75%
- _____ Over 75%

7. **ATTACH A DESCRIPTION OF YOUR PROGRAM.**
(This description must contain objectives of the program, summary of program content, description of format of instruction, time frame, and documentation of faculty/instructor qualifications. Explain how this program is related to alcohol and/or other drug abuse/dependency).

8. **Program Evaluation:** (Attach a copy of the form to be used for the purpose of program evaluation.)

9. **Proof of Completion:** (Attach a copy of the form you will use to document program completion.)

10. **Will this program be repeated?** / ___ / Yes / ___ / No

Number of times it is to be repeated _____
(Number) (Don't Know)

11. **Would you like your program advertised by ICB?** (No charge for inclusion in the Continuing Education Bulletin, print and website)

___ Yes ___ No

Advertising Contact Information:

Contact Name: _____

Phone Number: _____

Email: _____

Website: _____

12. **Fee you are charging for your program** \$ _____

13. **Application Fee:** The application fee is \$30 and is non-refundable. **Remit application fee with the application.** Make checks or money orders payable to ICB. **Please note, a 3.75% service charge will be added to all credit/debit card transactions.**
 ___ Mark only if requesting expedited processing and include an additional \$30.00 for this request.

Credit Card Number _____ - _____ - _____ - _____ **Expiration Date** _____
(VISA or Mastercard only)

(Please include the three-digit number listed near the signature line on the back of the credit card) **Security Code:** _____

Name on Card _____

Telephone Number (_____) _____ - _____

Credit Card Billing Address _____

City _____ **State** _____ **Zip Code** _____

RETURN APPLICATION TO: ICB, Inc.
401 East Sangamon Avenue
Springfield, IL 62702

14. **Signature of Contact Person:**

I hereby certify that I have read the application packet and instructions and understand their requirements. I further certify the information supplied in this application is true and accurate, to the best of my knowledge.

(Signature of Contact Person)

(Date)

15. **Release Statement** Please read and sign the following.

In making application for continuing education units I give my permission for ICB and its representatives to gather and collect information from third parties pertaining to this application. I acknowledge that such communications shall be treated as confidential between ICB, its representatives and such third party.

I hereby certify that I have read this entire application and that all of the information contained herein is true and complete. I understand that intentionally false or misleading statements will result in being denied continuing education program recognition. I understand that the required application fee is non-refundable.

I further agree to hold ICB, their Board members, officers, committee members, general members, employees, and evaluators free from any civil liability for damages or complaints by reason of any action that is within the scope and arising out of the performance of their duties which they, or any of them, may take in connection with the application and evaluation of this application and/or the failure of ICB to award continuing education units.

(Signature of Contact Person)

(Date)

C H E C K L I S T

___ Program Description ___ Sample of evaluation form ___ Instructor(s) resume

___ Time Frame/Agenda ___ Sample of certificate of completion

___ Date(s) of program ___ \$30 application fee

NOTICE OF REPEAT OF PROGRAM

Please use this form when notifying ICB that you are repeating or have repeated a program.

ICB PROGRAM NUMBER: _____

NAME OF PROGRAM: _____

DATE OF PROGRAM: _____

LOCATION OF PROGRAM: _____

POINT OF CONTACT: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

E-MAIL ADDRESS: _____

CHANGES: List any changes in the program, location of program, or presenters.
Attach presenters resume if using a different presenter.

ADVERTISEMENT: Would you like your program advertised by ICB?
(No charge for inclusion in the Continuing Education Bulletin, print form and website)

Yes

No

Advertising Contact Information:

Contact Name: _____

Phone Number: _____

Email: _____

Website: _____

SUBMIT THE CEUS FEE WITH THIS FORM: \$ _____
(\$5.00 per CEU)

MAKE CHECKS OR MONEY ORDERS PAYABLE TO ICB.

Please note, a 3.75% service charge will be added to all credit/debit card transactions.

Credit Card Number _____ - _____ - _____ - _____ Expiration Date _____
(VISA or Mastercard only)

(Please include the three-digit number listed near the signature line on the back of the credit card) Security Code: _____

Name on Card _____

Telephone Number (_____) _____ - _____

Credit Card Billing Address: _____

City _____ State _____ Zip Code _____

Mail to: ICB, Inc.
401 East Sangamon Avenue
Springfield, IL 62702