NORTH DAKOTA BOARD OF ADDICTION COUNSELING EXAMINERS

NDBACE

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

**RETURN FORM TO:**
North Dakota Board of Addiction Counseling Examiners
402 E MAIN AVE, Ste #5, Bismarck, ND 58501-4091
*Or email an electronic copy to board@ndbace.org*

# Clinical Trainee Completion Form

**Upon completion of a training program, the Clinical Training Program Director must complete this form and return it to the board office. You must also include a copy of the trainee's final monthly performance review, as well as oral examination verification of completion.**

## Trainee Information

Last Name: _____ First Name:_____

Middle Name: _____ Maiden Name: _____

Name of Clinical Training Program: _____

Training Completion Date: _____

I verify that the above-named trainee has completed 1400 hours of clinical training, which included 50 hours of supervision with a minimum of 30 hours of direct supervision in the required clinical areas (screening, assessment, and treatment planning; counseling services; service coordination, case management, and referral services; documentation; multicultural counseling, education, and professional ethics).

_____ _____
Clinical Training Program Director Date

_____
Printed Name

Address: _____

Phone: _____ Email Address: _____