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
505 Kansas City St., Rapid City, SD 57701
*Or email an electronic copy to board@ndbace.org*

# Individual Training Plan Request Form

**Prior to starting clinical training, you must complete this form and return it to the board office, along with an official 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.**

## 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 and requests approval to participate in an individualized training plan involving the following activities:

Facility _____ Clinical Supervisor _____

Type of training _____

_____

_____

Start and end dates of training _____

Facility _____ Clinical Supervisor _____

Type of training _____

Start and end dates of training _____

Rationale for needing an individualized training plan _____

**Submit an official copy of the trainee's transcript(s) verifying completion of the required academic coursework.**

| Academic Institution | Degree | Date Completed |
|---|---|---|
| | | |
| | | |
| | | |

_____ _____

Clinical Training Program Director Date

_____

Printed Name

Address: _____

Phone: _____ Email Address: _____