



**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

## Individual Training Plan Request Form

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

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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 \_\_\_\_\_

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Start and end dates of training \_\_\_\_\_

Rationale for needing an individualized training plan \_\_\_\_\_

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

Academic Institution	Degree	Date Completed
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_____	_____	_____
_____	_____	_____
_____	_____	_____

_____	_____
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Printed Name \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_