



The ACS certification is offered by the Center for Credentialing & Education.



CENTER FOR
**CREDENTIALING
& EDUCATION**™

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The Center for Credentialing & Education, Inc. (CCE) values diversity.
There are no barriers to certification on the basis of gender, race, creed, age, sexual orientation or national origin.



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Be sure to make copies of all your forms and documents before mailing your application. CCE will not return any forms or documents to you or to a third party once your application has been submitted.

WHAT IS AN APPROVED CLINICAL SUPERVISOR?

The ACS credential identifies to the mental health professions and to the public those professionals who have met advanced national professional supervision standards; promotes the professional identity, visibility and accountability of advanced clinical supervisors; and encourages the professional growth of advanced clinical supervisors.

ABOUT THE APPLICATION PROCESS

All applications are reviewed in the order of receipt within eight weeks and results will be sent via mail. Failure to include all required items (correctly completed) will result in the need for additional reviews. Each subsequent review will take eight weeks from the date of document receipt.

- Within 10 business days of receipt, CCE will mail a postcard verifying that the application has been received. **We ask that applicants not call to confirm receipt of application as time spent answering these inquiries slows the review process.**
- If additional documentation is needed for your application, CCE will contact you with details regarding the documentation needed and the deadline for submission. CCE reserves the right to request clarifying information as needed.

Once your application has been approved, CCE will mail you a confirmation letter and certificate.

If you have specific questions regarding the application and certification, contact CCE at:

CCE	Tel: 336-482-2856
3 Terrace Way	Fax: 336-482-2852
Greensboro, NC 27403-3660 USA	E-mail: cce@cce-global.org

Information about all of the credentials offered by CCE is available at www.cce-global.org.

ABOUT THE ACS CODE OF ETHICS

ACS applicants and certificants are responsible for ensuring that their behavior adheres to the standards identified in the ACS *Code of Ethics*.

An applicant must complete all portions of the ACS application, including the Ethics Certification and Attestation, and the Applicant Certification and Agreement/Release Authorization. Application disclosures and other ethics matters are reviewed in accordance with CCE procedure. Disclosures do not automatically render an individual ineligible for certification. CCE reserves the right to deny eligibility based on an ethics disclosure. Application fees are not refundable when an application is rejected.

The Credential Eligibility Policy Relating to Criminal or Lesser Offense Convictions and Other Disciplinary Matters, the *CCE Ethics Case Procedures* and the *ACS Code of Ethics* are available for your review on the CCE Web site at www.cce-global.org/Prof/Ethics.

REQUIREMENTS FOR STANDARD ENTRY TO ACS CERTIFICATION

1. Education:

A master's degree or higher in a mental health field. Degrees must be from a postsecondary educational institution or program accredited by an accrediting agency or state approval agency recognized by the U.S. Secretary of Education.

Please submit a copy of your (official or unofficial) transcript with your application. Copies of diplomas or Web printed transcripts will not be accepted.

Applicants with non-U.S. degrees:

All application materials must be submitted in English. If application materials are not available in English, applicants must arrange to have an English translation provided at their own expense. CCE accepts translations from University Language Services (www.universitylanguage.com). The translation must be forwarded directly to CCE by University Language Services.

2. Current Status as one of the following:

- a. NCC
- b. Licensed or Certified Mental Health Provider
- c. Licensed or Certified Clinical Supervisor

Please submit a copy license or credential along with your application.

3. Specialized Training:

An applicant must document completion of either of the following:

- a. A graduate course in clinical supervision, **OR**
- b. A total of 30 clock hours of workshop training in clinical supervision.

Clinical supervision training must be specific for supervisors or becoming supervisors. Courses in receiving clinical supervision will not be accepted.

Either A or B above must include, but is not limited to, each of the following content areas:

1. Roles and functions of clinical supervisors
2. Models of clinical supervision
3. Mental health-related professional development
4. Methods and techniques in clinical supervision
5. Supervisory relationship issues
6. Cultural issues in clinical supervision
7. Group supervision
8. Legal and ethical issues in clinical supervision
9. Evaluation of supervisee competence and the supervision process

4. Mental Health-Related Experience:

A minimum of three years of postmaster's experience in mental health services which must include at least 1,500 hours of direct service with clients is required. Doctoral-level practitioners/professionals can substitute one year of postmaster's work experience in mental health or mental health-related education for 300 hours of direct service with clients, up to a maximum of 900 hours. Doctoral-level internship(s) in mental health may also be used toward this requirement. Candidates must provide an official transcript verifying doctoral program internship. Experience may take place in any setting where direct clinical/mental health services are provided.

5. Supervision Experience/Endorsement:

- a. A minimum of 100 hours of clinical supervision of the mental health services provided to supervisees is required. Documentation of these hours must be completed by the designated clinical supervisor or mental health professional that can attest to the supervisory activity and endorse the applicant. The supervision may include individual and/or group supervision, with a maximum of ten members in a supervision group. Supervision of graduate students in training may be used to fulfill the requirement, **AND**
- b. Endorsement from a mental health professional attesting to clinical supervision capabilities must be completed (see page 11). The supervisor or endorser must be a National Certified Counselor (NCC) **OR** a licensed or certified mental health services provider (e.g. licensed professional counselor, licensed clinical social worker, licensed psychologist) **OR** a licensed or certified clinical supervisor. The supervisor/endorser must have training and/or experience in clinical supervision.

6. Self-Assessment and Professional Disclosure:

Candidates must submit a Professional Disclosure Statement. Candidates may submit the Disclosure Statement currently distributed to supervisees provided the 11 required areas listed below are addressed in the current statement. If the applicant is not currently employed in a supervisory capacity, the Disclosure Statement should be written as if the applicant is employed as a supervisor. If the supervisory responsibilities are an aspect of the applicant's employment (e.g. counselor educator), the statement should be written from that perspective. A Disclosure Statement will demonstrate an understanding of the multiple responsibilities of a clinical supervisor. It should include:

1. Business address and telephone number of the applicant pursuing the ACS credential;
2. The listing of degrees, credentials, and licenses held by the applicant for the ACS;
3. General areas of competence in mental health practice for which the applicant can provide supervision (e.g., Addictions counseling, career counseling);
4. A statement documenting applicant's training in supervision and experience in providing supervision;
5. A general statement addressing the applicant's model of or approach to supervision, including role of the supervisor, objectives and goals of supervision, and modalities (e.g., tape review, live observation);
6. A description of the evaluation procedures the applicant uses in the supervisory relationship;
7. A statement defining the limits and scope of confidentiality and privileged communication within the supervisory relationship;
8. A release, when applicable, indicating that the applicant is under supervision and that the supervisee may be discussed with the applicant's supervisor;
9. A fee schedule, if applicable;
10. Emergency contact information where the supervisee can reach the applicant in the event of an emergency;
11. A statement indicating that the applicant will follow the relevant credentialing body's *Code of Ethics* and the ACS *Code of Ethics* (available at www.cce-global.org).

Standard Entry applications must have their Professional Disclosure Statement reviewed by their endorser prior to submitting the application.

REQUIREMENTS FOR ALTERNATE ENTRY TO ACS CERTIFICATION

All candidates must hold a Master's degree (or higher) in a mental health field in order to be considered for the ACS certification.

Experienced supervisors may apply under the alternate requirements if they prepare and submit a Professional Disclosure Statement as outlined in Section 6 on page 5. In addition, they must currently be an NCC, a Licensed or Certified Mental Health Provider, or a Licensed or Certified Clinical Supervisor and also be ONE of the following:

- a. A mental health professional who can document at least three years of experience as a clinical supervisor and at least 500 hours providing clinical supervision to individuals and/or groups.
- b. An educator who is a mental health professional and can document at least two semesters of full time teaching in a mental health related program at a regionally-accredited institution. The educator's teaching assignments must include practicum or internship supervision courses, or related courses that require the educator to function as a clinical supervisor. Prior clinical supervision experience may be combined with current employment to meet this requirement.
- c. A doctoral candidate in a CACREP accredited program, who holds a Master's degree in a mental health field and is in the FINAL semester of doctoral studies, and who can document a minimum of two semesters of teaching assignments in practicum or internship supervision. Prior clinical supervision may be combined with current teaching assignments to meet this requirement. In addition, doctoral candidates must provide a transcript documenting successful completion of a clinical supervision graduate course.
- d. A mental health professional that possesses a recognized national or state credential in clinical supervision. To qualify under the option an applicant must include a copy of the active and current national or state credential. Credentials recognized include:
 - American Association for Marriage and Family Therapy: Approved Supervisor Designation
 - American Association of Pastoral Counselors: Certified Supervisors
 - British Association for Counselling and Psychotherapy: Counselling Supervisor Accreditation
 - NCCs who formerly held the designation of Clinical Supervisor through the Academy of Mental Health Counselors
 - Counselors who are currently licensed or certified as clinical supervisors by a state counselor credentialing board

SUBMITTING THE APPLICATION

Applications must include the application fee of \$110. The application fee is nonrefundable and nontransferable. Submission of an application and fee does not guarantee the ACS will be granted.

- Please use the most current application. (To ensure that you are using the most current form available, visit www.cce-global.org/ACS before submitting your application.)
- All application materials must be submitted in English. If application materials are not available in English, applicants must arrange to have an English translation provided at their own expense. Please see the Eligibility Requirements section for more information.
- All forms must include original signatures in blue ink. Photocopied or facsimile signatures will not be accepted.
- We recommend that all application materials be submitted to CCE in one packet.
- We recommend making copies of all unsealed application materials before submitting the originals to CCE.
- Review the checklist on the payment voucher to ensure your packet is complete before sending.
- Mail your application packet to CCE, P.O. Box 777759, Greensboro, NC 27417-7759.

RECERTIFICATION

All ACS certificates expire on August 31, five years following the year of initial certification. At that time, each certificate holder is required to recertify.

In order to recertify, ACS certificate holders must:

- Adhere to the ACS *Code of Ethics* (available at www.cce-global.org/Prof/Ethics).
- Complete 18 clock hours of continuing education during each five-year period of certification. Continuing education must be specific to clinical supervision. ACS certificate holders may include documentation of having received up to nine clock hours of supervision of their work as a clinical supervisor to partially fulfill the continuing education requirement.
- I agree that by submitting this form and/or payment to CCE I will complete the required continuing education and follow the ACS *Code of Ethics*. This attestation must be returned to CCE along with fees due.

Both must be received prior to the certification expiration date. CCE sends recertification notices with instruction, via postal mail during the year in which certification is due to expire. This notification is sent on July 15 of the recertification year along with the annual fee notice. ACS certificate holders who do not receive a recertification notice by August 1 during the year the certificate is due to expire should contact CCE right away. If CCE does not receive the signed recertification attestation and payment by the expiration date on the certificate, the individual's certification will expire. When an individual's certificate expires, a reinstatement application, \$50 reinstatement fee, documentation of 18 clock hours of continuing education, and full payment of any past due balance is required for reinstatement.

- Provide documentation of continuing education activities if selected for audit. Notification and instructions are included in the recertification notice of ACS certificate holders who are selected for audit.

FEES AND CREDENTIAL MAINTENANCE

Application Fee: \$110 USD

Fees are nonrefundable and nontransferable.

Annual maintenance fees: \$35 USD

The annual maintenance fee for certificate holders is \$35. CCE will send ACS certificants an annual statement on July 15 and ACSs must remit the fee by the August 31 to maintain certification.

If CCE does not receive payment by August 31, the individual's credential will become inactive. When an individual's credential becomes inactive, a reinstatement application, \$50 reinstatement fee, and full payment of past due balances are required before re-activation can occur.



PLEASE PRINT CLEARLY IN BLUE INK

1. First Name: _____

Last Name: _____

Previous name(s) used: _____

2. Preferred Mailing Address: _____

City, State/Province: _____

ZIP/Postal Code, Country: _____

3. Business Address (if different from above): _____

City, State/ Province: _____

ZIP/Postal Code, Country: _____

4. Home Telephone: _____

5. Business Telephone/Ext.: _____

6. E-mail: _____

Check here if you do NOT want your contact information and e-mail address shared CCE may publish the certificant's name, location and e-mail address on the GCDF Web site and will be sending updates/correspondence via e-mail in the near future. Please check if you do NOT want your e-mail address published.

7. Gender: Male Female

8. Date of Birth: _____
(mm/dd/yyyy)

9. How did you hear about the ACS credential? _____

10. Education/Degree (Please attach a copy of transcript(s)):

Highest Degree Earned	Date Degree Received	Major	Attendance Dates mm/yyyy to mm/yyyy	Institution Name and City/State

11. Licenses/Certifications (Please attach a copy of license/certificate). Use additional pages if necessary:

State	License/Certificate Type	License/Certificate Number	Issue Date	Expiration Date

MAIL TO:
Mail completed application packet and payment to:
CCE
PO Box 77759
Greensboro, NC 27417-7759
USA

FOR OFFICE USE ONLY
REF.#: _____
AMOUNT: _____
BATCH #: _____
DATE: _____

APPLICATION FOR APPROVED CLINICAL SUPERVISOR

12. Ethics Certification and Attestation (You must respond to each statement):

- | | | |
|--|------------------------------|-----------------------------|
| a. I understand that I am required to report in writing any changes concerning my responses to this application to CCE within sixty (60) days. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| b. I agree to act in accordance with the CCE policies including the Ethics Case Procedures and the ACS Code of Ethics. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| c. I have specifically identified to CCE all professional and occupational licenses and credentials. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| d. My past record is free of any charge or complaint related to governmental, regulatory or professional organizations. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| e. My past record is free of any charge or violation of any criminal or legal matter. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Note: Please provide a complete, detailed explanation of the circumstances related to “No” responses in items d or e above. You should also provide copies of the final disposition(s). Place the materials in a sealed envelope marked “ETHICS” and return with your application. Failure to provide required information will delay the processing of your application.

13. Applicant Certification and Agreement/Release Authorization:

I certify that the information provided in this application is accurate to the best of my knowledge.

I agree that CCE has the right to contact any person or organization in reviewing this application, and I authorize the release of any information requested by CCE to verify the accuracy of information provided. I further agree that CCE has the right to communicate with pertinent organizations about this application.

I understand that credentialing through CCE depends on my fulfillment of all required criteria including compliance with the ACS Code of Ethics. I understand that CCE certification does not create membership or other similar rights with CCE including the right to use CCE trademarks. I agree to comply with all CCE policies including my use of CCE designation marks.

I understand that certification through CCE is personal to me and may not be transferred to another individual or group. I also understand that any certification granted by CCE does not represent licensure or other authorization to practice business activities for a fee or otherwise. I release CCE and its representatives from all liability and claims arising from any occupational activity.

I agree to provide CCE with written notice within sixty (60) days of my knowledge the following:

- Any home or business address, telephone or email change
- Any modifications to this application
- Any formal charge or complaint related to a criminal or legal action
- Any other charge or complaint by a regulatory or professional organization related to my practice
- Any other court or governmental matter related to my occupational practice

I understand that professional biographical data and credential data is considered to be public information. I further agree that for research and statistical purposes only, data resulting from my participation in the CCE credentialing process may be used. I understand that all application materials become the property of CCE and that neither the originals nor photocopies will be returned.

In the event that my credential has a special sanction, I agree to comply with all directives of the CCE ethics office or the CCE Board of Directors.

Signature: _____ Date: _____

ORIGINAL SIGNATURES IN BLUE INK ONLY - COPIES WILL NOT BE ACCEPTED

Applicant's Name: _____ **Date:** _____

To qualify for the Approved Clinical Supervisor credential, you must have completed:

- A graduate course in clinical supervision, **OR**
- A total of 30 contact hours of workshop training in clinical supervision

The graduate course or workshop(s) must include each of the content areas listed below.

List below your graduate course(s) or workshop title(s) in clinical supervision. Indicate in which course/workshop each content area was covered. Include a copy of the transcript, certificate of attendance, or other documents verifying course completion.

Course or Workshop Title	Date Completed	Credit Hours/Clock Hours

Content areas:

Course or workshop title covering this area:

Roles and functions of a clinical supervisor _____

Models of clinical supervision _____

Professional development _____

Methods/techniques in clinical supervision _____

Supervisory relationship issues _____

Cultural issues in clinical supervision _____

Group supervision _____

Legal/ethical issues in clinical supervision _____

Evaluation of supervisee competence and the supervision process _____

Applicant's Name: _____

Note to Endorsers: You must be a current National Certified Counselor (NCC), a licensed/certified mental health provider or a licensed/certified clinical supervisor, and must have training in clinical supervision. If you do not meet these criteria, please return this form to the applicant so that s/he may ask someone else to complete it.

To the Center for Credentialing and Education:

I have been professionally acquainted with the named applicant and am not related to the applicant. To the best of my knowledge and belief, this applicant is of good standing in the profession, is of good moral character, and has demonstrated effective clinical supervision skills while under my supervision. I have read the Professional Disclosure Statement written by the applicant and attest to its accuracy. I hereby endorse this applicant to become an Approved Clinical Supervisor. I further affirm that I meet the criteria specified in the box above.

_____ Supervisor/Endorser Name (please print)	_____ Position Title
_____ Business Address	_____ Degree
_____ City, State, ZIP Code	_____ Telephone (include area code)
_____ Profession	_____ Professional Certification or License Number
_____ State or Certifying Organization	
_____ Applicant's Position	_____ Name of Agency/Institution

I verify that this applicant has provided _____ hours of clinical services with supervisees from _____ (mm/yyyy) to _____ (mm/yyyy).

Supervisor/Endorser's Signature: _____ Date: _____

Please offer other comments on the reverse of this sheet if necessary.

PHOTOCOPY THIS BLANK FORM AS NEEDED

Applicant's Name: _____

Request for Verification of Mental Health Practice Experience

I am applying to the Center for Credentialing & Education for the Approved Clinical Supervisor credential. I am required to provide documentation of three years of post-master's degree experience as a mental health practitioner which must include at least 1500 hours of direct services to clients. Please complete the EMPLOYER VERIFICATION INFORMATION below and return to me. My application cannot be processed without this form.

Applicant's Signature: _____ Date: _____

Employer Verification Information

TO BE COMPLETED BY THE EMPLOYER

This is to verify that _____ is/was employed by this agency/group for the period of _____ (mm/yyyy) to _____ (mm/yyyy) in the position of _____.

I verify that _____ total hours were spent providing direct mental health services to clients.

Employer's Signature: _____ Date: _____

Employer Information

Note: Information below pertains to the person completing the form on behalf of the ACS applicant. Please **print** your name on Line 1. Items 2 and 3 might not apply.

- 1. Name: _____
- 2. Degree: _____
- 3. Certified/Licensed By: _____
- 4. Title: _____
- 5. Agency/Institution: _____
- 6. Address: _____

- 7. Telephone: _____
- 8. E-mail: _____

Please offer other comments on the reverse of this sheet if necessary.

PHOTOCOPY THIS BLANK FORM AS NEEDED

Applicant's Name: _____

**Request for Verification of Professional Supervisory Experience
for Mental Health-Related Supervisors, Educators, & Doctoral Candidates**

I am applying for the Approved Clinical Supervisor credential. I am required to provide documentation of ONE of the following that primarily required me to perform the role of clinical supervisor. Please complete the VERIFICATION INFORMATION (A, B, or C) below and return to me. My application cannot be processed without this form.

Applicant's Signature: _____ Date: _____

Verification Information

A This is to verify that _____ is/was **employed by this agency/facility** for the period of _____ (mm/yyyy) to _____ (mm/yyyy) in the position of _____. His/her work assignments have included at least **three years of experience as clinical supervisor** and at least **500 hours of clinical supervision** of individuals or groups.

B This is to verify that _____ is/was **employed by this college/university** for the period of _____ (mm/yyyy) to _____ (mm/yyyy) in the position of _____. His/her teaching assignments have included at least **two semesters of mental health-related practicum or internship supervision or related courses** requiring him/her to **perform the role of clinical supervisor**.

C **(Applies only to doctoral candidates in a CACREP program)**
This is to verify that _____ is in the **final semester of doctoral study** at _____ (college/university). His/her teaching assignments have included at least **two semesters of mental health-related practicum or internship supervision or related courses requiring him/her to perform the role of clinical supervision**. **Doctoral candidates must provide a transcript documenting successful completion of a clinical supervision course.**

Supervisor Information

Information below pertains to the supervisor completing the form on behalf of the applicant. Please PRINT your name and contact information.

Name: _____ Degree: _____

Title: _____ Agency/Institution: _____

Certified/Licensed By: _____

Address: _____

Telephone: _____ E-mail: _____

Supervisor's Signature: _____ Date: _____

