

Addiction And Prevention Services

AAPS Credentialed Counselor

INFORMATION FORM

R03-302 (H) Each AAPS Counselor, Counselor Assistant and Counselor -in-Training must complete a basic information form as provided by AAPS for the purpose of data collection on those working in licensed substance abuse treatment centers.

All identifying personal information will be treated as **confidential**. AAPS will disclose your personal information, without notice, only if required to do so by law or in good faith belief that such action is necessary to conform to the edicts of the law or comply with legal process.

1.) I obtained my AAPS Credential by:

Grandfathering Completed 18 College hours Completed 27 college hrs + Associates Test-Out
Other

2.) I am currently working on my AAPS credential:

Completing 27 hours Plan to take the test

Please Print General Information

3.) Name _____ 4.) Birth Date _____ 5.) Male Female

6.) Home Address _____

7.) Home Telephone #() _____ 8.) City _____ 9.) State _____

10.) Zip _____ 11.) Home or Work E-mail _____

12.) Place of Employment _____

13.) Date Started ___/___/___ 14.) Work Address _____

15.) City _____ 16.) State _____ 17.) Zip _____ 18.) Work Telephone #() _____

19.) (Optional) What is your ethnicity?

African-American Asian-American European-American
Latino-American Hawaiian-Pacific Hispanic-American Multi-Ethnic-American
Native-American Other

Please Print Education Information

19.) What is your highest academic degree status? No H.S.Diploma H.S.Diploma or equivalent.
Some College Associates Bachelors Masters Ph.D Other

20.) College Major(s) _____

Credentialing

21.) Indicate type(s) of current or pending Certification and other License obtained

Board of Healing Arts
Board of Nursing
Behavioral Sciences Regulatory Board
National Association of Alcohol & Drug Abuse Counselors
Kansas Association of Addiction Professionals
International Certification & Reciprocity Consortium
Other

Work Experience

22.) What is your current discipline/profession? (check all that apply)

Addiction Counseling Counseling (other) Criminal Justice Medicine (primary care)
Nursing Psychology Social Work/Human Services Prevention
Local/State Government Agency Education Other (specify) _____

23.) What is your primary role at work? (check only one)

Management (supervisor, administrator)
Direct Services (counselor, assessment, intake)

How many total **years** of experience have you had in this role? _____

24.) How many **years** have you worked in the substance abuse treatment field? _____

25.) How many **years** have you worked in your current position? _____

Signature & Date

Signature _____ Date: ____/____/____

Mail to:
Kansas Association of Addiction Professionals
107 SW 6th Street Suite 200
Topeka, KS 66603