Request for Screening
Accelerated Addictions Counseling & Treatment Program (25HN)

College of Lake County

RETURN THIS FORM AND ALL REQUIRED DOCUMENTS TO:
Office of Registrar and Records
19351 West Washington Street • Grayslake • Illinois • 60030-1198
Phone: (847) 543-2061 • Fax: (847) 543-3061 • registrar@clcillinois.edu

The Accelerated Addiction Counseling & Treatment Program is an accelerated track of the Addiction Counseling & Treatment Certificate Program for individuals who have completed or are currently enrolled in a Master's Degree from an accredited clinical graduate program in Social Work, Counseling, Clinical Psychology, Human Services, or other clinical counseling-related field of study. Candidates who do not meet these requirements may be eligible for the Addiction Counseling & Treatment Certificate Program (Plan 25HG) or the AAS Addiction Counseling & Treatment (Plan 25HD).

Screening requirements should be completed prior to submitting this form.

Name:_____ CLC ID#_____

Former or Maiden Name:_____ Social Security #:_____

Address:_____ Phone: (_____)_____

_____ Admission for: ☐ Fall ☐ Spring Year:_____

I have submitted the following to the Admissions and Recruitment Office: (check the appropriate boxes)

A. Official transcript demonstrating Bachelor's degree completion ☐

B. Official transcript demonstrating Clinical Master's degree completion ☐

OR

Official transcript demonstrating current enrollment in a Clinical Master's degree program with at least 30 completed semester credits ☐

C. Degree and Course Information ☐

D. Internship/Practicum Information ☐

E. Signed Verification of 18 months of recovery or non-applicability (bottom of page) ☐

F. 2 Letters of Recommendation ☐

I have read and understand the information contained in this Screening Request form. I believe I am ready for screening consideration for admission to the Accelerated Addiction Counseling Treatment Program. I understand that if I am accepted into this program, my program of study will be updated for the term and year that I have indicated above, or the following term if accepted after the change of program deadline.

_____ _____
(Student Signature) (Date)

Signed Verification

I verify that I have no history of alcohol or other substance use or addictive disorders, or have been in recovery without relapse and out of treatment or correctional supervision for at least 18 months.

_____ _____
(Student Signature) (Date)

Updated 3/23/2017

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Degree and Course Information

Clinical Master's Degree: GPA _____

Type/Area	Institution	Credit Hours
_____	_____	_____
_____	_____	_____

Bachelor's Degree: GPA _____

Major	Institution	Credit Hours
_____	_____	_____
_____	_____	_____

Individual Counseling Courses:

Course Title and Number	Institution	Credit Hours
_____	_____	_____
_____	_____	_____

Group Counseling Courses:

Course Title and Number	Institution	Credit Hours
_____	_____	_____
_____	_____	_____

Diversity/Multi-Cultural Counseling Courses:

Course Title and Number	Institution	Credit Hours
_____	_____	_____
_____	_____	_____

Ethics Courses:

Course Title and Number	Institution	Credit Hours
_____	_____	_____
_____	_____	_____

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Internship/Practicum Information

Please submit documentation of Internship, such as evaluations, journals, assignments, process recordings, etc.

Course Title and Number	Institution	Credit Hours
_____	_____	_____
_____	_____	_____

Placement Agency: _____

Address: _____

_____

Supervisor: _____

Total Clock Hours: _____

Description of Internship Experience, Accomplishments, and Learning Outcomes:

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