NEBRASKA COMMISSION ON PROBLEM GAMBLING

700 S. 16th St., Lincoln NE 68508 (402) 471-4450

APPLICATION FOR CERTIFICATION AS A PROVISIONAL CERTIFIED DISORDERED GAMBLING COUNSELOR (PCDGC)

SECTION A - GENERAL INFORMATION

1. NAME: _____
   Last, First, Middle

2. HOME ADDRESS: _____
   Street City State Zip County

3. HOME PHONE: _____ 4. CELLULAR: _____

5. SOC SEC NO. _____ 6. DATE OF BIRTH: _____

7. FEMALE: ☐ MALE: ☐

8. EMAIL ADDRESS: _____

9. CURRENT EMPLOYER: _____

10. WORK ADDRESS: _____

11. WORK TELEPHONE: _____

12. Are you certified/licensed as a disordered gambling counselor nationally or in any other state?
    NO ☐ YES ☐ If yes, complete:
    State certified in: _____
    Certifying Entity: _____
    Address: _____
    Telephone No. _____
    Your Certification Title: _____

13. Has disciplinary action ever been taken on your license/certificate?
    NO ☐ YES ☐ If yes, complete:
    Date of Action: _____
    Type of Action: _____

14. Have you ever been convicted of a misdemeanor or a felony?
    NO ☐ YES ☐ If yes, complete:
    Crime Committed: _____
    Date of Conviction: _____
    Location of Court: _____

    Attach official court documents regarding circumstances of charges, disposition of the case, whether probation/parole has been completed (if applicable) and your current legal standing.

SECTION B - EDUCATION

Applicant shall present proof of compliance with the following requirements:

RECIPROCAL CERTIFICATION:

2-003.04 - An Applicant holding current certification issued by the National Council on Compulsive Gambling is eligible for certification in Nebraska by reciprocity, with no additional education or practicum requirements. **A copy of the active certificate shall be presented.**

1. Applicant shall have an Associate's degree (or higher) in human services or a related field.
   Check highest level completed:

   ☐ College Degree - Associate
   ☐ College Degree - Bachelor
   ☐ College Degree - Master
   ☐ College Degree - Doctorate

   Submit copies of proof of completion - diplomas or transcripts (Additional information may be required.)

UNIVERSITY AND COLLEGE (Undergraduate, Graduate, Doctorate)

2. Please complete the following information on any post secondary education completed by the applicant:

Name of School:			
Location:			
Major:		Minor:	
Degree Earned:		Date Issued:	

Name of School:			
Location:			
Major:		Minor:	
Degree Earned:		Date Issued:	

Name of School:			
Location:			
Major:		Minor:	
Degree Earned:		Date Issued:	

SPECIFIC EDUCATION CONTENT AREAS

3. Applicants must document seventy-two (72) hours of education related to the knowledge and skills of disordered gambling counseling.

   Verification of completion must be provided (copy of Bellevue University Certificate of Completion for the standard 60 hour disordered gambling course and additional 12 hours required by Nebraska

SECTION C - SUPERVISOR

Provide information on the person selected to act as your Practicum Supervisor:

Note - This person must be a supervisor certified by the Nebraska Commission on Problem Gambling
Attach proof of certification.

Practicum Supervisor:

NAME: _____ PHONE: _____

AGENCY: _____

WORK ADDRESS: _____
(Address)
_____
(City, State, Zip)

SECTION D - CODE OF ETHICS

Applicant must agree to subscribe and adhere to the following Code of Ethics:

1. Provide and support the highest quality of care in the recovery of all persons serviced which shall include referring, or releasing an individual to other health professionals or services, if that is in the individuals best interest.
2. Respect the unique characteristics of the professional counseling relationship which demands sound, non-exploitive inter-personal transactions between client and counselor.
3. Respect the therapeutic needs of the client by not engaging in a personal or sexual relationship with the client.
4. Respect the therapeutic needs of the client by not conducting any business or political transactions with the client, that may jeopardize their therapeutic needs.
5. Adhere to a strict policy of non-discrimination in the provision of services by not discriminating based on; race, disability, appearance, religion, age, sex, intelligence, sexual orientation, national origin, marital, economic, educational, or social status.
6. Respect the basic human rights of all clients including; their right to make their own decisions, to participate in any plans made in their interests, and to reject services unless a court order stipulates otherwise.
7. Adhere to the legal requirements for confidentiality of all records, materials, and communications, regarding clients, their families and significant others.
8. Assess their personal and professional strengths and limitations, biases and effectiveness on a continuing basis. Strive for self-improvement, and assume responsibility for professional growth through further education and training.
9. Respect the rights and views of fellow colleagues and members of other professions.
10. Refrain from the abuse of mood altering chemicals or gambling, in a manner that will reflect adversely on the credibility and integrity of the profession.
11. Report evidence of incompetent, unethical, unprofessional, or illegal practice of a certified disordered gambling counselor.

I have read and agree to be bound by this Code of Ethics.

_____

Signature (sign in blue ink) Date

SECTION E - AFFIDAVIT

Applicant must complete this section before a Notary Public.

STATE OF NEBRASKA)
) SS
COUNTY OF _____)

I, _____ (Applicant Legal Name)
being duly sworn, say that I am the person referred to in this application.

I hereby certify that all the information given herein is true and complete. I authorize any relevant investigations or the release of personal information to the Nebraska Commission on Problem Gambling, or its agents, pursuant to this application procedure. I understand that falsification of any portion of this application will result in my being denied certification, or revocation of same, upon discovery.

I further agree to hold the Nebraska Commission on Problem Gambling, its agents, employees, Certification Advisory Board members and examiners free from any civil liability for damages or complaints by reason of any action that is within the scope of the performance of their duties which may be taken in connection with the application and subsequent examinations and/or failure of the Nebraska Commisson on Problem Gambling to issue certification.

_____
Legal signature of Applicant (sign in blue ink)

Sworn before me this _____ day of _____, _____.

_____
Notary Public

(SEAL) My commission expires on: _____

SUBMIT APPLICATION TO:
Executive Director
Nebraska Commission on Problem Gambling
700 South 16th Street
Lincoln, NE 68508

ONLY ORIGINALS WILL BE ACCEPTED. SIGNATURES MUST BE IN BLUE INK.

PRACTICUM

An applicant shall complete a practicum that includes supervised disordered gambling counseling, working with diagnosed disordered gambling clients in the following counselor performance domains in a work setting:

ASSOCIATE'S DEGREE - 500 hours in the following:

- 100 hours minimum in the area of intake and assessment
- 100 hours minimum in the area of case management
- 200 hours minimum in the area of counseling
- 50 hours minimum in the area of client, family, and community education
- 50 hours minimum in the area of professional responsibility

BACHELOR'S DEGREE - 400 hours in the following:

- 80 hours minimum in the area of intake and assessment
- 80 hours minimum in the area of case management
- 160 hours minimum in the area of counseling
- 40 hours minimum in the area of client, family, and community education
- 40 hours minimum in the area of professional responsibility

MASTER'S DEGREE or State of Nebraska License in a mental or behavioral health field -

200 hours in the following:

- 40 hours minimum in the area of intake and assessment
- 40 hours minimum in the area of case management
- 80 hours minimum in the area of counseling
- 20 hours minimum in the area of client, family, and community education
- 20 hours minimum in the area of professional responsibility

Practicum hours must be documented on the "Verification and evaluation of Practicum" form and included with the application. Submit only originals. SIGNATURES MUST BE IN BLUE INK.

PRACTICUM SITE

Please complete the information below for your practicum site(s).

1. Type of Practicum:
   - ☐ Formal Post-Secondary Educational Program
   - ☐ Part of Work Experience (on-the-job)
   - ☐ Volunteer

2. Dates of Practicum: _____ _____ to _____ _____
   (Month/Year) (Month/Year)

3. Agency where Practicum occurred:
   _____
   (Agency Name)
   _____
   (Agency Program / Department / Division)
   _____
   (Address, City, State, Zip)

VERIFICATION OF HOURS

SUPERVISOR'S STATEMENT:

I hereby certify that I served as a Practicum Supervisor for disordered gambling counseling as documented and provided a minimum of one (1) hour of supervision for each ten (10) hours of performance.

for ______________________________ at ____

Applicant's name Name of Work Setting

from ___________________ to _____________________ The following recorded hours are accurate.

____ _______________

Signature of Supervisor (use blue ink) Date

Supervision Type: F - Face-to-face; O - Online T - Telephone U - Unsupervised

DOMAIN			DOMAIN			DOMAIN			DOMAIN			DOMAIN		
Intake and Assessment			Client, Family & Community Ed.			Professional Responsibility			Case Management			Counseling		
Min. Hours =			Min. Hours =			Min. Hours =			Min. Hours =			Min. Hours =		
Date	hr	type	Date	hr	type	Date	hr	type	Date	hr	type	Date	hr	type
Subtotal			Subtotal			Subtotal			Subtotal			Subtotal		

Supervision Type: F - Face-to-face; O - Online T - Telephon U - Unsupervised

DOMAIN			DOMAIN			DOMAIN			DOMAIN			DOMAIN		
Intake and Assessment			Client, Family & Community Ed.			Professional Responsibility			Case Management			Counseling		
Date	hr	type	Date	hr	type	Date	hr	type	Date	hr	type	Date	hr	type
TOTAL HOURS			**TOTAL HOURS**			**TOTAL HOURS**			**TOTAL HOURS**			**TOTAL HOURS**		

VERIFICATION AND EVALUATION OF PRACTICUM TRAINING

Applicant Name _____ SS # _____

Dear Practicum Supervisor:

I am applying to the Nebraska Commission on Problem Gambling for certification as a disordered gambling counselor.

Applicants must document a supervised training that includes performing required hours in the five performance domains.

I am entering the practicum phase with a _____ Degree in Education and therefore are required to perform the following minimum of hours in each domain:

_____ Hours in the area of Intake and Assessment
_____ Hours in the area of Case Management
_____ Hours in the area of Counseling
_____ Hours in the area of Client, Family, and Community Education
_____ Hours in the area of Professional Responsibility

There must be a minimum of one (1) hour of supervision for each ten (10) hours of performance. Verification of my Practicum training hours and an evaluation by my training supervisor is required.

Please return the completed verification and evaluation by _____ to the following address:

_____

_____ _____

Signature of Applicant (sign in blue ink) Date

Instructions to Application: Complete the information below and on the Practicum Record Sheet. List your performance dates and number of hours in each core function. List your hours in 15-minute increments with 15 minutes listed as .25 hours, 30 minutes as .50 hours, 45 minutes as .75 hours and one hour as 1.0 hours. Do not lump several dates together under a performance domain. Give this form to your practicum supervisor for verification. If your training occurred under more than one practicum supervisor, complete a separate form for each training.

Instructions to Practicum Supervisor: Review performance dates and hours listed by the applicant. If the information is accurate, sign the Supervisor's Statement and complete the evaluation section of this form. If the information is not accurate, return the unsigned form to the applicant.

Name of Practicum Supervisor: _____
Position Title of Practicum Supervisor: _____
Agency Where Training Occurred: _____
Agency Program/ Department/ Division _____
Address: _____
Address, City, State, Zip

Type of Training: ___ Post-Secondary Educational Program; ___ Part of Work Experience; ___ Volunteer

Dates of Training: _____ to _____
(Month / Year) (Month / Year)

Supervision Type: F - Face-to-face; O - Online T - Telephone U - Unsupervised

DOMAIN			DOMAIN			DOMAIN			DOMAIN			DOMAIN		
Intake and Assessment			Client, Family & Community Ed.			Professional Responsibility			Case Management			Counseling		
Date	hr	type	Date	hr	type	Date	hr	type	Date	hr	type	Date	hr	type
Subtotal			Subtotal			Subtotal			Subtotal			Subtotal		

Supervision Type: F - Face-to-face; O - Online T - Telephone U - Unsupervised

DOMAIN			DOMAIN			DOMAIN			DOMAIN			DOMAIN		
Intake and Assessment			Client, Family & Community Ed.			Professional Responsibility			Case Management			Counseling		
Date	hr	type	Date	hr	type	Date	hr	type	Date	hr	type	Date	hr	type
Subtotal			Subtotal			Subtotal			Subtotal			Subtotal		

This form is to be completed by the applicant's supervisor, printed and mailed to the address below.

NEBRASKA COMMISSION ON PROBLEM GAMBLING
GAMBLERS ASSISTANCE PROGRAM

Nebraska Commission on Problem Gambling
Attn: Executive Director
700 South 16th Street, Lincoln NE 68508

SUPERVISOR VERIFICATION AND EVALUATION FORM

Instructions to the Applicant: This form is to be filled out by your Commission approved clinical supervisor(s). Your responsibility is to fill out the application and carefully document your practicum or provisional work experience. Your supervisor must mail this form to the Commission after they have completed it. If you had multiple clinical supervisors, each must complete and submit this form.

Instructions to the Supervisor: Your supervision and evaluation of the quantity and quality of the applicant includes the monitoring of each performance hour as well as the overal clinical experience. Please complete this form and return to the Commission addressed above. **Do not return this form to the applicant.** Note that your responsibility is in the supervision of the performance hours, record keeping and clinical experience but not for the comletion of the application or additional forms on behalf of the applicant with the exception of this document.

SECTION A - PERSONAL INFORMATION

Name of Applicant: _____

Location of Practicum/Provisional Work Experience: _____

Applicant Dates of Employment: From_____ To _____

Total Hours: Completed, Supervised and Verified: _____

Name & Position of Supervisor: _____

Email Address: _____ Phone: _____

Work Address: _____

Supervisor Applicable Clinical Certificates and/or Licensures

1. Title & Number: _____ State or Organization:_____
   Issue & Expiration Dates:
2. Title & Number: _____ State or Organization:_____
   Issue & Expiration Dates:
3. Title & Number: _____ State or Organization:_____
   Issue & Expiration Dates:

Provide copies of certificates and/or licensures

Signature of Supervisor:_____ Date_____

Print name: _____

SECTION B - EVALUATION OF APPLICANT

Rate the applicant's performance in each area listed below. Check the number (1-5) that most nearly describes the applicant's ability in each area. Return the form to the Commission Executive Director. Please use the additional space in the rubric to comment on each specific area.

Use the following rate scale: 1 = Poor 2 = Less than Satisfactory 3 = Satisfactory 4 = Good 5 = Excellent

Knowledge / Skill Area	1	2	3	4	5
ORAL COMMUNICATION					
WRITTEN COMMUNICATION					
ACTIVE LISTENING					
APPROPRIATE SELF-DISCLOSURE					
EFFECTIVE CONFRONTATION					
RESPECTING CLIENTS AS INDIVIDUALS					
EXHIBITING GENUINENESS					
MOTIVATING CLIENTS TO PARTICIPATE IN TREATMENT					
SKILL IN SHARING ASSESSMENT FINDINGS WITH CLIENT AND WORKING THRU RESISTENCE					
CLARIFYING DYSFUNCTIONAL CLIENT BEHAVIOR AND ITS RAMIFICATIONS					
ABILITY TO SET APPROPRIATE BOUNDARIES					
CONDUCTING INITIAL SCREENING AND ONGOING CLIENT ASSESSMENT					
PROVIDING CLIENT INTAKE AND ORIENTATION					
DEVELOPING AND REVIEWING THE TREATMENT PLAN IN COLLABORATION WITH CLIENT					
INDIVIDUALIZING TREATMENT PLANS					
PROVIDING COUNSELING SERVICES IN ACCORDANCE WITH CLIENT NEEDS					
PROVIDING INDIVIDUAL COUNSELING					
PROVIDING CLIENT, FAMILY AND COMMUNITY EDUCATION					

Verification and Evaluation Form Continued

Knowledge / Skill Area	1	2	3	4	5
PROVIDING GROUP COUNSELING					
PROVIDING SERVICES TO SIGNIFICANT OTHERS					
APPLYING EFFECTIVE METHODS OF PROBLEM SOLVING, GOAL SETTING, AND DECISION MAKING					
IDENTIFYING CLIENT NEEDS BEST MET THRU REFERRAL TO OTHER COMMUNITY RESOURCES					
MAINTAINING ACCURATE AND TIMELY RECORDS: ASSESSMENTS/INTAKE/ TREATMENT/PLANS/NOTES/REFERRALS/DISCHARGE					
HANDING CLIENT RECORDS IN ACCORDANCE TO FEDERAL AND STATE REGULATIONS					
KNOWLEDGE OF FAMILY DYNAMICS AND INTERACTION					
KNOWLEDGE OF THE SIGNS AND SYMPTOMS OF PROBLEM/ PATHOLOGICAL GAMBLING					
ABILITY TO SCREEN FOR COMMON CO-MORBID DISORDERS					
ABILITY TO RECOGNIZE APPROPRIATE TREATEMENT MODALITIES FOR CLIENTS					
KNOWLEDGE OF PSYCHOLOGICAL FACTORS OF PROBLEM/ PATHOLOGICAL GAMBLING					
AWARENESS OF ISSUES BEYOND SCOPE OF PRACTICE AND ABILITY TO REFER					