NATIONAL CERTIFICATE IN TOBACCO TREATMENT PRACTICE (NCTTP) APPLICATION

I. Personal Information

Name: _____

Home Address: _____

City: _____ State/Province: _____

Country: _____ Zip Code: _____

Work Address: _____

City: _____ State/Province: _____

Country: _____ Zip Code: _____

Preferred Address: ☐ Home ☐ Work

Phone (work): _____ (cell): _____ Fax: _____

E-mail: _____

II. Payment/Fee Information

Application Fee: $ 150.00

☐ Check/Money Order (payable to NAADAC)

☐ Credit card ☐ Company card ☐ Personal card

☐ MasterCard ☐ Visa ☐ American Express

_____

Full name of card holder

_____ _____/_____

Credit card number *Expiration Date*

_____ ____/_____/_____

Signature *Date*

III. Eligibility/Application Requirements

STEP 1: Candidate must submit NCTTP application & supporting documentation for approval.

Candidate must:

1. Provide evidence of one of the following:

    a. High School diploma plus 4,000 hours (2 years full-time) of work in a human services work experience to be documented in Section VI of this application.
    b. Associate's Degree plus 2,000 hours (1 year full-time) of work in a human services work experience, to be documented in Section VI of this application.
    c. Bachelor's Degree or higher.

2. Provide a certificate of successful completion of a Tobacco Treatment Specialist training program that is accredited by the Council for Tobacco Treatment Training Program. A current list of accredited Tobacco Treatment Specialist training programs can be found at: http://ctttp.org/accredited-programs/.

3. Provide evidence documenting 240 hours of tobacco treatment practice experience following the completion of training. This experience must be completed within a two-year period. The application may be submitted before the 240 practice hours are completed in order to take the exam. All practice hours must be completed before the certificate will be awarded.
    a. If the candidate is in process of acquiring hours of practice, Section VII should be completed as much as possible, including description of tobacco treatment activities. Once practice hours are completed Section VII and Section I must be re-submitted by e-mail to ykouassi@naadac.org If the application is not complete with the 240 practice hours within two years from initial application, the applicant will need to resubmit a new application and fee of $150.

4. Attest to being tobacco-free (including use of electronic nicotine delivery devices such as vaping and e-cigarettes) for a minimum of the six months prior to submission of this application.

5. Adhere to the Tobacco Treatment Provider Code of Ethics and sign a statement that he or she has read and adheres to the Tobacco Treatment Provider Code of Ethics.

6. Must mail application and all supporting documents with the non-refundable application fee of $150 to:

    NAADAC
    National Certificate in Tobacco Treatment Practice
    44 Canal Center Plaza, Suite 301
    Alexandria, VA 22314

STEP 2: Candidate must pass the NCTTP examination within one year of the NCTTP application approval. However, the exam may be taken BEFORE the 240 practice hours are completed.

- Upon approval of NCTTP application, NAADAC will send candidate instructions for taking the NCTTP examination. Candidate will pay for the testing fee with the testing company at the time of registering for the NCTTP exam.
- Upon receiving notification of candidate's exam score from the testing company, NAADAC will notify the candidate of results by e-mail.
- NAADAC will mail out the candidate's national certificate after the candidate receives a passing score on the NCTTP exam, the practice hours have been completed, and the full NCTTP application has been approved.

NOTE: You may test before you complete the 240 Practice hours. If you are in the process of acquiring practice hours, complete Section VII as much as possible and describe your tobacco treatment activities.

IV. History of State/National/International Issued Professional Credential(s) and/or License(s)

List each credential/license you have held or currently hold. Attach additional pages if necessary.

Credential/License	State/Authority/Board	Expiration Date	Number
		____/____/____	
		____/____/____	
		____/____/____	
		____/____/____	

V. History of Education

A copy of your official diploma of the highest education level completed must be submitted with this application.

	School Name / Area of Study	Date of Graduation
High School	School: _____	____/____/____
Associate's Degree	School: _____ Area of Study: _____	____/____/____
Bachelor's Degree	School: _____ Area of Study: _____	____/____/____
Master's Degree	School: _____ Area of Study: _____	____/____/____
Post Graduate	School: _____ Area of Study: _____	____/____/____

VI. Human Services Work History

Human services is broadly defined as interpersonal work involved with meeting objectives associated with human needs. These needs can be focused on the prevention as well as the remediation of problems, or improving the overall quality of life of service populations.

If your highest level of education is less than a Bachelor's Degree, please provide your human services work history. Start with your current position first and work backwards. Attach additional pages as needed.

Current Employer: _____

Address: _____

Job title: _____

Position held from: (*month/year*) _____ to: (*month/year)* _____

Full-time ☐ Part-time ☐ Total number of hours worked: _____

Supervisor's Name: _____ Phone: _____

Supervisor's email address: _____

Brief job description:

Previous Employer: _____

Address: _____

Job title: _____

Position held from: (*month/year*) _____ to: (*month/year)* _____

Full-time ☐ Part-time ☐ Total number of hours worked: _____

Supervisor's Name: _____ Phone: _____

Supervisor's email address: _____

Brief job description:

Previous Employer: _____

Address: _____

Job title: _____

Position held from: (*month/year*) _____ to: (*month/year)* _____

Full-time ☐ Part-time ☐ Total number of hours worked: _____

Supervisor's Name: _____ Phone: _____

Supervisor's email address: _____

Brief job description:

VII. Documentation of Tobacco Treatment Practice Experience

1. Document the settings in which you obtained your tobacco treatment practice hours and the total number of tobacco treatment practice hours that you have successfully completed after you have completed a Tobacco Treatment Specialist training program accredited by the Council for Tobacco Treatment Training Programs.
2. Initial each of the Tobacco Treatment Core Competencies that you have demonstrated while conducting these tobacco treatment practice hours.
3. A colleague or supervisor must attest to the fact that you have completed these post-training practice hours and that you have performed responsibly and ethically.
4. If you are in the process of acquiring the 240 practice hours, please complete this section as much as possible and describe your tobacco treatment activities. After your hours are complete, you must resubmit Section I and Section VII by e-mail to ykouassi@naadac.org.

Attach additional pages as needed.

Setting: _____

Address: _____

Job title: _____

Total number of tobacco treatment practice hours: _____

Hours completed from: (*month/day/year*) _____ to: (*month/day/year)* _____

Supervisor's / Colleague's Name: _____ Phone: _____

Supervisor's / Colleague's email address: _____

Brief description of tobacco treatment activities:

Setting: _____

Address: _____

Job title: _____

Total number of tobacco treatment practice hours: _____

Hours completed from: (*month/day/year*) _____to: (*month/day/year)* _____

Supervisor's / Colleague's Name: _____ Phone: _____

Supervisor's / Colleague's email address: _____

Brief description of tobacco treatment activities:

TOBACCO TREATMENT PRACTICE CORE COMPETENCIES

☐ 1. **Tobacco Dependence Knowledge and Education**: Provide clear and accurate information about tobacco use, strategies for quitting, the scope of the health impact on the population, the causes and consequences of tobacco use.

☐ 2. **Counseling Skills:** Demonstrate effective application of counseling theories and strategies to establish a collaborative relationship, and to facilitate client involvement in treatment and commitment to change.

☐ 3. **Assessment Interview**: Conduct an assessment interview to obtain comprehensive and accurate data needed for treatment planning.

☐ 4. **Treatment Planning**: Demonstrate the ability to develop an individualized treatment plan using evidence-based treatment strategies.

☐ 5. **Pharmacotherapy**: Provide clear and accurate information about pharmacotherapy options available and their therapeutic use.

☐ 6. **Relapse Prevention:** Offer methods to reduce relapse and provide ongoing support for tobacco-dependent persons.

☐ 7. **Diversity and Specific Health Issues:** Demonstrate competence in working with population subgroups and those who have specific health issues.

☐ 8. **Documentation and Evaluation:** Describe and use methods for tracking individual progress, record keeping, program documentation, outcome measurement and reporting.

☐ 9. **Professional Resources:** Utilize resources available for client support and for professional education or consultation.

☐ 10. **Law and Ethics**: Consistently use a code of ethics and adhere to government regulations specific to the health care or work-site setting.

☐ 11. **Professional Development**: Assume responsibility for continued professional development and contributing to the development of others.

COLLEGUE OR SUPERVISOR ATTESTATION
(to be signed after at least 240 hours of practice)

I verify that this candidate has completed _____hours of tobacco treatment practice from ___/___/___ to ___/___/___ and has performed responsibly, ethically and completed their practice hours.

_____ _____
Supervisor or Colleague's Signature Date

_____ _____
Supervisor or Colleague's Name (*please print*) Phone

VIII. Candidate's Attestation

I certify that I meet the eligibility requirements for the National Certificate in Tobacco Treatment Practice, and that the information in this application and its supporting documents is accurate, correct and complete. I also certify that I have not been subject to criminal and/or ethical adjudication. NAADAC, the Association for Addiction Professionals is authorized to contact any institution, organization or individual listed on or included with this application for verification of my work experience and employment history. I understand that the NAADAC retains ownership of the NCTTP certificate and may, from time to time, make available certificate holder names and other information to potential service users.

_____ _____

Candidate's Signature Date

IX. Tobacco-Free Attestation

I verify that for at least the six-months prior to submitting this application I have not used any tobacco products including electronic nicotine delivery devices such as e-cigarettes or nicotine vaporizers:

_____ _____

Candidate's Signature Date

X. NCTTP Examination Passage Required

I understand that I must pass the NCTTP examination within one year of my application approval date in order to receive my NCTTP certificate. If I do not pass the NCTTP examination during this time period, I understand that I will need to submit a new NCTTP application with a new $150 application fee.

_____ _____

Candidate's Signature Date

XI. Tobacco Treatment Provider Code of Ethics

Purpose: This code of ethics is intended to guide the practice of Tobacco Treatment Providers. We recognize that Tobacco Treatment Providers are also members of other professional disciplines and will be guided by the code of ethics from these professions as well.

Tobacco Treatment Providers strive to maintain the highest level of professional competence as well as ethical professional and personal conduct. A Tobacco Treatment Provider agrees to all of the following:

1) Tobacco Treatment Providers respect the privacy, dignity, perspectives, and cultures of all individuals, and ensure fair and equitable treatment for all patients.

2) Tobacco Treatment Providers observe principles and organizational policies regarding informed consent and confidentiality of individuals.

3) Tobacco Treatment Providers provide patients with all the relevant and accurate information and resources they need to make well-informed decisions regarding tobacco use and the treatment for tobacco dependence.

4) Tobacco Treatment Providers accurately represent their capabilities, education, training and experience, and act within the boundaries of professional competence.

5) Tobacco Treatment Providers are truthful in dealings with the public and never misrepresent or exaggerate potential treatment benefits or services.

6) Tobacco Treatment Providers avoid activities which may be or may be perceived to be a conflict of interest or unethical in nature.

7) Tobacco Treatment Providers fulfill their professional obligation to maintain the highest possible level of competence through continued study and training as required to maintain their certification.

8) Tobacco Treatment Providers are tobacco-free. This includes no use of e-cigarettes or vaporizers, which are classified as tobacco products. If a Tobacco Treatment Provider begins using tobacco, they must a) discontinue the provision of tobacco treatment until they are again tobacco and vape free, b) engage in evidence-based tobacco treatment, and c) only resume provision of tobacco treatment once they are again tobacco-free.

I hereby attest that I have read, understand, and will adhere to the Tobacco Treatment Provider Code of Ethics.

_____ _____

Candidate's Signature Date

PROVIDING ANY OR ALL OF THE FOLLOWING INFORMATION WILL HAVE NO EFFECT ON THE EVALUATION OF YOUR APPLICATION.

The information requested below is necessary for NAADAC and ATTUD to accurately portray the demographic profile of our certificate holders as we meet with decision-makers to promote the reimbursement of services by qualified tobacco treatment providers.

Please circle the appropriate letter.

1. Primary job function:

a. Counselor
b. Clinical Supervisor
c. Program/Service Manager
d. Administrator/CEO
e. Health Education/Health Promotion Professional
f. Medical Care Provider
g. Program Director (Describe in the space provided below.)
h. Other
i. None

Program Director: _____

_____

2. Work Setting:

a. College or University
b. Community Health Center
c. Dental Practice
d. Health Education Program
e. Hospital or Medical Center
f. Mental Health Clinic
g. Public Health
h. Substance Use Disorders Facility
i. Voluntary or Social Service Agency
j. Wellness Program
k. Youth/Schools
l. Other (Describe in the space provided below.)
m. Prefer not to answer

Other Work Setting(s): _____

_____

3. Years of experience in tobacco treatment:

a. 0-1 year
b. 2-3 years
c. 4-5 years
d. 6-10 years
e. 11-15 years
f. 16 plus years
g. Prefer not to answer

4. Hours a week conducting tobacco treatment:

a. None
b. Less than 2 hours
c. 3-7 hours
d. 8-16 hours
e. 17-24 hours
f. 25-32 hours
g. 33-40 hours
h. 40 plus hours
i. Prefer not to answer.

5. Highest completed education:

a. High school diploma/equivalent
b. Associate's Degree/2-year degree
c. Bachelor's Degree
d. Master's Degree
e. Doctoral Degree/equivalent
f. Prefer not to answer

6. Currently enrolled in a degree program in a college/university?

a. Yes
b. No

7. Identified Gender:

a. Male
b. Female
c. Other
d. Prefer not to answer

8. Are you Hispanic or Latino?

a. Yes
b. No

9. Certified and/or licensed in your state?

a. Certified
b. Licensed
c. Certified and Licensed
d. Not certified or licensed

10. License/Certification held:

a. Administrator
b. Certified Health Education Specialist
c. Psychologist-Doctoral
d. Psychologist – Non-Doctoral
e. Dentist
f. Dental Hygienist
g. Dental Assistant
h. Health Educator
i. Mental Health Counselor/Specialist (Non-Doctoral)
j. Advanced Nursing Practice Provider
k. Nurse Practitioner
l. Nurse RN
m. Nurse MSN
n. Pharmacist
o. Physician – General or Family Practice
p. Physician – Specialist
q. Respiratory Therapy
r. Social Work
s. Substance Use Disorders Counselor
t. Traditional or Complementary Medical Professionals (acupuncture, naturopath, homeopath)
u. Other (Describe in the space provided below.)
v. Prefer not to answer

Other license(s)/certification(s): _____

_____

11. Why are you applying for the National Certificate in Tobacco Treatment Practice?

- ☐ a. I want to treat tobacco users.
- ☐ b. My organization is forcing me to.
- ☐ c. I want to get certified.
- ☐ d. I want to learn more about the field of tobacco treatment.
- ☐ e. I want to do research.
- ☐ f. To evaluate treatment program outcomes

12. What (if any) professional organizations are you a member of?

_____

_____

_____

_____

13. How do you identify your race/ethnicity?

- ☐ a. American Indian or Alaska Native
- ☐ b. Asian
- ☐ c. Black or African American
- ☐ d. Native Hawaiian or Other Pacific Islander
- ☐ e. White
- ☐ f. Unknown
- ☐ g. Other
- ☐ h. Prefer not to answer.

14. Decade of birth: _____

Candidate's Checklist

- ☐ Completed Personal information. (Section I)
- ☐ Included check/money order or provided credit card information (NAADAC has a no refund policy for incomplete applications.) (Section II)
- ☐ Enclosed copy of CTTTP certificate. (Section III)
- ☐ Completed History of Credential(s)/License(s). (Section IV)
- ☐ Completed History of Education section. (Section V)
- ☐ Completed Human Services Work History. (Section VI)
- ☐ Completed Documentation of Tobacco Treatment Practice Experience and my Supervisor or Colleague has verified my hours of tobacco treatment. (Section VII)
- ☐ Completed Candidate's Attestation. (Section VIII)
- ☐ Completed Tobacco-Free Attestation. (Section IX)
- ☐ Signed statement that candidate understands that passage of the NCTTP examination within one year of the application approval date is required in order to receive the NCTTP certificate. (Section X)
- ☐ Signed statement that candidate has read, understands, and will adhere to the Tobacco Treatment Provider Code of Ethics. (Section XI)

Application **must** be mailed to the address below:

NAADAC
ATTN: NCTTP
44 Canal Center Plaza, Suite 301
Alexandria, VA 22314