

# **CBACC DELINEATION OF RESPONSIBILITIES (S.5)**

*To be completed by a California Board Approved Clinical Consultant*

## **DO NOT RETURN THIS FORM TO THE APPLICANT**

Applicant's Name: \_\_\_\_\_

**BACC** - Please indicate the percent of employee/volunteer times spent on the duties listed below as completed by the applicant during an average 40 hour work week. Please rank, in the performance column, the applicant's ability to perform the following duties, using the following scale:

**0** - Don't Know, **1** - Poor, **2** - Average, and **3** - Above Average

<u>Duties</u>	<u>% of Time</u>	<u>Performance</u>
1. Outreach	_____	_____
2. Assessment	_____	_____
3. Intake	_____	_____
4. Individual Counseling	_____	_____
5. Family Counseling	_____	_____
6. Group Counseling	_____	_____
7. Client Education	_____	_____
8. Referrals to Other Resources	_____	_____
9. Client Record Keeping	_____	_____
10. Aftercare Services	_____	_____
11. Client Follow-up	_____	_____
12. Administrative Responsibilities	_____	_____
13. Community Activities ( <i>lectures, workshops, etc.</i> )	_____	_____
14. Research	_____	_____
15. Program Management	_____	_____
16. Medical Recommendations and Treatment	_____	_____
17. Other (specify): _____	_____	_____

Total time spent, weekly on duties: \_\_\_\_\_

\_\_\_\_\_ I have reservations of applicant meeting CCGC standards. (State reasons on the back of this form.)

Name and title of Clinical Consultant (*please print*): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Return this form (**S.5**) along with the **S.4** and **S.6** forms DIRECTLY to:

California Gambling Counselor Certification Board  
41690 Ivy St., Suite A7 ♦ Murrieta, CA 92562  
Phone (714) 765-5804 ♦ Fax (951) 266-0072