FORM (S.5) – BACC INFORMATION

CONFIDENTIAL

To be completed by IGCCB Board Approved Clinical Consultant

DO NOT RETURN THIS FORM TO THE APPLICANT

Applicant's Name: ____

Name and Title of BACC (please print): ____

Address: ____

Employer: ____

Position: ____

Email Address: __________________________Phone Number: _____________________

Please check the box(es) below that describe the workplace setting in which you supervise the applicant, and the population being served:

- ☐ Full time (applicant)
- ☐ Part time (applicant)
- ☐ Residential
- ☐ Out-patient
- ☐ Substance Use Disorder Treatment Program
- ☐ Program gambling treatment only
- ☐ Mental Health Agency
- ☐ Hospital
- ☐ Concurrent disorder program
- ☐ Prison Program
- ☐ Private Practice
- ☐ Disordered Gambling Integrated Program
- ☐ Youth
- ☐ Older Adults
- ☐ Other: ____

BACC's Signature: _________________________ **Date:** ______/_______/______

Return forms **S.5, S.6, S.7, and S.8** DIRECTLY to:

International Gambling Counselor Certification Board
730 11th Street, NW Suite 601 ◆ Washington DC 20001