# FORM (S.6) – BACC EVALUATION
# CONFIDENTIAL

*To be completed by IGCCB Board Approved Clinical Consultant*

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

**Applicant's Name:** _____

The information I am giving is my best judgment of the above named person's capabilities with respect to certification as a gambling counselor or co-occurring gambling specialist.

I hereby certify that I have been in a position to observe and have first-hand knowledge of the above named person's work during the period from _____ to _____.

**(month/year)** **(month/year)**

The applicant is applying for: ICOGS ☐ ICGC-I ☐ or ICGC-II ☐

The applicant has a total of:

☐ 100 counseling hours for Co-occurring Gambling Specialist (ICOGS)

☐ 100 paid/unpaid counseling hours for Level I gambling certification

☐ 2000 paid/unpaid counseling hours for Level II gambling certification

Based on my knowledge of this applicant's eligibility and professional experience:

☐ To my knowledge, the applicant **does** meet the below requirements:

☐ To my knowledge, the applicant **does not** meet the below requirements at this time

Direct contact hours for ICGC I and II include counseling activities provided for individuals with primary or secondary gambling disorder and/or their families/concerned others (may include ancillary activities such as clinical documentation, treatment team meetings, case management, etc.).

Direct contact hours for ICOGS include counseling activities that address gambling problems and/or the impact of gambling on recovery among clients with primary substance use or mental health disorders.

For more details on definition of direct contact hours and other certification criteria see www.igccb.org.

**Comments**:

_____

_____

_____

_____

**Name and title of BACC (please print):** _____

**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***