BREINING INSTITUTE
8894 GREENBACK LANE • ORANGEVALE, CALIFORNIA USA 95662-4019 • TELEPHONE (916) 987-2007

Advanced Credential for the Addiction Professional

# Medication-Assisted Treatment Counselor (MATC) Credential

The Medication-Assisted Treatment Counselor (MATC) credential is available to individuals with an underlying addiction professional license or certification and advanced experience as a medication-assisted treatment counselor, when they meet the MATC standards, document their eligibility, and either pass the multiple-choice on-line exam or complete MATC Education Course.

**There are no application fees to be granted the MATC, although you will need to pass the on-line MATC Exam or complete the MATC Education Course.**

Breining Institute is a private college and nationally-accredited certification institution, and has been dedicated to higher education, training, testing and certification for addiction professionals since 1986.

## ELIGIBILITY

**CURRENT CERTIFICATION OR LICENSE**
Must hold current addiction professional license or certification from an accredited, State-approved or nationally-recognized licensure or certifying agency

**EXPERIENCE**
One year full time (2,000 hours) clinical experience as a medication-assisted treatment counselor
Three years full time or 6,000 hours general clinical experience in alcohol and other drug (AOD) addiction counseling (may include MAT counseling)

**EXAMINATION**
Must receive passing score on the Breining Institute multiple-choice MATC Exam

**EXAM WAIVED IF COMPLETE 40-hour MATC EDUCATION COURSE**
Complete the 3-part, 40-hour training course related specifically to MAT competencies:
Part 1: Foundation Areas, Pharmacology, Screening, Assessment (10 hours)
Part 2: Counseling and Referral, Special Populations (15 hours)
Part 3: Effectiveness of Opioid Maintenance Treatment, Ethics (15 hours)

**PROFESSIONAL REFERENCES**
One reference from a supervisor of your work, or from a colleague in the same field; AND
Two references from professionals in the field of addictions who know of your work

**RENEWAL REQUIREMENT**
Every two years
Must maintain underlying professional license or certification
Minimum of 6 hours continuing education (CE) in medication-assisted treatment competencies

APPLICATION for the

# Medication-Assisted Treatment Counselor (MATC) Credential

Breining Institute • 8894 Greenback Lane • Orangevale, California USA 95662-4019 • Telephone (916) 987-2007 • Facsimile (916) 987-8823

**SECTION 1.** Please type or print all of your information clearly. Incomplete applications will not be processed.

First Name

Middle Name

Last Name

Address (Number, Street, Apartment or Suite Number)

City

State (or Province)

USA Zip Code

Country (other than USA)

Country Code

Primary Telephone Number (including Area Code)

Secondary Telephone Number (including Area Code)

Pager Number (including Area Code)

Facsimile Number (including Area Code)

E-mail Address

**SECTION 2.** This information is for verification purposes. Please print your information clearly.

Social Security Number (last 4 numbers only)

Date of Birth (Month-Day-Year)

Male Female

**SECTION 3. REQUIRED DOCUMENTATION**.

MATC EXAMINATION OR MATC EDUCATION COURSE

- ❑ Copy of MATC Exam Completion Certificate, which documents that you passed the MATC exam; OR
- ❑ Documentation of completing all three parts of the on-line MATC 40-hour Education Course.

EXPERIENCE

- ❑ MAT Clinical Experience documentation: Use one "Section 5" page for each employer or volunteer agency.
- ❑ General alcohol and other drug (AOD) Clinical Experience: Use one "Section 6" page for each employer or volunteer agency.
- ❑ General alcohol and other drug (AOD) Clinical Experience substitute, if applicable: Use one "Section 7" page for each educational institution.

REFERENCES

- ❑ Three Professional References: Use one "Section 8" page for each reference. Be sure to include one supervisor and two other references.

CODE OF ETHICS

- ❑ Signed Code of Ethics: Sign and date the Code of Ethics located at the "Section 9" page.

PHOTOGRAPH

- ❑ Current photograph, with your full name written on back.

COPY OF CURRENT ADDICTION PROFESSIONAL LICENSE OR CERTIFICATE

- ❑ Copy of State-approved, accredited or nationally-recognized license or certification related to the field must accompany application. May include medical doctors, psychologists, marriage and family therapists, registered nurses, and similar licensed and/or certified professionals working in the health care field.


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**SECTION 4.** DOCUMENTATION OF SUCCESSFUL COMPLETION OF MATC EXAM OR 40-HOUR MATC COURSE

You are required to provide documentation of completing either the MATC examination, or the 40-hour MATC Education Course. Both the examination and Education Course are available on-line, and you should have received a completion certificate upon your successfully passing and paying for the exam(s). Please include copies of those completion certificate(s) at this Section 4.

Place

Completion Certificates for either the

MATC Exam

or

MATC Education Course

here


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**SECTION 5.** MAT CLINICAL EXPERIENCE (**please duplicate this page for each different employer or volunteer agency**)

- You will need to document a minimum of 2,000 hours (one year) of clinical experience as a medication-assisted treatment counselor.

Applicant Name

Your Title or Position with the Agency / Organization

Name of Supervisor

Title / Position of Supervisor

Agency / Organization

Address (Number, Street, Apartment or Suite Number)

City

State (or Province)

USA Zip Code

Country (other than USA)

Country Code

Agency's Main Telephone Number (including Area Code)

Supervisor's Direct Telephone Number (including Area Code)

E-mail Address

Web Site Address

**Dates and hours associated with medication-assisted treatment activities within this organization (full time equals 2,000 hours/year):**

| **From:** | | **To:** | | **Total Hours:** | |
|---|---|---|---|---|---|
| | Month / Year | | Month / Year | | Approximate |

**Job Description:**

**Attestation of Agency / Organization Representative: I attest the above information is true and correct.**

Printed name of Agency Representative | Signature | Date


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**SECTION 6.** GENERAL AOD CLINICAL EXPERIENCE (**please duplicate this page for each different employer or volunteer agency**)

- You will need to document 6,000 hours (three years) of clinical experience as an alcohol or other drug (AOD) or addiction counselor.
- You may **substitute up to 4,000 hours of your general clinical experience** with experience teaching in an AOD program (see **Section 7**).

Applicant Name

Your Title or Position with the Agency / Organization

Name of Supervisor

Title / Position of Supervisor

Agency / Organization

Address (Number, Street, Apartment or Suite Number)

City

State (or Province)

USA Zip Code

Country (other than USA)

Country Code

Agency's Main Telephone Number (including Area Code)

Supervisor's Direct Telephone Number (including Area Code)

E-mail Address

Web Site Address

**Dates and hours associated with AOD counseling activities within this organization (full time equals 2,000 hours per year):**

| **From:** | | **To:** | | **Total Hours:** | |
|---|---|---|---|---|---|
| | Month / Year | | Month / Year | | Approximate |

**Job Description:**

**Attestation of Agency / Organization Representative: I attest the above information is true and correct.**

Printed name of Agency Representative | Signature | Date


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**SECTION 7.** CLINICAL EXPERIENCE SUBSTITUTE (**please duplicate this page for each different educational institution**)

Complete this section if you are seeking to substitute or supplement the General AOD Clinical Experience requirement (identified in **Section 6**) with your experience teaching a course or courses within the healing arts or related field at an approved or accredited institution of higher learning. You may substitute ten (10) hours of Clinical Experience for each hour of class that you have taught. (PLEASE NOTE: MUST HAVE A MINIMUM OF 2,000 HOURS – or 1 YEAR – OF ACTUAL CLINICAL MEDICATION-ASSISTED TREATMENT EXPERIENCE.)

Applicant Name

Your Title or Position at Educational Institution

Name of Supervisor or Department Head

Title / Position of Supervisor or Department Head

Educational Institution

Address (Number, Street, Apartment or Suite Number)

City

State (or Province)

USA Zip Code

Country (other than USA)

Country Code

Institution's Main Telephone Number (including Area Code)

Supervisor's Direct Telephone Number (including Area Code)

E-mail Address

Web Site Address

**Course Name(s) dates, and hours taught at this institution:**

| Course Title(s) | Dates that course(s) were taught | | | | Hours / class | Total classes | Total hours |
|---|---|---|---|---|---|---|---|
| | From: | | To: | | | | |
| | From: | | To: | | | | |
| | From: | | To: | | | | |
| | From: | | To: | | | | |
| | From: | | To: | | | | |
| | From: | | To: | | | | |

**Attestation of Educational Institution Representative: I attest the above information is true and correct.**

Printed name of Institution Representative  Signature  Date


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**SECTION 8.** PROFESSIONAL REFERENCES (**please duplicate this page for each reference**)

A total of three references from professionals in the field of addictions who can attest to your proficiency in the field:

- One reference must be from a supervisor of your work, or from a colleague in the healing arts field; **AND**
- Two references must be from professionals in the general field of addictions, who know of your work in the field.

Applicant Name

Name of Professional Reference

Relationship of Professional Reference to Applicant (Supervisor, Colleague or Addiction Professional)

Title / Position of Reference

Agency / Organization

Address (Number, Street, Apartment or Suite Number)

City

State (or Province)

USA Zip Code

Country (other than USA)

Country Code

Agency's Main Telephone Number (including Area Code)

Reference's Direct Telephone Number (including Area Code)

E-mail Address

Web Site Address

**Please explain why you believe that the Applicant should be awarded the Medication-Assisted Treatment Counselor Credential:**

Printed name of Professional Reference

Signature

Date



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**SECTION 9.** CODE OF ETHICS

Sign this Code of Ethics at the space provided below.

**Medication-Assisted Treatment Counselor (MATC) Credential**

**CODE OF ETHICS**

As a Medication-Assisted Treatment Counselor, I will comply with this Code of Ethics and do affirm:

- ❑ That my primary goal is recovery for the client and the client's family.
- ❑ That I have a total commitment to provide the highest quality of care to those who seek my professional services. That I shall not provide services beyond the terms and conditions of my professional certifications and/or licenses.
- ❑ That I shall evidence a genuine interest in all my clients, and do hereby dedicate myself to the best interest of my clients and to help them help themselves.
- ❑ That I shall maintain at all times an objective, professional relationship with all of my clients. I shall not engage in social or business relationships with my clients for my personal gain.
- ❑ That I shall be willing to recognize when it is in the best interests of my clients to release and refer them to another program or another helping individual.
- ❑ That I shall adhere to the Rule of Confidentiality with regard to all records, material and knowledge concerning my client, and shall protect his/her rights to confidentiality in accord with Code of Federal Regulations, Title 42 sections 2.1 through 2.67(1) and any other applicable regulations.
- ❑ That I shall cooperate with complaint investigation and supply information requested during such complaint investigations, subject to the confidentiality provisions cited above.
- ❑ That I shall not in any way discriminate between clients or fellow professionals on the basis of race, religion, age, gender, disability, national ancestry, sexual orientation or economic condition.
- ❑ That I shall respect the rights and views of my fellow Medication Assisted Treatment Counselors and other professionals. I will not verbally, physically or sexually harass, threaten, or abuse any program participant, patient, client or fellow addiction professional.
- ❑ That I shall maintain respect for institutional policies and management within agencies, and will take the initiative toward improvement of such policies and management when it will better serve the interests of my clients.
- ❑ That I have a continuing commitment to assess my own personal strengths, limitations, biases and effectiveness.
- ❑ That I shall continuously strive for self-improvement and professional growth through further education and training.
- ❑ That I have an individual responsibility for my own conduct in all areas, including, but not limited to, the use of mood-altering drugs. I shall not provide counseling or education services while under the influence of any amount of alcohol or illicit drugs (not including drugs or medication prescribed by a physician or other person authorized to prescribe drugs, used in the dosage and frequency prescribed; nor including over-the-counter medications used in the dosage and frequency described on the box, bottle or package insert).
- ❑ That I have an individual responsibility for myself in regard to sexual conduct and/or contact with clients, and shall not engage in sexual conduct with current program participants, patients or clients.
- ❑ These things I pledge to my professional peers and to my client.
- ❑ I hereby pledge to comply with this Code of Ethics, as well as to comply with a consistent code of conduct that may be applicable to a recovery or treatment program with which I may be affiliated.

Print name | Signature | Date


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**SECTION 10.** PHOTOGRAPH

Include a recent photograph of yourself. This photo will be used by Breining Institute to identify you. Write your full name on the back of the photo, which may be any size between 1" x 2" and 8" x 10". We will keep your photo in your file, and it will not be returned.

**SECTION 11.** PREVIOUS CERTIFICATION STATEMENT

Have you had a prior certification or licensure as an alcohol or drug counselor revoked? ❑ YES ❑ NO

If yes, please explain: _____

**SECTION 12.** DOCUMENTATION. Please check all that are applicable to your Application:

**Currently licensed or certified professional**

❑ **I attest that I am a currently licensed and/or certified addiction professional:**

Expiration date of current license or certificate (Month – Day – Year)

Title of license or certificate

License or certification number

Name of licensing or certifying agency

Web site address of licensing or certifying agency

**Documentation included with this Application (please check all that apply)**

❑ Copy of MATC Exam Completion Certificate.
❑ Copies of MATC Education Course Completion Certificates.
❑ MAT Clinical Experience documentation: Use one "Section 5" page for each employer or volunteer agency.
❑ General AOD Clinical Experience documentation: Use one "Section 6" page for each employer or volunteer agency.
❑ Clinical Experience Substitute documentation, if applicable: Use one "Section 7" page for each educational institution.
❑ Three Professional References: Use one "Section 8" page for each reference. Be sure to include one supervisor and two other references.
❑ Signed Code of Ethics: Sign and date the Code of Ethics located at the "Section 9" page.
❑ Current photograph, with your full name written on back.
❑ Copy of current addiction professional license or certificate.

**ATTESTATION OF INFORMATION AND DOCUMENTATION**

The undersigned Applicant declares that the information provided in the Application and within the supporting documentation is true and authentic. I intend to comply with the provisions of the Medication-Assisted Treatment Counselor (MATC) Code of Ethics. The Applicant understands that if at any time it is shown that the information or documentation provided is not true or is misrepresented, any fees which have been paid will be forfeited by Applicant, and certification as an MATC may be revoked.

_____ _____

Signature Date

**Return this completed Application and supporting Documentation by postal mail, fax or e-mail to:**

Breining Institute
8894 Greenback Lane
Orangevale, California USA 95662-4019
Fax: 916-987-8823
E-mail: College@Breining.edu

Questions?
Please call us at 916-987-2007

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