

SAM BROWNBACK
Governor

MAX L. FOSTER, JR..
Executive Director



700 S.W. Harrison St. Ste 420
Topeka, Kansas 66603-3929
(785) 296-3240
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www.ksbsrb.ks.gov

INSTRUCTIONS FOR LICENSURE APPLICATION THROUGH RECIPROCITY (LAC)

1. Before you begin to complete the application form enclosed herein, please read all instructions and review the statutes and regulations so that you will understand exactly what information is being requested. The statutes and regulations can be found on our website, www.ksbsrb.ks.gov. **Your must hold an active license in another state to apply for licensure through reciprocity.**
2. This application is for the Licensed Addiction Counselor (LAC). This is not a clinical level of licensure and does not allow for the diagnosis of substance use disorders. Please review the statutes and regulations for a detailed explanation of the levels of licensure as well as requirements for licensure. If you meet the requirements and wish to be licensed at the clinical level (LCAC), which allows for the diagnosis of substance use disorders. Please download and complete the Application through Reciprocity for LCAC.
3. Answer all questions on the application completely and accurately. The burden of proof in satisfying to the Board that you are eligible for licensure is upon you.
4. The \$100.00 application fee must accompany your application. Your check or money order should be made payable to "Behavioral Sciences Regulatory Board" or "BSRB". You may also pay by credit card. **ALL FEES ARE NON-REFUNDABLE.**
5. As part of the application process, you are required send **Attachment A = Out-Of-State Clearance form** to each of the licensing boards or jurisdictions you hold, or have held, a professional license, certificate, or registration. The licensing agency should complete the form and return it directly to the Board office.
6. **Routes for Reciprocity**

Route 1) Standards of your state's requirements are substantially equivalent to Kansas requirements for licensure as an addiction counselor. See L. 2010, ch. 45 and L. 2011, ch.114 beginning with Sec.10. Detailed requirements may be found in the regulations, which may be found on our website.

Route 2) A. Continuous registration, certification or licensure to practice addiction counseling during the five years immediately preceding the date of your application for reciprocity with Kansas. This must include the minimum professional experience required by the Board.

- Minimum professional experience is determined to be at least 15 hours of work experience per week for 9 months during each of the 5 years immediately preceding the date of application. Submit Attachment B attesting to your professional work experience.

B. Absence of disciplinary action of a serious nature brought by a registration, certification or licensing Board. This will be attested to on Attachment A and should be completed by your licensing agency.

C. (i) At least a baccalaureate degree in addiction counseling or a degree from a regionally accredited university or college; **or**

(ii) At least a baccalaureate degree in a related field, approved by the Board, from a regionally accredited university or college with all required coursework completed. You will use Attachment D to show the required coursework that you completed. Please ensure an official transcript is sent directly from your university or college to the Board office. Transcripts sent from the applicant cannot be accepted.

Allow 30 days for review of your application. Please **check the status of your application on our website** www.ksbsrb.ks.gov, under "*Applicants.*"

Application Checklist

When you submit your application to the Board office the following items should be included:

- The completed application form;
- If you are applying using Route 2 – Attachment B and if your degree is in a related field Attachment C;
- \$100.00 application fee

Please submit a complete application so that your application will not have to be returned.

These additional items need to be sent directly to the Board office by the appropriate institutions:

- Attachment A = Out-of-State Clearance form, submitted directly by any state or jurisdiction which you hold or have held a license, registration, or certification;
- Transcript(s) showing your degree and any additional coursework you have completed, sent directly from the university or college to the Board.

Allow 30 days for review of your application. Please **check the status of your application on our website www.ksbsrb.ks.gov**, under “Applicants.”

The Board office will contact you by mail, email, or phone regarding the status of your application. Be sure the Board office has current contact information on file for you. It is the applicant's responsibility to notify the Board in writing of any name or address change that might occur during the application process.

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LICENSURE APPLICATION THROUGH RECIPROCITY (LAC)

Application Fee Required: \$100 check, money order or credit card made payable to BSRB

This application is only for applicants who are licensed, registered, or certified in another state to practice addiction counseling and are applying under the reciprocity statute.

I. Identifying information: (Please type or print clearly in ink)

Legal Name: _____
Last First Middle

Maiden/Other names used: _____ Gender: _____

Date of Birth: _____ Social Security Number: _____ (Note: Your social security number is required pursuant to 42 U.S.C.S. § 666(a)(13), K.S.A. 74-148 and K.S.A. 74-139, and may be used for child support enforcement purposes or provided to the Kansas director of taxation upon request.)

Preferred E-Mail Address: _____ Preferred Mailing: Home _____ Business _____

Home Phone: _____ Cell Phone (optional): _____

Home Address: _____ Apartment Number: _____

City: _____ State: _____ Zip+4: _____

Business Phone: _____ Business Name: _____

Business Address: _____ Suite Number: _____

City: _____ State: _____ Zip+4: _____

Address of Record: (Note: The address of record is not required. It is a separate address that will be kept on file to be given out when requested by the public through the Kansas Open Records Act. If you do not indicate an address of record, your preferred mailing address will be used.)

Street Address: _____

City: _____ State: _____ Zip+4: _____

II. Information on Previous Licensure:

A. Do you currently hold a certificate, registration or license to practice in addiction counseling in another state or jurisdiction? Yes _____ No _____

If "yes", please answer the following questions:

- Under what name: _____
- For which state: _____ License Number: _____
- For which credential: _____ Is this a clinical level? Yes _____ No _____
- Does this credential allow you to practice independently, including the diagnosis and treatment of substance use disorders? Yes _____ No _____
- Date Issued: _____ Expiration Date: _____
- Was this continuous licensure? Yes _____ No _____
If no, what period of time where you NOT licensed: _____

B. Have you ever filed any application for licensure or registration in Kansas? Yes____ No____
If "yes", please answer the following questions:

1. Under what name: _____

2. When: _____ For which credential: _____

We must receive an Out-Of-State Clearance form from all states in which you hold or have held a license, registration, or certification. This is not limited to addiction counseling.

III. Merit of the Public Trust:

Please answer the following questions. **Note: If you answer "Yes" to any of the following 10 questions, you are required to submit as part of your application a signed, dated type-written explanation that gives specific details including disposition of the matter.**

1. Have you ever been charged with or convicted of a felony or misdemeanor other than a traffic violation?
Yes____ No____
2. Have you ever had a complaint filed with a professional association or a certifying, licensing, or registering body against you for alleged unethical behavior or unprofessional conduct?
Yes____ No____
3. Have you ever had disciplinary action taken against you for unethical behavior, unprofessional conduct or any other grounds?
Yes____ No____
4. Have you used any alcohol, narcotic, barbiturate other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent within the last 2 years?
Yes____ No____
5. Have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice behavioral sciences with reasonable skill and safety within the past 2 years?
Yes____ No____
7. Have you used controlled substances which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the direction of a licensed health care provider within the past 2 years?
Yes____ No____
8. Has any state, jurisdiction, providence, or professional organization denied your application for credentials or professional membership?
Yes____ No____
9. Have you ever been sued for malpractice, or agreed to pay a settlement in a malpractice suit?
Yes____ No____
10. Has any governmental agency ever substantiated allegations made against you for physical, mental or emotional abuse or neglect, sexual abuse, or exploitation of (1) a child, (2) a resident of an adult care home, medical care facility, psychiatric hospital or state institution for the mentally retarded, or (3) an adult?
Yes____ No____

IV. Educational Qualifications:

A. Transcript(s):

All transcripts must be sent directly from your college or university to the Board office. The Board cannot accept any transcripts received from the applicant.

Route 1) You are required to provide verification of your degree. This may be verified by the licensing agency in your state or jurisdiction on the Out-Of-State Clearance form. However, if the licensing agency will not provide this information you are required to have an official transcript(s) submitted to the Board office.

Route 2) If your degree is in addiction counseling you are required to provide verification of your degree This may be verified by the licensing agency in your state or jurisdiction on the Out-Of-State Clearance form. However, if the licensing agency will not provide this information you are required to have an official transcript(s) submitted to the Board office; or

If your degree is in a related field you are required to have an official transcript(s) submitted to the Board office. This will be used to verify your degree as well as the required coursework.

B. List all colleges or universities you have attended and at what level:

INSTITUTION	DATES OF ATTENDANCE From - To	MAJOR/AREA OF CONCENTRATION	DEGREE RECEIVED	DATE DEGREE CONFERRED

C. Give other name(s) under which your coursework was taken or your degree was conferred, if different from the name you use now:

VI. Examination:

Did you complete the national Examination for your profession? Yes ___ No ___

If you answered "yes" please answer the following:

1. Name of examination: _____ Who Administers the examination: _____
2. What level of examination did you complete: _____
3. Through what state or jurisdiction: _____ Date exam was taken: _____
4. Did you pass in your jurisdiction? Yes ___ No ___ Score Received: _____

Be sure to request verification of your passing score on Attachment A or scores may be sent to the Board office directly from the examination service.

VIII. Applicant's Attestation:

- A. I have reviewed the licensure eligibility requirements prior to submitting this application. Yes ___ No ___
- B. I have completed the application materials and procedures honestly and in good faith. Yes ___ No ___
- C. I understand that the members and staff of BSRB are compelled by law to uphold, implement and enforce the licensure statutes and regulations as written. Yes ___ No ___
- D. I understand that all state records pertaining to application and licensure may be used to conduct research or program evaluation, but any such research will not personally identify the applicants or licensees, either directly or indirectly. Yes ___ No ___
- E. I understand that the Board has the statutory authority to refuse to grant licensure to, or may suspend, revoke, condition, limit, qualify, or restrict the license of any individual that has knowingly made a false statement on a BSRB form required for licensure or licensure renewal. Yes ___ No ___
- F. I **have read** and am familiar with the appropriate statutes and regulations governing the practice of the professional license for which I am applying. Yes ___ No ___
- G. I understand that **once the Board receives my application I am bound by, and will abide by, the statutes and regulations** governing the profession of the license for which I am applying Yes ___ No ___

Signature: _____ Date: _____

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APPLICATION FOR LICENSURE THROUGH RECIPROCITY

Attachment A - Out-of-State Clearance Form

Instructions:

Section 1 is to be completed by the applicant and sent to the state or jurisdiction in which a license, registration, or certification is held or has been held. Additional copies of this form may be made and used as needed by the applicant. Section 2 is to be completed by a representative of your licensing board and returned directly to the Behavioral Sciences Regulatory Board.

I. SECTION 1: This section is to be completed by the applicant:

- A. Name: _____
- B. Social Security #: _____ Date of Birth: _____
- C. Maiden or other name in which license was issued: _____
- D. Type of Credential held in the other state _____
- E. Type or Field of Practice: _____
- F. License Number: _____
- G. Date of Issuance: _____
- H. Date of Expiration: _____
- I. Level of Licensure (Baccalaureate, Masters, Doctorate): _____
- J. Current licensing requirements to be submitted with out of state clearance form ? **Yes** ____ **No** ____
If you are applying for licensure through "substantially equivalent" licensing requirements, your current licensing agency will need to provide current licensing requirements with this form.

II. SECTION 2: This section is to be completed by the State Board. Upon completion, please return this form to: **BSRB, 700 S.W. Harrison St., Ste. 420, Topeka, KS 66603-3929.**

- A. Type of Credential (please circle applicable designation): Licensure ____ Registration ____ Certification ____
- B. Type or Field of Practice: _____
- C. Lic/Reg/Cert Title _____ Lic/Reg/Cert Number: _____
- D. Date Issued: _____ Date of Expiration: _____
- E. Did license ever lapse or expire prior to date of expiration listed in letter "D"? **Yes** ____ **No** ____
If yes, please explain _____
- F. Level of Lic/Reg/Cert (Baccalaureate, Masters, Doctorate): _____
- G. Does this license allow independent practice including the diagnosis and treatment of substance use disorders?
Yes ____ **No** ____
- H. Is Lic/Reg/Cert in Good Standing? **Yes** ____ **No** ____ If "no", please state reason(s):

I. Has the Lic/Reg/Cert ever been suspended or revoked? **Yes**____ **No**____ If **“yes”**, please state reason(s):

J. Has the Lic/Reg/Cert ever been surrendered voluntarily in lieu of an investigation? **Yes**____ **No**____
If **“yes”**, please explain:

K. Degree Received _____ Major _____ Date Degree Received _____

L. University or Institution of where degree was completed _____

M. Current licensing requirements are attached with this clearance form? **Yes** ____ **No** _____

N. Examination Information:

Name of examination taken? _____

Who Administered the examination? _____

What level of examination did the licensee complete ? _____

Through what state or jurisdiction _____ Date exam was taken _____

Required score to pass? _____ Score Received _____ Passed? **Yes** __ **No** __

N. Additional Comments:

Signature of State Board Representative: _____ Date: _____

Printed Name: _____

Official Title/Position: _____

State or Jurisdiction: _____

Agency: _____

Mailing Address: _____

Phone Number: _____ Fax Number: _____

Email Address: _____



APPLICATION FOR LICENSURE THROUGH RECIPROCITY
Attachment B - ATTESTATION OF PROFESSIONAL PRACTICE IN ADDICTION COUNSELING

I. Please complete the following information:

Applicant Name: _____

Lic/Reg/Cert Type: _____ Lic/Reg/Cert #: _____

I _____, attest that I have engaged the professional practice of addiction counseling an average of at least 15 hours per week for 9 months during each of the 5 years immediately preceding the date of this application for licensure through reciprocity.

Please provide the requested information for each work site you where you have practiced during the five years immediately preceding the date of this application. Attach an additional sheet if necessary.

Business Name: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Dates and Hours Worked at This Site: _____
Start Date End Date Number of hours worked per week

Business Name: _____

Business Name: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Dates and Hours Worked at This Site: _____
Start Date End Date Number of hours worked per week

Business Name: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Dates and Hours Worked at This Site: _____
Start Date End Date Number of hours worked per week

II. Signature

Signature of Applicant: _____ Date: _____

Printed Name: _____



**APPLICATION FOR LICENSURE THROUGH RECIPROCITY
Attachment C- ACADEMIC BACKGROUND FORM**

Name: _____ **Date:** _____

If you hold a degree in a related field you must show proof of completing the required coursework found in K.A.R. 102-7-3(c).

Please indicate the courses you completed that meet these requirements. Courses cannot be duplicated. If the relationship between the courses(s) you took and the course content category is not readily apparent, please attach course syllabus or the university's course catalog to this form.

The following activities shall **NOT** be reported, substituted for or counted toward the academic coursework requirements:

1. academic coursework that has a failing or incomplete grade;
2. academic coursework that was audited;
3. continuing education, in-service, or on-the-job training;
4. nonacademic coursework or training;

Note: A maximum of three semester credit hours or academic equivalent may be completed in independent study. If your college or university awarded quarter or trimester credit hours rather than semester hours, please indicate by putting a Q (for quarter hours) or a T (for trimester hours) adjacent to the reported number of credit hours throughout the form.

A minimum of three semester credit hours are required in categories one through eight. A minimum of six hours is required in category nine.

1. **Addiction Treatment** which shall include studies in the philosophies, practices, policies and outcomes of the most generally accepted, culturally sensitive, and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems.

Course #	Course Title	Credit Hrs	University
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. **Methods of Individual Counseling** which shall include studies utilizing culturally sensitive, evidence-based approaches to individual counseling.

Course #	Course Title	Credit Hrs	University
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. **Methods of Group Counseling** which shall include studies utilizing culturally sensitive, evidence-based approaches to group counseling.

Course #	Course Title	Credit Hrs	University
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. **Pharmacology** which shall include the study of behavioral, psychological, physical, and social effects of psychoactive substances.

Course #	Course Title	Credit Hrs	University
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. **Co-Occurring Disorders** which shall include studies of an understanding of terms, service delivery systems, assessment, and strategies for working with clients with co-occurring disorders.

Course #	Course Title	Credit Hrs	University
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. **Addiction Services Coordination** which shall include studies of the established diagnostic criteria for substance use disorders for culturally sensitive screening, assessment, treatment planning, referrals, service coordination, documentation, and consultation.

Course #	Course Title	Credit Hrs	University
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. **Legal and Ethical Issues** which shall include studies of the ethical, legal and culturally sensitive behavioral standards of conduct for the addiction counselor.

Course #	Course Title	Credit Hrs	University
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. **Family and Community Studies** which shall include studies of the importance of family, social networks, community systems and the development of cultural competence in the treatment and recovery process.

Course #	Course Title	Credit Hrs	University
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

9. **Practicum, or its equivalent** is a supervised experience that integrates didactic learning that is related to substance use disorders with practical experience.

Course #	Course Title	Credit Hrs	University
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Credit Card Payment Form

Only complete when paying by credit card.

The credit cards accepted are American Express, Discover, MasterCard and Visa.

Amount of Purchase: \$ _____

Credit Card: American Express _____ Discover _____
MasterCard _____ Visa _____

Credit Card Acct. # _____

Credit Card Expiration Date ____ / ____

Name as it appears on the card _____

Signature: _____ Date _____

For Office Use Only:

Approval Number _____ Date _____