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## Training Plan Amendment – New/Additional Work Site Addiction Counseling

This form should only be used if you have an approved training plan on file with the BSRB and you have changed work sites or are adding an additional work site.

### I. Information regarding supervisee:

Name \_\_\_\_\_ LAC/LMAC Number \_\_\_\_\_  
Home Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ (Optional)  
Email \_\_\_\_\_

### II. Information regarding the new/additional employment site:

A. Submit the supervisee's official position description, for this work site, with the amendment.

B. Is this a new work site or an additional work site? \_\_\_\_\_

C. End date of employment from previously approved training plan work site: \_\_\_\_\_

D. Date new/additional employment began: \_\_\_\_\_

E. Name of Agency and address where the supervisee will be accruing hours towards the LCAC

Agency \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

Title of supervisee's position in this supervised setting \_\_\_\_\_

Will you be working at any time outside the State of Kansas? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, is your clinical supervisor clinically licensed in the state in which you will be working? Yes \_\_\_\_\_ No \_\_\_\_\_

F. Will the supervisee be involved in the process of diagnosing clients? Yes \_\_\_\_\_ No \_\_\_\_\_

**\*\*If answer is yes, please describe how. \*\***

