

**CLINICAL ADDICTION COUNSELING LICENSURE  
APPLICATION FOR CURRENTLY LICENSED BSRB CLINICAL/INDEPENDENT PRACTITIONERS**

*Instructions*

This form may only be completed if you hold a LP, LSCSW, LCPC, LCP or LCMFT in the State of Kansas.

You must submit a complete application, which includes the following materials, or your application will be returned to you.

Please read all instructions and review the statutes and regulations, before beginning to complete the application. The statutes and regulations may be found on our website, [www.ksbsrb.ks.gov](http://www.ksbsrb.ks.gov).

1. **Application:** Answer all questions on the application completely and accurately. If you answer yes to any questions in section VI, Background Information, additional information will be requested.
2. **Fee:** The \$50.00 application fee must accompany your application. Make check or money order payable to "Behavioral Sciences Regulatory Board" or "BSRB". Credit card or cash, for the exact amount, are also accepted. **ALL FEES ARE NON-REFUNDABLE.**
3. **Attestation:** An attestation form from a Kansas licensed professional is required as part of your complete application packet.
  - a) The completed attestation should be returned to you in a sealed envelope with the signature across the seal. Include it with the application submitted to the Board office. **NOTE: The attesting licensee must sign across the seal of the envelope or your application will be returned. (see example below)**
  - b) The attesting licensee must be authorized to engage in the practice of diagnosis and treatment of mental disorders and/or substance use disorders at the independent level.
  - c) The attesting licensee must be able to attest to your competency to diagnose and treat substance use disorders.
4. **Review:** The Board cannot determine whether you are eligible for a license until all of the application materials have been received and approved by the Board office.

Please allow 30 days for review of your application. **When your application has been reviewed you will be notified of your eligibility by mail or email.**

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

- The completed and signed application form.
- The application fee of \$50.00 made payable to BSRB by cash, check, money order, or credit card.
- The completed Attestation form. (in a sealed, signed envelope)

Behavioral Sciences Regulatory Board  
700 SW Harrison St. Suite 420  
Topeka, KS 66603-3929  
Max L. Foster, Jr., Executive Director



Phone: 785-296-3240  
Fax: 785-296-3112  
[www.ksbsrb.ks.gov](http://www.ksbsrb.ks.gov)  
Laura Kelly, Governor

**CLINICAL ADDICTION COUNSELING LICENSURE  
APPLICATION FOR CURRENTLY LICENSED BSRB CLINICAL PRACTITIONERS**  
*Application*

You are eligible only if you hold a LP, LSCSW, LCPC, LCP or LCMFT in the State of Kansas.

**Application Fee: \$50.00 cash, credit card, check, or money order payable to BSRB**

**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 Name:** \_\_\_\_\_ **Business Phone:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_

**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:** \_\_\_\_\_

**\*\*Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP)\*\***

Are you willing to be included on a registry of potential volunteers to provide your professional services during an emergency? **Please check all that apply.**

Within your county of residence: \_\_\_\_\_ Within 75 miles of your residence: \_\_\_\_\_  
Anywhere in the State of Kansas: \_\_\_\_\_ Outside of the State of Kansas: \_\_\_\_\_

**II. Application/Licensure Information:**

Provide the following information regarding your clinical licensure:

- A. Type of BSRB clinical license: \_\_\_\_\_
- B. Issue Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
(attach additional sheet if needed)
- C. Under what name:  
\_\_\_\_\_

**III. Proof of Competency for the Clinical Level of License: Attestation from a person who holds a clinical/independent level.**

Provide the required information below for the licensee who is completing the attestation:

- A. Name: \_\_\_\_\_
- B. License Type: \_\_\_\_\_ License Number: \_\_\_\_\_

**IV. Background Information: (Please circle yes or no)**

Circle either “yes” or “no” to the following questions. **If you answer “yes,”** please attach a detailed written explanation. Additionally, if you have been convicted of a crime a criminal background check will be required. See the instruction page for more information.

1. Have you ever been convicted of a felony?  
**Yes No**
2. Have you ever been convicted of a misdemeanor crime against persons?  
**Yes No**
3. Have you ever been found guilty of or liable for fraud or deceit in connection with services rendered as an addiction counseling service provider by a civil or criminal court of law or board of a professional organization?  
**Yes No**
4. Have you ever knowingly aided or abetted a person, not a licensed addiction counselor, in representing him/her as a licensed addiction counselor?  
**Yes No**
5. 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**
6. 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. Have you ever been found to be in violation of a professional association’s code of ethics or of a state licensing board’s rules and regulations or statutes regarding professional conduct?  
**Yes No**
9. Have you ever paid a judgment or settlement in a negligence action that concerned your addiction counselor profession?  
**Yes No**
10. Have you ever resigned from a professional association, withdrawn from an undergraduate or graduate program or surrendered your license to a state licensure board while an ethical complaint was pending against you?  
**Yes No**

11. Have you ever identified yourself as an addiction counselor in Kansas (excluding student work)?  
**Yes No**
12. 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**

**VIII. Applicant's Attestation:**

Please **circle** either "yes" or "no" to the following questions.

1. I have reviewed the licensure eligibility requirements prior to submitting this application.  
**Yes No**
2. I have completed the application materials and procedures honestly and in good faith.  
**Yes No**
3. I understand that the members and staff of the BSRB are compelled by law to uphold, implement, and enforce the licensure statutes and regulations as written.  
**Yes No**
4. I understand that all state records pertaining to application and licensure may be used to conduct research or program evaluation, but such research will not personally identify the applicants or licensees, either directly or indirectly.  
**Yes No**
5. 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 renewal.  
**Yes No**
6. I **have read** and am familiar with the statutes and regulations that govern the practice of addiction counseling in the state of Kansas.  
**Yes No**
7. I understand that **once the Board receives my application I am bound by the statutes and regulations governing the practice of addiction counseling in Kansas.**  
**Yes No**

**I hereby affirm that to the best of my knowledge all my answers to the foregoing are correct. I further agree that all state records pertaining to my application and licensure may be used to conduct research or program evaluation, provided that the research does not personally identify me, directly or indirectly.**

---

SIGNATURE OF APPLICANT

DATE OF APPLICATION

**NAME or ADDRESS CHANGE:** 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.



**APPLICATION FOR LCAC LICENSURE**

***Attachment A - ATTESTATION FROM A LICENSED PROFESSIONAL***

**Instructions to Applicant:** This form must be completed by someone whose license allows for diagnosis and treatment of mental disorders and/or substance use disorders at the independent level. At the time of application, submit this attestation to BSRB in a **signed, sealed envelope**.

Name of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**To be completed by the licensee completing attestation:**

The above-named individual is applying for a clinical addiction counselor license. The Behavioral Sciences Regulatory Board is asking that you provide a written response attesting to this individual's competency to diagnose and treat substance use disorders. Please answer **all** questions to the best of your knowledge and return this completed form to the applicant in a sealed envelope with your signature across the seal of the envelope to insure confidentiality.

- 1. Name: \_\_\_\_\_
- 2. Business Name: \_\_\_\_\_
- 3. Street Address: \_\_\_\_\_
- 4. City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- 5. Phone: \_\_\_\_\_ Email: \_\_\_\_\_
- 6. License Type: \_\_\_\_\_ License #: \_\_\_\_\_
- 7. Are you related by blood or marriage to the applicant? Yes \_\_\_\_\_ No \_\_\_\_\_
- 8. How long have you known the applicant? \_\_\_\_\_  
Month/Year
- 9. In what work setting have you known the applicant: \_\_\_\_\_
- 10. In your opinion is the applicant competent to diagnose and treat substance use disorders independently? Yes \_\_\_\_\_ No \_\_\_\_\_
- 11. What relationship (supervisor, co-worker, etc.) have you had with the applicant which has aided you in forming an opinion of his/her competence to diagnose and treat substance use disorders: \_\_\_\_\_
- 12. What evidence can you provide related to the applicant's competence to diagnose and substance use disorders?  
\_\_\_\_\_  
\_\_\_\_\_

**Licensee's Attestation:** I certify the foregoing answers and information furnished above are given in good faith with the understanding that it will be utilized for purposes of determining the applicant's competence to diagnose and treat substance use disorders in the State of Kansas. Any response or information I have provided is true and correct to the best of my knowledge and belief. Where I have relied upon other sources of information, they are only those which I believe to be accurate and reliable.

\_\_\_\_\_  
Signature Date

**Please return form to applicant in a sealed envelope with your signature across the seal.**

Behavioral Sciences Regulatory Board  
700 SW Harrison St. Suite 420  
Topeka, KS 66603-3929

Max L. Foster, Jr., Executive Director



Phone: 785-296-3240  
Fax: 785-296-3112  
[www.ksbsrb.ks.gov](http://www.ksbsrb.ks.gov)

Laura Kelly, Governor

## 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 \_\_\_\_\_