

CLINICAL ADDICTION COUNSELORS (LCAC) LICENSURE APPLICATION

Instructions

Please read all instructions and review the statutes and regulations, before beginning to complete the application. The statutes and regulations can be found on our website, www.ksbsrb.ks.gov.

1. **Application:** Please answer all questions on the application completely and accurately. If there have been any convictions of a felony or other past or current events that potentially raise questions about your ability to merit the public trust, additional information will be requested.
2. **Fee:** Instructions for paying the \$50.00 application fee may be found on **Appendix A. FEES ARE NON-REFUNDABLE.**
3. **Academic Background form:** If you do not hold a master's degree from a program accredited by the National Addiction Studies Accreditation Commission (NASAC) you must complete the Academic Background form and submit with your complete application.
4. **Graduate Practicum Review form:** If you do not hold a master's degree from a program accredited by NASAC you must complete the Graduate Practicum Review form and submit with your complete application. This form must be completed by the program director that academically supervised your practicum experience. The completed form should be returned to you in a sealed envelope with their signature across the seal. **(see example on second page of instructions)**
5. **Transcript:** As part of the application process, an official transcript mailed directly from the Registrar's office is required. **Only transcripts received directly from the university can be accepted.**
6. **Professional References:** Three references are required as part of your complete application packet. The professional reference form included in the application packet will need to be copied.
 - a) Each reference should return the completed form to you in a sealed envelope with their signature across the seal. The three reference forms will need to be included when your application is submitted to the Board office. NOTE: It is very important that references sign across the seal of the envelope to assure the Board of the confidentiality and integrity of the referencing process.
 - b) One of the references must be from the **on-site supervisor** from your current or most recently completed graduate addiction counseling practicum. If this person is unavailable the director of the field education program or a designated person who has knowledge of your practicum based on your program records shall complete the form.
 - c) The additional two references must be authorized by law to practice addiction counseling or to practice in a related field.
7. **Out-of-State Verification:** If you are or have ever been licensed, registered, or certified in one of the behavioral or health sciences in another state, the Out-of-State Verification Form will need to be completed by the other state(s). This form needs to be returned directly to the Board office. **Only forms received directly from the other state(s) can be accepted.**
8. **Review:** It is extremely important for you to understand that the Board cannot determine whether you are eligible to sit for the examination until all of the application materials have been received and approved by the Board office.

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

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

If you are currently an LMAC in Kansas, you will need to submit the following documentation:

- The completed application form (please complete all pages so that your application will not have to be returned);
- The application fee of \$50.00; See Appendix A
- The Post-Graduate Supervisor Attestation(s).
- If not previously submitted to the Board, a transcript as instructed below.

If you are not an LMAC in Kansas, you will need to submit the following documentation:

- The completed application form (please complete all pages so that your application will not have to be returned);
- The application fee of \$50.00 made payable to BSRB by cash, check, money order, or credit card;
- Post-Graduate Supervisor Attestation(s).
- The three (3) completed Professional Reference Forms;
- The Graduate Practicum Review Form, if you graduated from a non-NASAC program;
- The Academic Background Form, if you graduated from a non-NASAC program;

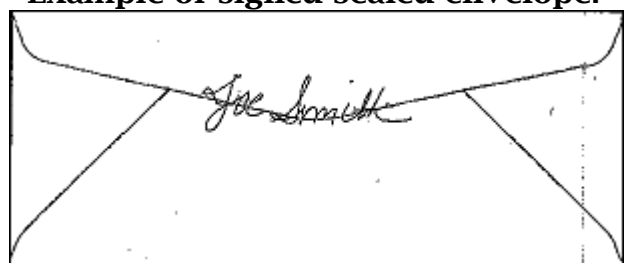
These additional items need to be sent directly to the Board office by the appropriate institutions:

- If not previously submitted to the Board, an official transcript that shows the master’s degree earned and the date the degree was conferred from your university;
- An Out-of-State Verification Form, if ever licensed in another state;
- Exam scores, if applicable.

The regulations will not be adopted until July 1, 2011. Therefore, changes may occur to the requirements. Please do not submit the application prior to July 1st.

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

Example of signed sealed envelope:



CLINICAL ADDICTION COUNSELOR LICENSURE APPLICATION LCAC
Application

Application Fee: \$50.00 please see Appendix A

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.)

Ethnic Information: African American _____ Native American _____ Asian Indian _____ Asian-Other _____
(Optional) Hispanic _____ Pacific Islander _____ White – Non Hispanic _____ Other _____
(Please Specify)

Languages that you speak: English _____ Spanish _____ Sign _____ Other _____
(Optional) (Please Specify)

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:** _____

****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:

Circle "yes" or "no" to the following questions. Please attach an additional sheet if needed.

A. Do you currently hold, or have you ever held a license, certificate, or registration in Kansas?
Yes No If "yes", please answer the following questions:

1. Which credential: _____ Under what name: _____

B. Other than the credential listed above, have you ever filed **any** application for licensure or registration in Kansas?
Yes No If "yes", please answer the following questions:

2. For which credential: _____ When: _____

3. Under what name: _____

C. Do you currently hold, or have you ever held a certificate, registration or license to practice in one of the behavioral or health sciences in another state or jurisdiction?
Yes No If "yes", please answer the following questions:

1. Which credential: _____ In which state or jurisdiction: _____

2. Under what name: _____

3. Issue Date: _____ Expiration Date: _____

If you currently hold, or have ever held a certificate, registration, or license to practice in one of the behavioral or health sciences in another state or jurisdiction, you will need to have the former state Board(s) complete the Out-of-State Verification Form. Upon completion, they should send the form directly to the board office.

III. Educational Information:

A. Complete the following information for the college or university where you received your master's degree, as well as any college or university where you completed any additional addiction counselor coursework.

Please attach an additional sheet if needed.

1. Name: _____

2. Location (City and State): _____

3. Degree Received: _____ Date of Degree: _____

4. Name of School: _____

5. Location of School: _____

6. Degree Received: _____ Date of Degree: _____

B. Transcript: You are required to provide an official transcript from the Registrar's office of the college or university where your degree was granted. Please direct the school to send the transcript directly to the Board office. **The board can not accept transcripts sent directly from the applicant.**

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

If you are currently licensed as an LAC in Kansas, please skip to Section V – Background History

D. Which ONE of the following degree qualifications do you have currently?

1. _____ A master's degree in addiction counseling or a related field, if the applicant began the program before May 1, 2011 and the master's degree is conferred on or before June 1, 2012, from a program that was approved by the Kansas department of social and rehabilitation services, division of addiction and prevention services.
2. _____ A master's degree in addiction counseling or a related field and at the time the degree was granted, the program was accredited by the National Addiction Studies Accreditation Commission (NASAC).
3. _____ A master's degree in one of the related fields: education _____, criminal justice _____, counseling _____, healing arts _____, human development and family studies _____, human services _____, marriage and family therapy _____, nursing _____, psychology _____, social work _____ or theology, that **INCLUDED** coursework that meets the educational requirements outlined in K.A.R. 102-7-3. You **WILL** need to complete the Academic Background Form and the Graduate Practicum Review Form.
4. _____ A master's degree in one of the related fields: education _____, criminal justice _____, counseling _____, healing arts _____, human development and family studies _____, human services _____, marriage and family therapy _____, nursing _____, psychology _____, social work _____ or theology, with **ADDITIONAL** coursework that meets the educational requirements outlined in K.A.R. 102-7-3. You **WILL** need to complete the Academic Background Form and the Graduate Practicum Review Form.

E. Practicum Information:

1. Dates of Practicum: _____
2. Practicum Agency: _____
3. Practicum Agency Address: _____
4. Name of Supervisor: _____
5. Supervisor's Address: _____

F. Graduate Practicum Review form: If you do not hold a master's degree from a program accredited by NASAC you must complete the Graduate Practicum Review form and submit with your complete application. This form must be completed by the program director that academically supervised your practicum experience. The completed form should be returned to you in a sealed envelope with their signature across the seal.

IV. References' Requirements:

A. You should submit the completed reference forms, in their **sealed (signed across the seal)** envelopes, at the time of application. Your references should meet the guidelines as specified below:

1. You must submit one professional reference from your on-site practicum supervisor (please see instructions for further detail) **and**, two references from who are authorized to engage in the practice of addiction counseling or a related field. References should be familiar with your professional conduct and competence and may not be related.

B. REFERENCES: Please print the requested information below for each of your references.

Names	Credentials	Agency and Address	Phone #
Practicum/Work Supervisor			

V. Merit of Public Trust:

Circle “yes” or “no” to the following questions. **If you answer “yes”,** please attach a detailed written explanation.

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. 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

VI. Applicant’s Attestation:

Circle “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 CLINICAL ADDICTION COUNSELOR LICENSURE: LCAC

Professional Reference Form

Instructions for the applicant: Please complete **Section I** and submit to the referencing individuals for completion. Additional copies of this form may be made and used as needed. Completed Professional Reference forms shall be submitted **in the unopened sealed envelopes** as part of your complete application packet.

Instructions for the reference: Please complete **Section II** and return the complete reference form in an envelope, **signed across the seal** and return to the applicant.

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

To: (Name of reference-please print) _____

From: (Name of Applicant-please print) _____

I am applying for licensure as a clinical addiction counselor in the State of Kansas and I am required to provide information to support that application. This form, bearing my signature, gives my consent and authorization to release any and all information and/or documents that may be material to an evaluation of my merit of the public trust. I authorize the Behavioral Sciences Regulatory Board (BSRB) and its representatives to consult with you regarding my professional competence, character, ethical qualifications, health status, ability to work cooperatively with others and other qualifications for licensure.

I release from liability any and all individuals, institutions and organizations that provided information to the BSRB or its representatives, in substantial good faith and without malice, concerning my merit of the public trust and my qualifications for licensure. I consent to the inspection by the BSRB and its representatives of all documents that may be material to an evaluation of my qualifications and competence. I understand that this consent for release of information will be in effect for a period of one year from the date of consent.

Please mail this completed form directly to me in a sealed envelope with your signature across the seal. **Please be certain to seal the envelope and sign over the seal.** I am responsible for submitting to the BSRB the completed form in its sealed envelope as part of my application packet.

Signature of Applicant: _____ **Date:** _____

Section II:

Please answer **all** questions to the best of your knowledge. Return this completed form to the applicant in a sealed envelope with your signature across the seal of the envelope to insure confidentiality.

To qualify to serve as a professional reference, the referencing individual must be:

1. Unrelated to the applicant;
2. able to address the applicant's professional conduct, competence and merit of the public trust;
3. be authorized by law to practice clinical addiction counseling or to practice in a related field;
4. one of the references must be from the individual that provided the on-site supervision of the practicum. If this person is unavailable the director of the program or a designated person who has knowledge of the applicant's practicum based on the applicant's program records.

Note: If you do not qualify to serve as a professional reference, please alert the applicant.

I. Professional Reference's Information:

- A. Name: _____
- B. Business Name: _____
- C. Street Address: _____
- D. City _____ State: _____ Zip: _____
- E. Phone: _____ Fax: _____
- F. Educational Background: _____ Professional Title: _____
- G. Do you hold a professional license? Yes _____ No _____ **If "yes", please answer the following questions.**
 - 1. Professional License held: _____ License #: _____
 - 2. State of Issuance: _____ Issuance Date: _____ Expiration Date: _____

II. Please circle yes or no to following questions.

- A. Were you the applicant's on-site practicum supervisor?
Yes No
- B. What relationship (such as employer, supervisor, co-worker, instructor) have you had with the applicant which has aided you in forming any opinion of his/her character:

- C. Have you supervised the applicant in a work setting?
Yes No If yes please list the dates you supervised the applicant.
Beginning Date: Month _____ Year _____ **Ending Date:** Month _____ Year _____
- D. Are you related by blood or marriage to the applicant?
Yes No If yes, please state relationship to the applicant. _____
- E. How long have you known the applicant? _____

III. Professional Reference's Knowledge of Applicant: (Please circle yes or no)

- A. Please consider the candidate's behavior in the following areas: good judgment, integrity, honesty, fairness, credibility, reliability, respect for others, respect for the laws of the state and nation, self-discipline, self-evaluation, initiative, and commitment to the clinical addiction counseling profession and its values and ethics. Does the candidate, in your opinion, possess the moral standards and fitness required for working as a clinical addiction counselor?
Yes No If your answer is "no", please elaborate in detail in an attached statement.
- B. Are you aware of any significant facts concerning the applicant's background that would reflect **unfavorably** on the applicant's character and fitness to practice clinical addiction counseling?
Yes No If your answer is "yes", please state these facts in detail on an attached statement.
- C. Do you recommend the applicant for licensure to practice clinical addiction counseling in Kansas?
Yes No If not, please elaborate in detail in an attached statement.
- D. **If you have known the applicant for less than 6 months** please list some specific examples of what you have witnessed that allows you to make the above mentioned determinations.

E. Please expand or add any comments or information that you believe will aid the Behavioral Sciences Regulatory Board (BSRB) in evaluating the applicant's ability to practice clinical addiction counseling and merit of public trust for licensure as a clinical addiction counselor in Kansas.

IV. Professional Reference's Attestation:

Reference'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 ability to practice addiction counseling and merit of the public trust in order to be licensed as a clinical addiction counselor 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:** _____



APPLICATION FOR LICENSURE AS A LICENSED CLINICAL ADDICTION COUNSELOR: LCAC

Academic Background Form

Name: _____ Date: _____

In order to establish educational eligibility related to L. 2010, ch. 45, §15 as defined in K.A.R. 102-7-3, applicants that did not complete their degree in a NASAC accredited program are required to complete the following information, as it relates to their academic background.

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;
5. coursework taken for undergraduate credit

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.

1. **Addiction Recovery Services** (Minimum of 3 semester credit hours required.) Which shall include the study and critical analysis of philosophies and theories of addiction and scientifically supported models of prevention, intervention, treatment, and recovery for addiction and other substance-related problems.

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

2. **Advanced Methods of Individual and Group Counseling** (Minimum of 3 semester credit hours required.) Which shall include the study of practical skills related to evidence-based, culturally sensitive individual and group counseling techniques and strategies designed to facilitate therapeutic relationships and the educational and psychosocial development of clients as specifically related to their addiction.

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

3. **Clinical Supervision** (Minimum of 3 semester credit hours required.) Which shall include studies of the tasks and functions of the clinical supervisor and the ability to assess development of competencies, conduct supervisory interviews, and design professional development plans.

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

4. **Advanced Pharmacology and Substance Use Disorders** (Minimum of 3 semester credit hours required.) Which shall include the study of the pharmacological properties and effects of psychoactive substances; physiological, behavioral, psychological, and social effects of psychoactive substances; drug interactions; medication-assisted addiction treatment; and pharmacological issues related to co-occurring disorders treated with prescription psychotropic medications.

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

5. **Integrative Treatment of Co-Occurring Disorders** (Minimum of 3 semester credit hours required.) Which shall include the study of the relationship between addiction and co-occurring mental or physical disorders or other conditions and evidenced-based models for the screening, assessment, and collaborative treatment of co-occurring disorders.

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

6. **Assessment and Diagnosis** (Minimum of 3 semester credit hours required.) Which shall include the study of a comprehensive clinical assessment process that addresses age, gender, disability, and cultural issues; the signs, symptoms, and diagnostic criteria used to establish substance use-disorder diagnoses; and the relationship between diagnosis, treatment, and recovery.

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

7. **Professional Ethics and Practice** (Minimum of 3 semester credit hours required.) Which shall include the study of professional codes of ethics and ethical decision making; client privacy rights and confidentiality; legal responsibilities and liabilities of clinical supervision; and professional identity and development issues.

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

8. **Applied Research** (Minimum of 3 semester credit hours required.) Which shall include the study of the purposes and techniques of behavioral sciences research, including qualitative and quantitative 102-7-3 Page 5 approaches, research methodology, data collection and analysis, electronic research skills, outcome evaluation, critical evaluation and interpretation of professional research reports, and practical applications of research. A maximum of three semester hours, or the academic equivalent, may be completed in thesis or independent research courses.

9. Course #	Course Title	Credit Hrs	University
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

10. **Practicum or its Equivalent** (Minimum of 6 semester credit hours required.) Your graduate practicum courses that you have completed.

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



APPLICATION FOR LICENSURE AS A CLINICAL ADDICTION COUNSELOR: LCAC

**Post-graduate Supervised Clinical Experience
Supervisor's Attestation**

Consent and Authorization to Release Information

Applicant's Name (Please print): _____

Supervisor's Name (Please print): _____

To my supervisor:

I am applying for license as a clinical addiction counselor in the State of Kansas, and I am required to provide information in support of that application. This form bearing my signature, gives my consent and authorization to release any and all information and documents that may be material to an evaluation of my qualifications and competence.

I authorize the Behavioral Sciences Regulatory Board (BSRB) and its representatives to consult with you regarding my professional competence, character, ethical qualifications, ability to work with others, and any other qualifications for licensure.

I release from liability any and all individuals, institutions, and organizations that provide information to the BSRB or its representatives, in substantial good faith and without malice, concerning my professional conduct, ethics, character and other qualifications for licensure. I consent to the inspection by the BSRB of all documents that may be material to an evaluation of my qualifications and competence. I understand that this consent for release of information will be in effect for a period of one year from the date of consent.

Please return this completed attestation to me IN A SEALED ENVELOPE, WITH YOUR SIGNATURE OVER THE SEAL. I am responsible for submitting this completed reference, in the unopened sealed envelope as part of my application packet.

Signature of Applicant

Date

I. Setting where supervised postgraduate experience occurred:

A. Agency/Practice Setting name: _____

B. Address: _____

C. Phone: _____ Fax: _____

D. Dates of supervision provide by you: From _____ to _____

II. Supervised hours while under your supervision:

A. Average number of hours that applicant worked per week: _____

B. **Total** number of post graduate clinical experience hours that applicant completed _____

C. Total number of post graduate clinical experience hours that involved **direct, face to face clinical contact providing substance abuse assessment and treatment** _____

D. Total number of supervision **sessions** provided to the applicant: _____

E. Total number of supervision **hours** provided to the applicant: _____

F. Total number of hours of supervision provided **individually** to the applicant _____

G. Total number of hours of clinical supervision provided in a **group** setting with six or less supervisees: _____

III. Supervisor's Qualifications at the time supervision was provided:

- A. License type _____ License number: _____
- B. Original date of issue: _____ State: _____
- C. Is this license an independent, clinical level of licensure? Yes ___ No ___
- D. Were you under any disciplinary sanction, restriction or have any disciplinary action pending by a professional licensing or credentialing board at the time you provided supervision Yes ___ No ___
- E. Did you have, at least in part, clinical responsibility for the supervisee's functioning in the practice of addiction counseling? Yes ___ No ___
- F. Did you have a harmful dual relationship with the supervisee? Yes ___ No ___
- G. Did you have knowledge and experience with the supervisee's client population? Yes ___ No ___
- H. Did you have knowledge and experience with the methods of practice that the supervisee employs? Yes ___ No ___
- I. Did you ensure that each was aware that the supervisee was practicing addiction counseling under supervision? Yes ___ No ___
- J. Did you have an understanding of the organization and administrative policies and procedures of the practice setting? Yes ___ No ___
- K. Were you a member of the staff in the supervisee's practice setting? Yes ___ No ___

If "no", please answer the following questions:

- 1. Did you have an understanding of the mission of the practice setting? Yes ___ No ___
- 2. Was the extent of your of your responsibilities clearly defined with respect to the client cases to be supervised and your role, if any, in the personnel evaluation within the practice setting? Yes ___ No ___
- 3. Was the responsibility for payment for supervision clearly defined? Yes ___ No ___
- 4. If the supervisee paid you directly for supervision, did you maintain your responsibility to the client and the practice setting? Yes ___ No ___

IV. Supervisor's requirements within the supervision process:

- A. For any hours accrued on or after August 1, 2011:
 - 1. Did you provide at least 1 hour of supervision for every 20 hours of direct client contact? Yes ___ No ___
 - 2. Did you meet with the supervisee at least 2 separate times monthly? Yes ___ No ___
 - 3. Did you meet with at least once a month with the supervisee for one-on-one clinical supervision occurring with you and the supervisee in the same physical space? Yes ___ No ___
 - 4. Did your supervision include diagnosis and treatment of mental disorders? Yes ___ No ___

If you answered "no" to any of the questions above, please explain on a separate sheet of paper.

- B. For any hours accrued before August 1, 2011:
 - 1. Did you provide supervision that was scheduled and formalized? Yes ___ No ___
 - 2. Did the supervision include review and examination of cases? Yes ___ No ___
 - 3. Did you provide assessment of the supervisee's competencies? Yes ___ No ___

If you answered "no" to any of the questions above, please explain on a separate sheet of paper.

- C. If you provided supervision in a group format, how many supervisees were in those groups? _____

- D. Did you provide oversight, guidance and direction of the supervisee's practice by assessing and evaluating the supervisee's performance? Yes ___ No ___
- E. Did you provide supervision in a process distinct from personal therapy, didactic instruction, or addiction counseling consultation? Yes ___ No ___
- F. Did you ensure that your scope of responsibility and authority in the supervisee's practice setting was clearly defined? Yes ___ No ___
- G. Did you periodically evaluate the supervisee's role and their clinical functioning as an addiction counselor? Yes ___ No ___
- H. Did you provide supervision consistent with the education, training, experience, and ability of the supervisee? Yes ___ No ___

V. Evaluation of the Applicant's supervised experience:

A. Please summarize the types of clients and client situations dealt with during the supervised experience:

- B. Did the applicant complete all supervision goals and objectives? Yes ___ No ___
- C. Was the applicant's performance throughout the period of supervision consistently acceptable? Yes ___ No ___

D. Please assess the applicant's performance in regard to the following components of clinical addiction counseling practice. **NOTE: If you rate any of the following categories as "unacceptable", please attach a statement outlining the basis for those ratings or for your reservations concerning licensing this applicant for independent clinical addiction counselor.**

	Acceptable	Unacceptable
1. Assessment	_____	_____
2. Diagnosis	_____	_____
3. Treatment	_____	_____
4. Consultation	_____	_____
5. Evaluation	_____	_____

E. Please evaluate the applicant's merit of public trust in regard to the following qualities:

	Acceptable	Unacceptable
1. Good judgment:	_____	_____
2. Integrity:	_____	_____
3. Honesty:	_____	_____
4. Fairness:	_____	_____
5. Credibility:	_____	_____
6. Reliability:	_____	_____
7. Respect for others:	_____	_____
8. Respect for state and federal laws:	_____	_____
9. Self discipline:	_____	_____
10. Self-evaluation:	_____	_____
11. Initiative:	_____	_____
12. Commitment to addiction counselor values/ethics:	_____	_____

F. Do you recommend this applicant for licensure at the independent practice, clinical level in addiction counseling? Yes ___ No ___ **If "no", please attach a statement that describes the basis for your denial.**

VI. Attestation of the Supervisor:

I have personally known the above applicant that has made application to the BSRB for licensure as a clinical addiction counselor, and attest that said applicant has been practicing in the clinical setting as indicated, and has been supervised by me in that specialty.

In signing this form, I understand that I am attesting that all the information provided in this attestation form is true, accurate, and submitted in good faith. I understand that in accordance with Kansas statutes, anyone knowingly making a false statement on any form of the BSRB shall be guilty of a Class B misdemeanor.

Signature

Date



APPLICATION FOR LICENSURE AS A LICENSED CLINICAL ADDICTION COUNSELOR: LCAC

Graduate Practicum Review Form

This form is NOT required of applicants who graduated from a NASAC accredited or candidacy program

Instructions for Applicant: Section 1 should be completed by the applicant and then sent to the Graduate Program Director of the Addiction Counseling Program for completion. Please include a self-addressed, stamped envelope. Additional copies of this form may be made and used as needed by the applicant. The applicant shall submit the completed Graduate Practicum Review Form in the unopened envelope that has been signed or stamped across the seal by the Graduate Program Director, at the time of application.

Section 2: The Graduate Program Director should complete Section 2 and return the completed form in a sealed envelope signed across the seal to the applicant.

I. Section 1: To be completed by the Applicant:

- A. Applicant's Name: _____
- B. Date of Birth: _____ Student ID #: _____
- C. Degree and Graduation Date: _____
- D. Applicant's Mailing Address: _____
- E. Graduate Program Director: _____
- F. Educational Institution: _____
- G. Mailing Address: _____

II. Section 2: To be completed by Graduate Program Director and returned to the Applicant in a sealed envelope signed across the seal:

The above named applicant has applied to the Kansas Behavioral Sciences Regulatory Board for licensure as an addiction counselor. It appears that the baccalaureate program from which the applicant graduated was not accredited or approved for candidacy status by NASAC *as of the date the applicant graduated*. In order for the Board to make a determination as to whether the applicant meets educational qualifications pursuant to L. 2010, ch. 45, §15 as defined in K.A.R. 102-7-3, ***the items listed below need to be completed by the graduate program director and returned to the applicant for submission in the application packet.*** Please return this form to the applicant in the enclosed envelope, sealed, with your signature/stamp across the seal

- A. Please state the regional accreditation held by the university awarding the graduate degree completed by the applicant:

- B. Please state the professional accreditation (if any) held by the graduate program completed by the applicant:

- C. As part of the applicant's graduate program, please verify that the applicant satisfactorily completed an addiction counseling experience or its equivalent as follows:
 - 1. Consisted of at least 600 hours: Yes ___ No ___
 - 2. 100 hours of supervision inclusive of at least 50 hours of individual supervision, provided by the program's faculty and agency supervisors: Yes ___ No ___

D. If you answered "No" to any of the above items, please explain: _____

I hereby affirm that to the best of my knowledge all answers to the above items are true and correct.

(Print): _____
Graduate Program Dean or Director

Phone Number: _____ Email Address: _____

(Signature): _____
Graduate Program Dean or Director

Date: _____

APPLICATION FOR CLINICAL ADDICTION COUNSELOR LICENSURE: LCAC

Out-Of-State Verification Form

Instructions:

Section I is to be completed by the applicant and then sent to the out-of-state board for completion. Additional copies of this form may be made and used as needed by the applicant.

Section II is to be completed by a representative of the out-of-state board and then returned directly to the Board office at the address above.

I. Applicant Information

I, _____, am applying for addiction counseling licensure in the state of Kansas. In order to be considered for licensure in Kansas, I am required to provide official documentation related to my credential status and standing in your state. Accordingly, I am requesting that you complete Section 2 below, AND RETURN TO the Kansas Behavioral Sciences Regulatory Board (BSRB).

- A. Name under which my license was issued: _____
- B. Name under which my license was issued (if different): _____
- C. Licensure Type: _____ Licensure Number: _____
- D. Issue Date: _____ Expiration Date: _____
- E. Signature: _____ Date: _____

II. Statement from Out-Of-State Board

- A. Name appearing on license in your state: _____
- B. Licensure Type: _____ License Number: _____
- C. Date Issued: _____ Date of Expiration: _____
- D. Level of Licensure (baccalaureate, masters, clinical): _____
- E. Licensed by: Examination: _____ Reciprocity: _____ Grandfathered: _____
Other (Specify): _____

F. If Licensed by Exam:

- Name of Exam: _____
- Exam Level: _____ Date of Exam: _____
- Score Received - Raw: _____ Scaled: _____ Percent: _____ State Cutoff Score: _____

G. Is License in good standing? Yes _____ No _____ **If “No”, please attach copies of all releasable information and state reason(s):** _____

H. Has License been Revoked or Suspended? Yes _____ No _____ **If “Yes”, please attach copies of all releasable information and state reason(s):** _____

I. Additional comments: _____

Printed Name of State Board Representative: _____

Signature: _____ **Date:** _____

Official Title/Position: _____

Name of State Board: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Fax Number:** _____

Upon completion, please return this form directly to:

**Behavioral Sciences Regulatory Board
700 S.W. Harrison St, Ste 420
Topeka, KS 66603-3929**

State Seal

Appendix A

Payment Instructions

1. Individuals wishing to submit payments to the BSRB using a credit card or electronic check should:
 - a. visit the BSRB website at ksbsrb.ks.gov
 - b. select the “SERVICES” drop-down tab from the top of the home screen, and
 - c. click on the “Make A Payment” link. From this page, you will be asked to provide information allowing us to identify the applicant, select the item you wish to pay for, and you will be able to make a payment for that item.

For use of the secure payment platform, the state of Kansas charges a 2.5 percent processing fee for credit card payments or a \$1.50 flat fee for use of an electronic check. After completing payment, you will receive a confirmation e-mail to confirm your payment.

2. Individuals wishing to submit payments to the BSRB office using a check-by-mail or with a money order may continue to mail payments to the Behavioral Sciences Regulatory Board, 700 SW Harrison St., Ste. 420, Topeka, KS 66603. There is no additional fee for processing checks-by-mail or money orders sent to the BSRB office.

The application fee may be paid before or after you submit your application. The application will not be processed until the fee has been received.