

## MASTERS ADDICTION COUNSELORS (LMAC) 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](http://www.ksbsrb.ks.gov).

1. **Application:** Answer all questions completely and accurately. The burden of proof in satisfying the Board that you are eligible for licensure is upon you. Thus, if you have been convicted of a felony or if there have been other past or current events that potentially raise questions about your ability to merit the public trust, you will be required to provide additional information and may be asked to appear before the Board to explain these matters.
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. **Academic Background form:** You must complete the Academic Background form and submit it with your completed application.
4. **Graduate Practicum Review form:** You must complete the Graduate Practicum Review form and submit it with your completed application. This form must be completed by the program director who was the academic supervisor for 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 or emailed 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 completed 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 not available, 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 master's addiction counseling or to practice in a related field at the master's level.
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) licensing board. This form needs to be returned directly to the Board office. **Only forms received directly from the other state(s) licensing board 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](http://www.ksbsrb.ks.gov), under "Applicants."

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

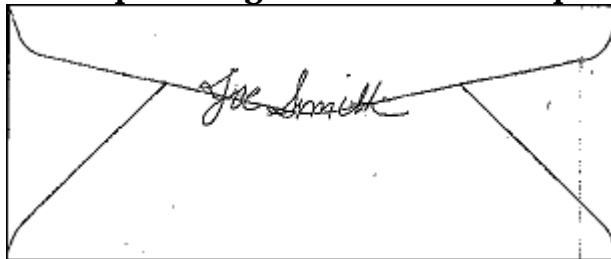
- The completed application form (please complete all pages so that your application will not have to be returned);
- The application fee of \$50.00 made payable to BSRB by cash, check, money order, or credit card;
- The three (3) completed Professional Reference Forms;
- The Graduate Practicum Review Form
- The Academic Background Form

**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.

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

**Example of signed sealed envelope:**



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



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

Max L. Foster, Jr., Executive Director

Laura Kelly, Governor

## MASTERS ADDICTION COUNSELOR LICENSURE APPLICATION LMAC

### *Application*

**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.)

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.** Are you seeking temporary Licensure? **Yes No**

**B.** 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: \_\_\_\_\_

**C.** 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: \_\_\_\_\_

**D.** 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 of School: \_\_\_\_\_

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:

\_\_\_\_\_

**D. Please check which requirements ONE of the following degree qualifications do you have currently?**

1. \_\_\_\_ A master's degree in addiction counseling.
2. \_\_\_\_ A master's degree in another field of study and as part of or in addition to the master's degree coursework, have completed the coursework requirements outlined in K.A.R 102-7-3,

**E. Practicum Information:**

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

**If more than one practicum site,**

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

**F. Graduate Practicum Review form:** At the time of application, submit, in a sealed and signed envelope, the Graduate Practicum Review form. This form must be completed by the program director from the college or university that academically supervised your graduate practicum experience in addiction counseling.

**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 persons who are authorized to engage in the practice of addiction counseling at the master's level or a master's level in 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. Background History:**

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. 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**

**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

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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.

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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.

Revised: 10/14/16



**APPLICATION FOR MASTERS ADDICTION COUNSELOR LICENSURE: LMAC**

***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 completed reference form in an envelope, **signed across the seal** 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 master's 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 master's addiction counseling or to practice at the master's level 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 not available, the director of the program or a designated person who has knowledge of the applicant's practicum based on the applicant's program records may provide the reference.

**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 master's 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 master's 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 masters 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.

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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 master's addiction counselor in Kansas.

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**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 master's 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 MASTERS ADDICTION COUNSELOR: LMAC**

**Academic Background Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

In order to establish educational eligibility required in K.S.A 65-6610 as defined in K.A.R. 102-7-3, applicants are required to provide 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. **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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. **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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. **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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. **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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. **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 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.

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

8. **Practicum or its Equivalent** Which shall include clinical experience that integrates didactic learning supporting the diagnosis and treatment of substance use disorders.

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

9. **Additional Courses** (Minimum of 6 semester credit hours required.) Which shall include six additional graduate semester hours of academic coursework that contributes to the development of advanced knowledge or skills in addiction counseling, supervision, or research.

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



**APPLICATION FOR LICENSURE AS A LICENSED MASTERS ADDICTION COUNSELOR: LMAC**

**Graduate Practicum Review Form**

**Instructions for Applicant:** Complete Section 1 and then submit to the Graduate Program Director where your graduate Addiction Counseling Practicum was completed. Please include a self-addressed, stamped envelope. Additional copies of this form may be made and used as needed. You will submit the completed Graduate Practicum Review Form(s) in the unopened envelope with your complete application to the Board office.  
**Section 2** is to be completed by the Graduate Program Director.

**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. Graduate Program Director: \_\_\_\_\_
- E. Educational Institution: \_\_\_\_\_

**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 master's addiction counselor. In order for the Board to make a determination as to whether the applicant meets educational qualifications pursuant to K.S.A. 65-6610 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. List the regional accreditation held by the university awarding the graduate degree completed by the applicant:  
\_\_\_\_\_
- B. List the professional accreditation (if any) held by the graduate program completed by the applicant:  
\_\_\_\_\_
- C. Please verify that the applicant satisfactorily completed an addiction counseling graduate practicum, or its equivalent, which included the following:
  - 1. Completed at least 300 hours of client contact: Yes \_\_\_ No \_\_\_
  - 2. Supervision provided at a ratio of at least one hour of supervision for every 10 hours of client contact. Supervision was provided by the program's faculty and agency supervisors, of which at least one supervisor was licensed at the clinical level by the board: 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: \_\_\_\_\_

Behavioral Sciences Regulatory Board  
700 SW Harrison St. Suite 420  
Topeka, KS 66603-3929  
David B. Fye, JD, Executive Director



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

**APPLICATION FOR MASTERS 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. Current name: \_\_\_\_\_
- 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**

Revised: 10/14/16

Behavioral Sciences Regulatory Board  
700 SW Harrison St. Suite 420  
Topeka, KS 66603-3929  
**David B. Fye, JD**, 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 \_\_\_\_\_