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

Kansas
Behavioral Sciences
Regulatory Board

Phone: 785-296-3240
Fax: 785-296-3112
www.ksbsrb.ks.gov

Max L. Foster, Jr., Executive Director

Laura Kelly, Governor

INSTRUCTIONS FOR LICENSURE APPLICATION THROUGH RECIPROCITY (LAC)

1. Before you begin to complete the application form enclosed herein, please read all instructions and review the statutes and regulations so that you will understand exactly what information is being requested. The statutes and regulations can be found on our website, www.ksbsrb.ks.gov. **Your must hold an active license in another state to apply for licensure through reciprocity.**

2. This application is for the Licensed Addiction Counselor (LAC). This is not a clinical level of licensure and does not allow for the diagnosis of substance use disorders. Please review the statutes and regulations for a detailed explanation of the levels of licensure as well as requirements for licensure. If you meet the requirements and wish to be licensed at the clinical level (LCAC), which allows for the diagnosis of substance use disorders. Please download and complete the Application through Reciprocity for LCAC.

3. Answer all questions on the application completely and accurately. The burden of proof in satisfying to the Board that you are eligible for licensure is upon you.

4. The $50.00 application fee must accompany your application. Your check or money order should be made payable to "Behavioral Sciences Regulatory Board" or "BSRB". You may also pay by credit card. **ALL FEES ARE NON-REFUNDABLE**.

5. As part of the application process, you are required send **Attachment A** = **Out-Of-State Clearance form** to each of the licensing boards or jurisdictions you hold, or have held, a professional license, certificate, or registration. The licensing agency should complete the form and return it directly to the Board office.

6. **Routes for Reciprocity**

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

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

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

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

   C. At least a baccalaureate degree.

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

Application Checklist

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

- ☐ The completed application form;
- ☐ If you are applying using Route 2 – Attachment B and if your degree is in a related field Attachment C;
- ☐ $50.00 application fee

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

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

- ☐ Attachment A = Out-of-State Clearance form, submitted directly by any state or jurisdiction which you hold or have held a license, registration, or certification;
- ☐ Transcript, if your licensing board will not provide your education information.

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

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

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Application Fee Required: $50 check, money order or credit card made payable to BSRB

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

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

Legal Name: _______________ _______________ _______________
Last **First** **Middle**

Maiden/Other names used: _______________ **Gender**: _______________

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

Preferred E-Mail Address: _______________ **Preferred Mailing:** Home____ Business____

Home Phone: _______________ **Cell Phone (optional):** _______________

Home Address:_______________ **Apartment Number:**_______________

City: _______________ **State:** _______________ **Zip+4:**_______________

Business Phone: _______________ **Business Name:** _______________

Business Address: _______________ **Suite Number:** _______________

City: _______________ **State:** _______________ **Zip+4:**_______________

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

Street Address: _______________

City: _______________ **State:** _______________ **Zip+4:**_______________

II. Information on Previous Licensure:

A. Do you currently hold a certificate, registration or license to practice in addiction counseling in another state or jurisdiction? Yes____ No____

If "yes", please answer the following questions:

1. Under what name: _______________
2. For which state: _______________ License Number: _______________
3. For which credential: _______________ Is this a clinical level? Yes ____ No____
4. Does this credential allow you to practice independently, including the diagnosis and treatment of substance use disorders? Yes ____ No ___
5. Date Issued: _______________ Expiration Date: _______________
6. Was this continuous licensure? Yes ____ No ____
   If no, what period of time where you **NOT** licensed: _______________

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

1. Under what name:____
2. When:_________________________ For which credential:____

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

III. Merit of the Public Trust:

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

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

IV. Educational Qualifications:

A. Transcript(s):

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

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

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

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

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

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

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

VI. Examination:

Did you complete the national Examination for your profession? Yes____ No____
If you answered "yes" please answer the following:

1. Name of examination: ___________________ Who Administers the examination: ________________
2. What level of examination did you complete: ____
3. Through what state or jurisdiction: _______________ Date exam was taken: ___________________
4. Did you pass in your jurisdiction? Yes____ No____ Score Received: ___________________________

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

VIII. Applicant's Attestation:

A. I have reviewed the licensure eligibility requirements prior to submitting this application. Yes____ No____

B. I have completed the application materials and procedures honestly and in good faith. Yes____ No____

C. I understand that the members and staff of BSRB are compelled by law to uphold, implement and enforce the licensure statutes and regulations as written. Yes____ No____

D. I understand that all state records pertaining to application and licensure may be used to conduct research or program evaluation, but any such research will not personally identify the applicants or licensees, either directly or indirectly. Yes____ No____

E. I understand that the Board has the statutory authority to refuse to grant licensure to, or may suspend, revoke, condition, limit, qualify, or restrict the license of any individual that has knowingly made a false statement on a BSRB form required for licensure or licensure renewal. Yes____ No____

F. I **have read** and am familiar with the appropriate statutes and regulations governing the practice of the professional license for which I am applying. Yes____ No____

G. I understand that **once the Board receives my application I am bound by, and will abide by, the statutes and regulations** governing the profession of the license for which I am applying Yes____ No____

Signature:____Date:______________________________________

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APPLICATION FOR LICENSURE THROUGH RECIPROCITY

Attachment A - Out-of-State Clearance Form

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

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

A. Name:______________________________

B. Social Security #:______________________________Date of Birth:______________________________

C. Maiden or other name in which license was issued: ______________________________

D. Type of Credential held in the other state______________________________

E. Type or Field of Practice:______________________________

F. License Number:______________________________

G. Date of Issuance:______________________________

H. Date of Expiration:______________________________

I. Level of Licensure (Baccalaureate, Masters, Doctorate):______________________________

J. Current licensing requirements to be submitted with out of state clearance form ? **Yes** _____ **No** _____
If you are applying for licensure through "substantially equivalent" licensing requirements, your current licensing agency will need to provide current licensing requirements with this form.

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

A. Type of Credential (please circle applicable designation): Licensure_____Registration_____Certification_____

B. Type or Field of Practice:______________________________

C. Lic/Reg/Cert Title ______________________________ Lic/Reg/Cert Number:______________________________

D. Date Issued:______________________________Date of Expiration:______________________________

E. Did license ever lapse or expire prior to date of expiration listed in letter "D"? **Yes** ___ **No** ____

If yes, please explain ______________________________

F. Level of Lic/Reg/Cert (Baccalaureate, Masters, Doctorate): ______________________________

G. Does this license allow independent practice including the diagnosis and treatment of substance use disorders?
Yes ___ **No** ____

H. Is Lic/Reg/Cert in Good Standing? **Yes**____**No**____ If "**no**", please state reason(s):

____

____

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

____

____

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

____

____

K. Degree Received _________ Major ___________________ Date Degree Received __________________

L. University or Institution of where degree was completed _______________________________________

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

N. Examination Information:

Name of examination taken?____

Who Administered the examination?____

What level of examination did the licensee complete ? _______________________________

Through what state or jurisdiction ___________ Date exam was taken __________________

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

N. Additional Comments:

Signature of State Board Representative: ____________________________________ Date: ____________________

Printed Name: ____

Official Title/Position: ____

State or Jurisdiction: ____

Agency: ____

Mailing Address: ____

Phone Number: __________________________________ Fax Number:_____________________________________

Email Address: ____

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

I. Please complete the following information:

Applicant Name: ____

Lic/Reg/Cert Type: ____________________________________ Lic/Reg/Cert #:__________________________

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

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

Business Name: ____

Business Address: ____

City: ____ State: _________________ Zip:_______________

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

____

Business Name: ____

Business Name: ____

Business Address: ____

City: ____ State:__________________ Zip:_______________

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

____

Business Name: ____

Business Address: ____

City: ____ State: _________________ Zip:_______________

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

II. Signature

Signature of Applicant: ____________________________________ Date: _________________________________

Printed Name: ____

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Credit Card Payment Form

Only complete when paying by credit card.

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

Amount of Purchase: $____________

Credit Card: American Express _______ Discover ________
MasterCard ________ Visa __________

Credit Card Acct. # __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Credit Card Expiration Date ___ ___ / ___ ___

Name as it appears on the card ____

Signature: _______________________________ Date_________________

For Office Use Only:

Approval Number __________________ **Date** ________________