

## 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](http://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. **Fee:** Instructions for paying the \$50.00 application fee may be found on **Appendix A**. 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 for at least 48 of the 54 months immediately preceding the date of 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 4 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](http://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;
- The application fee of \$50.00; See Appendix A

**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](http://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.*

David B. Fye, JD, Executive Director

Laura Kelly, Governor

## LICENSURE APPLICATION THROUGH RECIPROCITY (LAC)

**Application Fee: \$50.00 please see Appendix A**

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: \_\_\_\_\_

- A. Are you a military servicemember (a current member of any branch of the United States armed services, United States military reserves or national guard of any state, or a former member with an honorable discharge) Yes \_\_\_ No \_\_\_  
(If yes, please provide a copy of your military ID, a copy of your DD-214, or other proof of military service.)
- B. Are you a military spouse (the spouse of a military servicemember)? Yes \_\_\_ No \_\_\_  
(If yes, please provide a copy of your military ID, DD-214, or other proof of military service.)
- C. Have you established residency in the State of Kansas? Yes \_\_\_ No \_\_\_
- D. If no, do you intend to establish residency in the State Kansas? Yes \_\_\_ No \_\_\_  
If "Yes" please explain: \_\_\_\_\_

### 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:

- Under what name: \_\_\_\_\_
- For which state: \_\_\_\_\_ License Number: \_\_\_\_\_
- For which credential: \_\_\_\_\_ Is this a clinical level? Yes \_\_\_ No \_\_\_
- Does this credential allow you to practice independently, including the diagnosis and treatment of substance use disorders? Yes \_\_\_ No \_\_\_
- Date Issued: \_\_\_\_\_ Expiration Date: \_\_\_\_\_
- 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:**

**A.** If you answer yes to question 1 and/or 2, regarding convictions, you are required to complete the Conviction Packet. Click on this link to download [Conviction Packet](#) or you may find this packet on our website, [www.ksbsrb.ks.gov](http://www.ksbsrb.ks.gov) under forms. See # 2 in the instructions.

1. Have you ever been convicted of a felony? Yes \_\_\_ No \_\_\_
2. Have you ever been convicted of a misdemeanor crime against a person? Yes \_\_\_ No \_\_\_

**B.** If you answer “Yes” to any of the following 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.**  
*Your application will not be processed without this information.*

3. 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 \_\_\_
4. Have you ever had disciplinary action taken against you for unethical behavior, unprofessional conduct or any other grounds? Yes \_\_\_ No \_\_\_
5. Have you used any alcohol, narcotic, barbiturate or 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 \_\_\_
4. 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 \_\_\_
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 \_\_\_
6. 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 \_\_\_
7. Has any state, jurisdiction, providence, or professional organization denied your application for credentials or professional membership? Yes \_\_\_ No \_\_\_
8. Have you ever been sued for malpractice, or agreed to pay a settlement in a malpractice suit? Yes \_\_\_ No \_\_\_
9. 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 addition 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.

**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. Some state boards will not verify exam scores.

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

**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 Information:

University or College where degree was granted \_\_\_\_\_

What Degree did the licensee receive \_\_\_\_\_ Major \_\_\_\_\_

Date Degree Received \_\_\_\_\_

L. 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: \_\_\_\_\_

## *Appendix A*

### *Payment Instructions*

1. Individuals wishing to submit payments to the BSRB using a credit card or electronic check should:

- (1) visit the BSRB website at [ksbsrb.ks.gov](http://ksbsrb.ks.gov)
- (2) select the “SERVICES” drop-down tab from the top of the home screen, and
- (3) 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.

**For Office Use Only:**

**Approval Number** \_\_\_\_\_ **Date** \_\_\_\_\_