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 (LCAC)

1. Before you begin to complete the application form, 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. **You must hold an active license in another state to apply for licensure through reciprocity.**

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

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 cash or credit card. **ALL FEES ARE NON-REFUNDABLE**. There is a separate fee for the original license. This license fee is not paid until you have been notified that you have been approved for licensure.

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 a clinical addiction counselor. See KSA 65-6607 through 65-6620 and as amended in L. 2011, ch.114 beginning with Sec.10. Detailed requirements may be found in the regulations. All statutes and regulations can be found on our website.

   Route 2) A. Continuous registration, certification or licensure to practice clinical 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 masters degree.

   D. In addition to the requirements listed in #6 after meeting route 1 or 2, you must also demonstrate the ability to diagnosis and treat substance use disorders through at least two of the following areas acceptable to the board:

1. (i) Satisfactory completion of 15 graduate credit hours supporting diagnosis and treatment of substance use disorders which includes: three graduate semester hours of discrete coursework in ethics, three graduate semester hours of discrete coursework in the diagnosis and treatment of substance use disorders that includes studies of the established diagnostic criteria for substance use disorders, and coursework that addresses interdisciplinary referrals, interdisciplinary collaborations, and treatment approaches; **OR**

(ii) Passing a national Examination for clinical addiction counseling.

2. One or both of the following types of documentation which will need to cover a period of at least 3 years; - Use Attachment C.
(i) An attestation by a supervisor or other designated representative of your employer that you have had at least 3 years of clinical practice, including at least 8 hours of client contact per week during 9 months or more of each year in a treatment facility, community mental health center or its affiliate, state mental hospital, or another employment setting in which the applicant engaged in clinical practice that included diagnosis or treatment of substance use disorders; **OR**
(ii) an attestation by the applicant that the applicant engaged in at least three years of independent clinical practice that included diagnosis or treatment of substance use disorders, as well as supporting documentation, please see Attachment C for a list of appropriate documentation.
3. An attestation that the applicant has demonstrated competence in diagnosis or treatment of substance use disorders, which shall be signed by either a professional licensed to practice medicine and surgery or another professional licensed to diagnose and treat mental disorders or substance use disorders, or both, in independent practice. – Use Attachment D.

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:

All applicants must submit the following:

- ☐ $50.00 application fee;
- ☐ The completed application form;
- ☐ Appropriate attachments showing competence to diagnosis and treat substance use disorders;

Applicants applying using Route 2 must submit the following:

- ☐ If you are applying using Route 2 – Attachment B showing 5 years of practice as a clinical addiction counselor, and Attachment E if your degree is in a related field;

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.

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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LICENSURE APPLICATION THROUGH RECIPROCITY (LCAC)

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 clinical 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 <u>all</u> states in which you hold or have held a license, registration, or certification. This is not limited to clinical addiction counseling.

III. <u>Merit of the Public Trust</u>:

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):

<u>All transcripts must be sent directly from your college or university or licensing agency to the Board office. The Board cannot accept any transcripts received from the applicant.</u>

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:
_____

V. Examination or Coursework, i*f you are using passage of an approved examination **OR** the 15 hours of graduate coursework to show competence to diagnose and treat substance use disorders, please complete the appropriate section below.*

Examination:

Did you complete a national Examination for clinical addiction counseling? 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.

15 Graduate Hours for Clinical Licensure

If you are using the coursework option, you must show completion of at least 15 graduate credit hours supporting the diagnosis and treatment of substance use disorders, which shall include the following:

- Three graduate semester hours of discrete coursework in ethics;
- three graduate semester hours of discrete coursework in the diagnosis and treatment of substance use disorders that includes studies of the established diagnostic criteria for substance use disorders; and
- coursework that addresses interdisciplinary referrals, interdisciplinary collaborations, and treatment approaches.

Course #	Course Title	Credit Hrs	University/College
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Be sure to request a transcript be sent directly from your university or college to the Board office.

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 SW 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 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: _____

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APPLICATION FOR LICENSURE THROUGH RECIPROCITY
Attachment B - ATTESTATION OF PROFESSIONAL PRACTICE IN CLINICAL 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 clinical 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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Regulatory Board

APPLICATION FOR LICENSURE THROUGH RECIPROCITY

Attachment C - ATTESTATION OF CLINICAL EXPERIENCE ATTACHMENT

Applicant Name _____

If you were in an independent practice setting when you completed the required three years of clinical experience, please complete Section A and attach appropriate documentation, as listed below and return the form with your application for licensure.

If you were an employee when you completed the required three years of clinical experience, please skip section A and have your work supervisor complete section B. The supervisor should return the completed form in a sealed envelope with their signature across the seal. You will then submit the form in the unopened envelope with the rest of your application.

A. Independent Practice: If you worked in an independent practice setting, please complete the following:

Name of Agency _____ Phone _____

Address of Agency _____ City_____ State_____ Zip_____

I _____, attest that I have engaged in a minimum of 3 years of independent clinical practice which included diagnosis and treatment of mental disorders.

Please attach one of the following forms of documentation before submitting form to the Kansas BSRB:

- Published job description,
- Description of your practice in a public information brochure,
- Description of services in an informed consent document, or
- A similar published statement demonstrating you have engaged in independent clinical practice for a minimum of 3 years **OR**
- An attestation signed by a professional licensed to practice medicine and surgery, or a licensed psychologist, a licensed specialist clinical social worker, or a professional licensed to diagnosis and treat mental disorders in independent practice.

Signature of Applicant _____ Date_____

Printed Name of Applicant _____

B. Instructions for Supervisor: Please complete only section B and return to the applicant in a sealed envelope with your signature across the seal.

Name of Employer _____

Address of Employer _____
Street City State Zip

Employer Phone _____ Employer Fax _____

Applicant's Position/Title _____ Applicant's Lic/Reg/Cert Type _____

Applicant's Work Dates _____
Start Date End Date

Continued

Does the applicant have at least 3 years of clinical practice that included diagnosis and treatment of mental disorders?
Yes ____ **No** ____

If yes, did the applicant conduct at least 8 hours of client contact per week for 9 months or more of each year?
Yes ____ **No** ____

If no, how many client contact hours completed per week, per year? _____

Work Description: _____

_____

_____

Supervisor's Lic/Reg/Cert: Type:_____ Number: _____

I have been personally acquainted with the applicant **for** _____ **years.**

I attest that the applicant _____**is** _____**is not** competent in diagnosis and treatment of mental disorders.

I attest that the foregoing information supplied by the applicant is true to the best of my knowledge I believe the applicant to be of good professional character and worthy of confidence.

Supervisor Signature:_____ Date: _____

Printed Name of Supervisor: _____

Please place this form in a sealed envelope, sign across the closed seal and return to the applicant.

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Regulatory Board

APPLICATION FOR LICENSURE THROUGH RECIPROCITY
Attachment D - ATTESTATION FROM A LICENSED PROFESSIONAL

Instructions to Applicant: This form should be completed by a professional licensed to diagnose and treat mental disorders or substance use disorders, or both, in independent practice. The referencing individual should return the completed form to you in a sealed envelope with their signature across the seal. You will then submit the form in the unopened envelope with the rest of your application.

Name of Applicant: _____ Date: _____

Instructions to Referencing Individual Completing the Form: The above named individual is applying for licensure in the State of Kansas. Please provide a written response attesting to this individual's competency to diagnose and treat substance use disorders. Return the completed form to the applicant in a sealed envelope with your signature across the seal.

A. Name of Referencing Individual: _____ Title: _____

B. License Type:_____ License Number: _____

C. Business Name: _____ Phone:_____

D. Business Address: _____
Street Address City State Zip

E. Are you related by blood or marriage to the applicant? Yes ____ No _____
If yes, state relationship:_____

F. How long have you known the applicant: _____

G. In what work setting have you known the applicant, include name of agency:_____
_____

H. What relationship (such as supervisor or co-worker) have you had with the applicant which has aided you in forming your opinion of his/her competence to diagnose or treat substance use disorders: _____
_____

I. Are you aware of any significant facts concerning the applicant's background which would reflect unfavorably on the applicant's character and fitness to practice as a clinical addiction counselor? Yes ____ No ____
If yes, please state these facts as fully as possible on a separate sheet of paper.

J. In your opinion is the applicant competent to diagnose or treat substance use disorders? Yes ____ No _____

K. What evidence can you provide related to the applicant's competence to diagnose and treat substance use disorders? Include amount and length of experience. (Feel free to expand on a separate sheet of paper if needed).
_____
_____
_____

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 competence to diagnose and treat substance use disorders in the State of Kansas. Any response or information I have provided is true and correct to the best of my knowledge and belief. Where I have relied upon other sources of information, they are only those which I believe to be accurate and reliable

Reference's Signature:_____ Date: _____

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

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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 _____**