Behavioral Sciences Regulatory Board
700 SW Harrison St. Suite 420
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**David B. Fye, JD,** Executive Director

Kansas
Behavioral Sciences
Regulatory Board

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www.ksbsrb.ks.gov
**Laura Kelly**, Governor

## CLINICAL ADDICTION COUNSELORS (LCAC)
## LICENSURE APPLICATION

# *Instructions*

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

1. **Application:** Please answer all questions on the application completely and accurately. If there have been any convictions of a felony or other past or current events that potentially raise questions about your ability to merit the public trust, additional information will be requested.

2. **Fee:** Instructions for paying the $50.00 application fee may be found on **Appendix A**. FEES ARE NON-REFUNDABLE.

3. **Academic Background form:** If you do not hold a master's degree from a program accredited by the National Addiction Studies Accreditation Commission (NASAC) you must complete the Academic Background form and submit with your complete application.

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

5. **Transcript:** As part of the application process, an official transcript mailed directly from the Registrar's office is required. **Only transcripts received directly from the university can be accepted.**

6. **Professional References:** Three references are required as part of your complete application packet. The professional reference form included in the application packet will need to be copied.
   - **a)** Each reference should return the completed form to you in a sealed envelope with their signature across the seal. The three reference forms will need to be included when your application is submitted to the Board office. NOTE: It is very important that references sign across the seal of the envelope to assure the Board of the confidentiality and integrity of the referencing process.
   - **b)** One of the references must be from the **on-site supervisor** from your current or most recently completed graduate addiction counseling practicum. If this person is unavailable the director of the field education program or a designated person who has knowledge of your practicum based on your program records shall complete the form.
   - **c)** The additional two references must be authorized by law to practice addiction counseling or to practice in a related field.

7. **Out-of-State Verification:** If you are or have ever been licensed, registered, or certified in one of the behavioral or health sciences in another state, the Out-of-State Verification Form will need to be completed by the other state(s). This form needs to be returned directly to the Board office. **Only forms received directly from the other state(s) can be accepted.**

8. **Review:** It is extremely important for you to understand that the Board cannot determine whether you are eligible to sit for the examination until all of the application materials have been received and approved by the Board office.

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

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

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

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

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

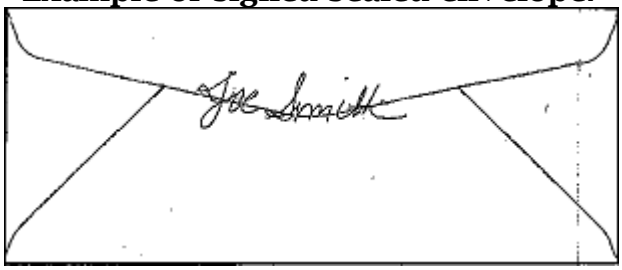
- The completed application form (please complete all pages so that your application will not have to be returned);
- The application fee of $50.00 made payable to BSRB by cash, check, money order, or credit card;
- Post-Graduate Supervisor Attestation(s).
- The three (3) completed Professional Reference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

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

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

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

**Example of signed sealed envelope:**



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# CLINICAL ADDICTION COUNSELOR LICENSURE APPLICATION LCAC

# *Application*

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

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

**Legal Name:** _____ _____ _____
**Last** **First** **Middle**

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

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

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

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

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

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

**Home Address:**_____ **Apartment Number:**_____

**City:** _____ **State:** _____ **Zip+4:**_____

**Business Phone:** _____ **Business Name:** _____

**Business Address:** _____ **Suite Number:** _____

**City:** _____ **State:** _____ **Zip+4:**_____

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

**Street Address:** _____

**City:** _____ **State:** _____ **Zip+4:**_____

## **Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP)**

Are you willing to be included on a registry of potential volunteers to provide your professional services during an emergency? **Please check all that apply.**

Within your county of residence: _____ Within 75 miles of your residence: _____

Anywhere in the State of Kansas: _____ Outside of the State of Kansas: _____

## II. Application/Licensure Information:

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

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

**1.** Which credential:_____ Under what name:_____

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

**2.** For which credential:_____ When:_____

**3.** Under what name:_____

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

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

**2.** Under what name:_____

**3.** Issue Date: _____ Expiration Date: _____

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

## III. Educational Information:

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

Please attach an additional sheet if needed.

**1.** Name:_____

**2.** Location (City and State):_____

**3.** Degree Received:_____ Date of Degree:_____

**4.** Name of School:_____

**5.** Location of School:_____

**6.** Degree Received:_____ Date of Degree:_____

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

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

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

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

1. ____ A master's degree in addiction counseling or a related field, if the applicant began the program before May 1, 2011 and the master's degree is conferred on or before June 1, 2012, from a program that was approved by the Kansas department of social and rehabilitation services, division of addiction and prevention services.

2. ____ A master's degree in addiction counseling or a related field and at the time the degree was granted, the program was accredited by the National Addiction Studies Accreditation Commission (NASAC).

3. ____ A master's degree in one of the related fields: education ___, criminal justice ___, counseling ___, healing arts ___, human development and family studies ___, human services ___, marriage and family therapy ___, nursing ___, psychology ___, social work ___ or theology, that **INCLUDED** coursework that meets the educational requirements outlined in K.A.R. 102-7-3. You **WILL** need to complete the Academic Background Form and the Graduate Practicum Review Form.

4. ____ A master's degree in one of the related fields: education ___, criminal justice ___, counseling ___, healing arts ___, human development and family studies ___, human services ___, marriage and family therapy ___, nursing ___, psychology ___, social work ___ or theology, with **ADDITIONAL** coursework that meets the educational requirements outlined in K.A.R. 102-7-3. You **WILL** need to complete the Academic Background Form and the Graduate Practicum Review Form.

**E. Practicum Information:**

**1.** Dates of Practicum:_____

**2.** Practicum Agency:_____

**3.** Practicum Agency Address: _____

**4.** Name of Supervisor:_____

**5.** Supervisor's Address:_____

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

## IV. References' Requirements:

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

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

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

| Names | Credentials | Agency and Address | Phone # |
|---|---|---|---|
| | | | |
| | | | |
| Practicum/Work Supervisor | | | |

## V. Merit of Public Trust:

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

1. Have you ever been convicted of a felony?
   **Yes No**
2. Have you ever been convicted of a misdemeanor crime against persons?
   **Yes No**
3. Have you ever been found guilty of or liable for fraud or deceit in connection with services rendered as an addiction counseling service provider by a civil or criminal court of law or board of a professional organization?
   **Yes No**
4. Have you ever knowingly aided or abetted a person, not a licensed addiction counselor, in representing him/her as a licensed addiction counselor?
   **Yes No**
5. Have you used any alcohol, narcotic, barbiturate other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent within the last 2 years?
   **Yes No**
6. Have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice behavioral sciences with reasonable skill and safety within the past 2 years?
   **Yes No**
7. Have you used controlled substances which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the direction of a licensed health care provider within the past 2 years?
   **Yes No**
8. Have you ever been found to be in violation of a professional association's code of ethics or of a state licensing board's rules and regulations or statutes regarding professional conduct?
   **Yes No**
9. Have you ever paid a judgment or settlement in a negligence action that concerned your addiction counselor profession?
   **Yes No**
10. Have you ever resigned from a professional association, withdrawn from an undergraduate or graduate program or surrendered your license to a state licensure board while an ethical complaint was pending against you?
    **Yes No**
11. Has any governmental agency ever substantiated allegations made against you for physical, mental or emotional abuse or neglect, sexual abuse, or exploitation of (1) a child, (2) a resident of an adult care home, medical care facility, psychiatric hospital or state institution for the mentally retarded, or (3) an adult?
    **Yes No**

## VI. Applicant's Attestation:

**Circle** "yes" or "no" to the following questions.

1. I have reviewed the licensure eligibility requirements prior to submitting this application.
   **Yes No**
2. I have completed the application materials and procedures honestly and in good faith.
   **Yes No**
3. I understand that the members and staff of the BSRB are compelled by law to uphold, implement, and enforce the licensure statutes and regulations as written.
   **Yes No**
4. I understand that all state records pertaining to application and licensure may be used to conduct research or program evaluation, but such research will not personally identify the applicants or licensees, either directly or indirectly.
   **Yes No**

5. I understand that the Board has the statutory authority to refuse to grant licensure to, or may suspend, revoke, condition, limit, qualify, or restrict the license of any individual that has knowingly made a false statement on a BSRB form required for licensure or renewal.
   **Yes No**
6. I **have read** and am familiar with the statutes and regulations that govern the practice of addiction counseling in the state of Kansas.
   **Yes No**
7. I understand that **once the Board receives my application I am bound by the statutes and regulations governing the practice of addiction counseling in Kansas.**
   **Yes No**

**I hereby affirm that to the best of my knowledge all my answers to the foregoing are correct. I further agree that all state records pertaining to my application and licensure may be used to conduct research or program evaluation, provided that the research does not personally identify me, directly or indirectly.**

SIGNATURE OF APPLICANT DATE OF APPLICATION

**NAME or ADDRESS CHANGE:** It is the applicant's responsibility to notify the Board in writing of any name or address change that might occur during the application process.

Kansas
Behavioral Sciences
Regulatory Board

**APPLICATION FOR CLINICAL ADDICTION COUNSELOR LICENSURE: LCAC**

# *Professional Reference Form*

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

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

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

**To:** (Name of reference-please print) _____

**From:** (Name of Applicant-please print) _____

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

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

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

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

**Section II:**

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

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

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

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

## I. Professional Reference's Information:

**A.** Name: _____

**B.** Business Name: _____

**C.** Street Address: _____

**D.** City _____ State: _____ Zip: _____

**E.** Phone: _____ Fax: _____

**F.** Educational Background: _____ Professional Title: _____

**G.** Do you hold a professional license? Yes_____ No_____ **If "yes", please answer the following questions.**

**1.** Professional License held: _____ License #: _____

**2.** State of Issuance: _____ Issuance Date: _____ Expiration Date: _____

## II. Please circle yes or no to following questions.

**A.** Were you the applicant's on-site practicum supervisor?
**Yes** **No**

**B.** What relationship (such as employer, supervisor, co-worker, instructor) have you had with the applicant which has aided you in forming any opinion of his/her character:

_____

**C.** Have you supervised the applicant in a work setting?
**Yes** **No** **If yes please list the dates you supervised the applicant.**

**Beginning Date:** Month_____ Year_____ **Ending Date:** Month_____ Year_____

**D.** Are you related by blood or marriage to the applicant?
**Yes** **No** **If yes,** please state relationship to the applicant. _____

**E.** How long have you known the applicant? _____

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

**A.** Please consider the candidate's behavior in the following areas: good judgment, integrity, honesty, fairness, credibility, reliability, respect for others, respect for the laws of the state and nation, self-discipline, self-evaluation, initiative, and commitment to the clinical addiction counseling profession and its values and ethics. Does the candidate, in your opinion, possess the moral standards and fitness required for working as a clinical addiction counselor?
**Yes** **No** **If your answer is "no", please elaborate in detail in an attached statement.**

**B.** Are you aware of any significant facts concerning the applicant's background that would reflect **unfavorably** on the applicant's character and fitness to practice clinical addiction counseling?
**Yes** **No** **If your answer is "yes", please state these facts in detail on an attached statement.**

**C.** Do you recommend the applicant for licensure to practice clinical addiction counseling in Kansas?
**Yes** **No** **If not, please elaborate in detail in an attached statement.**

**D.** **If you have known the applicant for less than 6 months** please list some specific examples of what you have witnessed that allows you to make the above mentioned determinations.

_____

_____

_____

_____

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

_____

_____

_____

_____

## IV. Professional Reference's Attestation:

Reference's Attestation: I certify the foregoing answers and information furnished above are given in good faith with the understanding that it will be utilized for purposes of determining the applicant's ability to practice addiction counseling and merit of the public trust in order to be licensed as a clinical addiction counselor in the State of Kansas. Any response or information I have provided is true and correct to the best of my knowledge and belief. Where I have relied upon other sources of information, they are only those which I believe to be accurate and reliable.

**Signature:**_____ **Date:**_____

Kansas
Behavioral Sciences
Regulatory Board

## APPLICATION FOR LICENSURE AS A LICENSED CLINICAL ADDICTION COUNSELOR: LCAC

### Academic Background Form

Name:_____Date:_____

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

Please indicate the courses you completed that meet these requirements. Courses cannot be duplicated. If the relationship between the courses(s) you took and the course content category is not readily apparent, please attach course syllabus or the university's course catalog to this form.

The following activities shall **NOT** be reported, substituted for or counted toward the academic coursework requirements:

1. academic coursework that has a failing or incomplete grade;
2. academic coursework that was audited;
3. continuing education, in-service, or on-the-job training;
4. nonacademic coursework or training;
5. coursework taken for undergraduate credit

Note: A maximum of three semester credit hours or academic equivalent may be completed in independent study. If your college or university awarded quarter or trimester credit hours rather than semester hours, please indicate by putting a Q (for quarter hours) or a T (for trimester hours) adjacent to the reported number of credit hours throughout the form.

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

| Course # | Course Title | Credit Hrs | University |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

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

| Course # | Course Title | Credit Hrs | University |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

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

| Course # | Course Title | Credit Hrs | University |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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

| Course # | Course Title | Credit Hrs | University |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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

| Course # | Course Title | Credit Hrs | University |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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

| Course # | Course Title | Credit Hrs | University |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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

| Course # | Course Title | Credit Hrs | University |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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

**9.**

| Course # | Course Title | Credit Hrs | University |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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

| Course # | Course Title | Credit Hrs | University |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Kansas
Behavioral Sciences
Regulatory Board

## APPLICATION FOR LICENSURE AS A CLINICAL ADDICTION COUNSELOR: LCAC

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

### Consent and Authorization to Release Information

Applicant's Name (Please print):_____

Supervisor's Name (Please print):_____

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

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

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

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

_____

Signature of Applicant Date

## I. Setting where supervised postgraduate experience occurred:

A. Agency/Practice Setting name:_____

B. Address:_____

C. Phone:_____Fax:_____

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

## II. Supervised hours while under your supervision:

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

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

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

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

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

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

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

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

A. License type _____License number:_____

B. Original date of issue:_____State:_____

C. Is this license an independent, clinical level of licensure? Yes____ No____

D. Were you under any disciplinary sanction, restriction or have any disciplinary action pending by a professional licensing or credentialing board at the time you provided supervision Yes____ No____

E. Did you have, at least in part, clinical responsibility for the supervisee's functioning in the practice of addiction counseling? Yes____ No____

F. Did you have a harmful dual relationship with the supervisee? Yes____ No ____

G. Did you have knowledge and experience with the supervisee's client population? Yes____ No____

H. Did you have knowledge and experience with the methods of practice that the supervisee employs? Yes____ No____

I. Did you ensure that each was aware that the supervisee was practicing addiction counseling under supervision? Yes____ No____

J. Did you have an understanding of the organization and administrative policies and procedures of the practice setting? Yes____ No____

K. Were you a member of the staff in the supervisee's practice setting? Yes____ No____
**If "no", please answer the following questions:**

1. Did you have an understanding of the mission of the practice setting? Yes____ No____
2. Was the extent of your of your responsibilities clearly defined with respect to the client cases to be supervised and your role, if any, in the personnel evaluation within the practice setting? Yes____ No____
3. Was the responsibility for payment for supervision clearly defined? Yes____ No____
4. If the supervisee paid you directly for supervision, did you maintain your responsibility to the client and the practice setting? Yes____ No____

## IV. Supervisor's requirements within the supervision process:

A. For any hours accrued on or after August 1, 2011:
1. Did you provide at least 1 hour of supervision for every 20 hours of direct client contact? Yes____ No____
2. Did you meet with the supervisee at least 2 separate times monthly? Yes____ No____
3. Did you meet with at least once a month with the supervisee for one-on-one clinical supervision occurring with you and the supervisee in the same physical space? Yes____ No____
4. Did your supervision include diagnosis and treatment of substance use disorders? Yes____ No____

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

B. For any hours accrued before August 1, 2011:
1. Did you provide supervision that was scheduled and formalized? Yes___ No____
2. Did the supervision include review and examination of cases? Yes___ No____
3. Did you provide assessment of the supervisee's competencies? Yes___ No____

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

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

D. Did you provide oversight, guidance and direction of the supervisee's practice by assessing and evaluating the supervisee's performance? Yes____ No____

E. Did you provide supervision in a process distinct from personal therapy, didactic instruction, or addiction counseling consultation? Yes___ No____

F. Did you ensure that your scope of responsibility and authority in the supervisee's practice setting was clearly defined? Yes____ No____

G. Did you periodically evaluate the supervisee's role and their clinical functioning as an addiction counselor? Yes____ No____

H. Did you provide supervision consistent with the education, training, experience, and ability of the supervisee? Yes____ No____

## V. Evaluation of the Applicant's supervised experience:

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

_____

B. Did the applicant complete all supervision goals and objectives? Yes____ No____

C. Was the applicant's performance throughout the period of supervision consistently acceptable? Yes____No____

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

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

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

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

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

## VI. Attestation of the Supervisor:

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

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

_____

Signature Date

Kansas
Behavioral Sciences
Regulatory Board

**APPLICATION FOR LICENSURE AS A LICENSED CLINICAL ADDICTION COUNSELOR: LCAC**

**Graduate Practicum Review Form**
**This form is NOT required of applicants who graduated from a NASAC accredited or candidacy program**

**Instructions for Applicant**: Section 1 should be completed by the applicant and then sent to the Graduate Program Director of the Addiction Counseling Program for completion. Please include a self-addressed, stamped envelope. Additional copies of this form may be made and used as needed by the applicant. The applicant shall submit the completed Graduate Practicum Review Form in the unopened envelope that has been signed or stamped across the seal by the Graduate Program Director, at the time of application.
Section 2: The Graduate Program Director should complete Section 2 and return the completed form in a sealed envelope signed across the seal to the applicant.

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

A. Applicant's Name: _____

B. Date of Birth:_____ Student ID #:_____

C. Degree and Graduation Date:_____

D. Applicant's Mailing Address:_____

E. Graduate Program Director:_____

F. Educational Institution:_____

G. Mailing Address:_____

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

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

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

_____

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

_____

C. As part of the applicant's graduate program, please verify that the applicant satisfactorily completed an addiction counseling experience or its equivalent as follows:
   1. Consisted of at least 300 hours: Yes____No____
   2. At lease one hours of supervision for every 10 hours of client contact: 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

Kansas
Behavioral Sciences
Regulatory Board

Phone: 785-296-3240
Fax: 785-296-3112
www.ksbsrb.ks.gov
**Laura Kelly**, Governor

**APPLICATION FOR CLINICAL ADDICTION COUNSELOR LICENSURE: LCAC**

# *Out-Of-State Verification Form*

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

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

## I. Applicant Information

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

**A.** Name under which my license was issued: _____

**B.** Name under which my license was issued (if different):_____

**C.** Licensure Type: _____Licensure Number: _____

**D.** Issue Date: _____ Expiration Date: _____

**E.** Signature:_____ Date: _____

## II. Statement from Out-Of-State Board

**A.** Name appearing on license in your state:_____

**B.** Licensure Type: _____License Number: _____

**C.** Date Issued: _____ Date of Expiration: _____

**D.** Level of Licensure (baccalaureate, masters, clinical): _____

**E.** Licensed by: Examination:_____ Reciprocity:_____ Grandfathered:_____

Other (Specify): _____

**F. If Licensed by Exam:**

Name of Exam: _____

Exam Level:_____ Date of Exam: _____

Score Received - Raw:_____ Scaled:_____ Percent:_____ State Cutoff Score:_____

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

_____

_____

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

_____

_____

**I.** Additional comments: _____

_____

_____

**Printed Name of State Board Representative:** _____

**Signature:** _____ **Date:** _____

**Official Title/Position:** _____

**Name of State Board:** _____

**Mailing Address:** _____

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

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

**Upon completion, please return this form directly to:**

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

State Seal

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

Kansas
Behavioral Sciences
Regulatory Board

Phone: 785-296-3240
Fax: 785-296-3112
www.ksbsrb.ks.gov
**Laura Kelly**, Governor

# *Appendix A*

## *Payment Instructions*

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

a. visit the BSRB website at ksbsrb.ks.gov
b. select the "SERVICES" drop-down tab from the top of the home screen, and
c. click on the "Make A Payment" link. From this page, you will be asked to provide information allowing us to identify the applicant, select the item you wish to pay for, and you will be able to make a payment for that item.

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

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

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