Reset Form

APPLICATION FOR LICENSURE AS A CLINICAL ADDICTION COUNSELOR (LCAC)

State Form 54089 (R3 / 1-13)
Approved by State Board of Accounts, 2013

BEHAVIORAL HEALTH AND HUMAN SERVICES LICENSING BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2064
E-mail: pla5@pla.IN.gov

INSTRUCTIONS: Please return this completed form to ***Professional Licensing Agency*** *at the above stated address.*

* Your Social Security number is being requested by this state agency in accordance with IC 25-1-5-11. Disclosure is mandatory and this record cannot be processed without it.

FOR OFFICE USE ONLY	
APPLICATION FEE:	
DATE FEE PAID *(month, day, year)*:	
RECEIPT NUMBER	
LICENSE NUMBER ISSUED:	
PERMIT NUMBER ISSUED:	
DATE LICENSE ISSUED *(month, day, year)*:	

Attach one passport quality photograph here (*See instructions*)

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden or previous*)

Current address (*number and street, city, state, and ZIP code*)

Permanent address (*if different from above*)

Work telephone number ( )	Home telephone number ( )	E-mail address
Social Security number *	Date of birth (*month, day, year*)	Place of birth (*city and state*)

Please indicate exactly how you wish your name to appear on your license.

Are you applying for a temporary permit? ☐ Yes ☐ No

Please check all that apply:

☐ I am applying for licensure by examination and will be taking:

- ☐ The International Advanced Examination for Alcohol & Drug Counselors through IC & RC
- **OR**
- ☐ The Master Addiction Counselor through NAADAC

☐ I am applying for licensure by exemption from examination (ENDORSEMENT)

- ☐ I have passed the (*name of examination*) _____

Date *(month, day, year)*: _____ State taken in: _____

GRADUATE EDUCATION (Master's or Doctoral)

Name of academic institution	Department	Program title
Location (*city and state*)	Dates attended (*mm/yy - mm/yy*)	Degree earned
Name of academic institution	Department	Program title
Location (*city and state*)	Dates attended (*mm/yy - mm/yy*)	Degree earned
Name of academic institution	Department	Program title
Location (*city and state*)	Dates attended (*mm/yy - mm/yy*)	Degree earned

OTHER STATE LICENSURE / CERTIFICATION

Do you hold, or have you ever held, a license / certification / registration / permit to practice any regulated health profession by a state licensing board? ☐ Yes ☐ No

(*If yes, list all states below, including Indiana, in which you have held a license / certification / registration / permit to practice any state regulated occupation.*)

Type of License / Certificate / Registration / Permit	State	Number	Date Issued *(month, day, year)*	Status
1.				
2.				
3.				
4.				
5.				

ALL APPLICANTS MUST ANSWER THE FOLLOWING QUESTIONS

If your answer is "yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location and date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No

2. Have you ever been denied license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state (*including Indiana*) or country? ☐ Yes ☐ No

3. Do you have any condition or impairment *(including a history of alcohol or substance abuse)* that currently interferes, or if left untreated, may interfere with your ability to practice as a clinical addiction counselor in a competent and professional manner? ☐ Yes ☐ No

4. Have you ever been convicted of, plead guilty to or nolo contendre to:
   (A) a violation of a Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substance or drug addiction? ☐ Yes ☐ No
   (B) any offense, misdemeanor or felony in any state? (e*xcept for minor violations of traffic laws resulting in fines*) ☐ Yes ☐ No

5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline of limitations? ☐ Yes ☐ No

6. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No

7. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties perjury that the above statements are true, complete and correct.

Signature of applicant	Date (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency, or the Behavioral Health and Human Services Licensing Board, any files, documents, records or other information pertaining to the undersigned requested by the Agency, or the Board, or any of their authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency, or the Behavioral Health and Human Services Licensing Board, to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency, and the Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm, that I have read the above statements and agree to same.

Signature of applicant	Date signed (*month, day, year*)

FORM C
VERIFICATION OF CLINICAL ADDICTION COUNSELOR COURSEWORK

Part of State Form 54089 (R3 / 1-13)

All information on this form must be typed or clearly printed.

Please list the course titles in the areas indicated below, or the graduate courses, as they appear on your transcript, that in your opinion, meet the following requirements. If the title of the course you are wishing to apply towards these requirements does not clearly reflect these content areas, you should also submit additional supporting documentation, such as course descriptions from your college or university's catalog.

Twenty-seven (27) semester hours or forty-one (41) quarter hours of graduate coursework that must include graduate course credits with material in at least the following content areas. Please indicate whether these are semester or quarter hours below.

Addiction Counseling Theories and Techniques

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter Year

Clinical Problems

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter Year

Psychopharmacology

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter Year

Psychopathology

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter Year

Clinical Appraisal and Assessment

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter Year

Theory and Practice of Group Addiction Counseling

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter Year

Counseling Addicted Family Systems

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter Year

Multicultural Counseling

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter Year

Research Methods in Addictions

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter Year

Human Development

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter Year

FORM P
VERIFICATION OF PRACTICUM FOR LICENSURE AS A CLINICAL ADDICTION COUNSELOR (LCAC)

Part of State Form 54089 (R3 / 1-13)

INSTRUCTIONS: 1. *The applicant must complete Section A, then forward to the educational institution at which the practicum was completed.*
2. *Section B must be completed by an official of the institution that has granted the academic credit for this supervised clinical experience.*

SECTION A - APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden or previous*)	Social Security number *

My minimum seven hundred (700) hour practicum was completed under the auspices of the following educational institution:

Name of institution	
Location (*city and state*)	
Date practicum began (*month, year*)	Date practicum was completed (*month, year*)

I completed the practicum at the following location:

Specific location of field experience

SECTION B - VERIFICATION OF COMPLETION OF SEVEN HUNDRED (700) HOUR PRACTICUM

As an official of the school named above, I certify that the above-named applicant has completed seven hundred (700) hours of clinical addiction counseling services for the purpose of enabling the student to develop basic theory skills and to integrate professional knowledge and skills during the completion of the practicum, internship, or field experience and included the following:

1. A minimum of two hundred eighty (280) face-to-face client contact hours of addiciton counseling services under the supervision of a licensed clinical addiction counselor who has at least five (5) years of experience or a qualified supervisor.
2. A minimum of one hundred five (105) hours of supervision from a licensed clinical addiction counselor who has at least five (5) years experience as a qualified supervisor.

I certify that the supervision for this practicum, internship, or field experience was conducted by an individual who is supervising within his/her scope of experience and training and holds an active license at the time of the supervision as a clinical addiction counselor, clinical social worker, marriage and family therapist, a physician with training in psychiatric medicine, a psychologist, clinical nurse specialist in psychiatric medicine or a mental health nursing, another state-regulated addiction counseling professional or if the experience was gained in a state where no regulation exists by an addictions or behavioral health professional of equivalent status. I further certify that the supervising individual has at least five (5) years of experience in providing addiction services.

Signature of school official	Date (*month, day, year*)

Printed name of school official	Title of school official
Name of program faculty member	Name of alternate supervisor
Name of site supervisor	Position held at the institution
Name of institution	
Name of applicant (*last, first, middle, maiden or previous*)	

FORM E2

VERIFICATION OF EXPERIENCE FOR LICENSURE AS A CLINICAL ADDICTION COUNSELOR (LCAC)

Part of State Form 54089 (R3 / 1-13)

*Complete **SECTION A** and then forward this form to your previous or current employer(s) for completion of **SECTION B**. You must submit proof that you have acquired at least 3,000 hours of post-graduate clinical experience over a two (2) year period of time. **This form may be duplicated if your 3,000 hours of experience have been completed at more than one place of employment.** If you are no longer able to contact your previous employer(s), you may complete **SECTION C** (on the reverse side of this form) for each previous place of employment. Sign the form(s) in the presence of the Notary Public and have your signature notarized, then return the form to the Professional Licensing Agency at the address listed in the lower left hand corner of this form.*

SECTION A / APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Social Security number *
Name of employer	Dates of employment (*month/year to month/year*)
Location of place of employment or place of practice	

SECTION B / EMPLOYER / EMPLOYMENT INFORMATION

This section is to be completed by the applicant's previous or current employer, notarized and sent directly to the Professional Licensing Agency at the address listed in the lower left hand corner of this form.

Total number of months the above-named applicant served in the practice of clinical addiction counseling: _____

Total number of hours served at the address below: _____

The above-named applicant was providing clinical addiction counseling services directly to clients on an average of at least _____ hours per week, during the period of time he / she was in my employment.

Address(es) of where the above-named applicant provided the majority of his / her clinical addiction counseling services:

_____

_____

I swear that the above information is true and correct to the best of my knowledge and belief.

SEAL OF NOTARY PUBLIC

_____
Signature of employer

_____
Printed name of employer and title

( )
Cellular telephone number

( )
Work telephone number

_____
E-mail address

_____
Date (*month, day, year*)

RETURN THIS FORM TO:
Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, IN 46204

FORM E2

VERIFICATION OF EXPERIENCE FOR LICENSURE AS A CLINICAL ADDICTION COUNSELOR (LCAC) *(cont.)*

Part of State Form 54089 (R3 / 1-13)

SECTION C / AFFIRMATION OF EXPERIENCE

To be completed by applicant if the applicant's previous employer is no longer able to complete ***SECTION B,*** *Please indicate below the reason why your previous employer is no longer able to complete* ***SECTION B, If you are affirming experience acquired through more than one previous employer this form may be duplicated, but you must submit one notarized AFFIRMATION OF EXPERIENCE for each previous employer that is no longer able to complete SECTION B.***

I am unable to have my previous employer(s) complete SECTION B for the following reason:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please briefly explain:

_____

_____

Total number of months that you have been providing clinical addiction counseling services directly to clients on an average of at least _____ hours per week, at the address below: _____

Total number of hours served at the address below: _____

Period of time in which you provided these services: _____ (*month / year*) to _____ (*month / year*)

Name of facility and address where clinical addiction counseling services were provided:

_____

_____

Provide the name of a professional colleague who can attest to the validity of the above statements:

_____ ( ) _____

Name of colleague (*last, first, middle, maiden*) Daytime telephone number of colleague

_____

Address of colleague *(number and street, city, state, and ZIP code)*

_____

List all graduate degrees, credentials and / or state board issued licenses / certifications held by this colleague

APPLICANT'S AFFIRMATION

(*To be completed only if applicant is unable to complete SECTION B*)

_____ _____

Signature of applicant (*Sign only in the presence of the Notary Public*) Date (*month, day, year*)

Before me, the undersigned, a Notary Public for _____ County, State of _____

_____, personally appeared and acknowledged in the foregoing

(*Name of applicant*)

statements as true and correct to the best of his / her knowledge and belief this _____ day of _____, 20 _____.

_____, Notary Public.

(*Signature of Notary Public*)

County of Residence: _____

My Commission Expires: _____

FORM S2

VERIFICATION OF SUPERVISION FOR LICENSURE AS A CLINICAL ADDICTION COUNSELOR (LCAC)

Part of State Form 54089 (R3 / 1-13)

*Complete **SECTION A** and then forward this form to your previous or current supervisor(s) for completion of **SECTION B**. You must submit proof that you have received at least two hundred (200) hours of face to face supervision with one hundred (100) hours under individual supervision and one hundred (100) hours must be under group supervision that was provided by an approved addictions or behavioral health professional with at least five (5) years of experience in providing addiction services. **This form may be duplicated if your two hundred (200) hours of face to face supervision have been completed through multiple supervisors.** If you are no longer able to contact your previous supervisor(s), you may complete **SECTION C** (on the reverse side of this form) for each previous supervisor. Sign the form(s) in the presence of the Notary Public and have your signature notarized, then return the form to the Professional Licensing Agency at the address listed in the lower left hand corner of this form.*

SECTION A / APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Social Security number *
Name of supervisor	Dates of supervision (*month/year to month/year*)

SECTION B / SUPERVISOR INFORMATION

This section is to be completed by the applicant's previous or current supervisor, notarized and sent directly from the applicant's previous or current supervisor to the Professional Licensing Agency at the address listed in the lower left hand corner of this form.

Total number of hours of face to face supervision you provided to the above-named applicant: _____

The above-named applicant was providing clinical addiction counseling services directly to clients at the time of my supervision?

☐ Yes ☐ No If No, please explain: _____

_____

I hold the following graduate degree(s), credential(s), and / or state board issued license(s) / certification(s) that qualify me to serve as a clinical addiction counselor supervisor: _____

_____

I swear that the above information is true and correct to the best of my knowledge and belief.

SEAL OF NOTARY PUBLIC

_____
Signature of supervisor

_____
Printed name of supervisor

( )
Cellular telephone number

( )
Work telephone number

_____
E-mail address

_____
Date (*month, day, year*)

RETURN THIS FORM TO:
Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, IN 46204

FORM S2

VERIFICATION OF SUPERVISION FOR LICENSURE AS A CLINICAL ADDICTION COUNSELOR (LCAC) *(cont.)*

Part of State Form 54089 (R3 / 1-13)

SECTION C / AFFIRMATION OF SUPERVISION

To be completed by applicant if your previous supervisor is no longer able to complete ***SECTION B,*** *Please indicate below the reason why your previous supervisor is no longer able to complete* ***SECTION B. If you are affirming supervision received from more than one previous supervisor, this form may be duplicated but you must submit one notarized AFFIRMATION OF SUPERVISION for each previous supervisor that is no longer able to complete SECTION B.***

Please indicate below the reason why your previous supervisor is no longer able to complete SECTION B.

My previous supervisor named below is:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please briefly explain:

_____

_____

Supervision was provided by: _____
(*Name of supervisor / last, first, middle, maiden*)

Total number of hours of face-to-face supervision you have received from this supervisor while providing clinical addiction counseling services directly to clients: _____

Date of Supervision: _____ (*month / year*) to _____ (*month / year*)

List all graduate degrees, credentials and / or state board issued licenses / certifications that qualified this individual to serve as a mental health counselor supervisor: _____

_____

APPLICANT'S AFFIRMATION

(*To be completed only if applicant is unable to complete SECTION B*)

_____ _____
Signature of applicant (*Sign only in the presence of the Notary Public*) Date (*month, day, year*)

Before me, the undersigned, a Notary Public for _____ County, State of _____

_____, personally appeared and acknowledged in the foregoing
(*Name of applicant*)

statements as true and correct to the best of his / her knowledge and belief this _____ day of _____, 20 _____.

_____, Notary Public.
(*Signature of Notary Public*)

County of Residence: _____

My Commission Expires: _____

ALL INFORMATION ON THIS FORM SHOULD BE TYPED OR CLEARLY WRITTEN.

FORM EE

VERIFICATION OF EXPERIENCE FOR LICENSURE AS A CLINICAL ADDICTION COUNSELOR (LCAC)

Part of State Form 54089 (R3 / 1-13)

TO BE USED ONLY IF YOU ARE APPLYING BY EXEMPTION FROM EXAMINATION.

*Complete **SECTION A** and then forward this form to your previous or current employer(s) for completion of **SECTION B**. You must submit proof that you have been engaged in the practice of addiction counseling for not less than three (3) of the previous five (5) years. **This form may be duplicated if your three (3) years of experience have been completed at more than one place of employment.** If you are no longer able to contact your previous employer(s), or you have been in private practice, you may complete **SECTION C** for each previous place of employment. Sign the form(s) in the presence of the Notary Public and have your signature notarized, then return the form to the Professional Licensing Agency at the address **listed in the lower left hand corner of this form.***

SECTION A / APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Social Security number *
Name of employer	Dates of employment or practice (*month/year to month/year*)
Location of place of employment or place of practice	

SECTION B / EMPLOYER / EMPLOYMENT INFORMATION

This section is to be completed by the applicant's previous or current employer, notarized and sent directly from the applicant's previous or current employer to the Professional Licensing Agency at the address listed in the lower left hand corner of this form.

Total number of months the above-named applicant served in the practice of clinical addiction counseling: _____

Total number of hours served under my employment: _____

The above-named applicant was providing clinical addiction counseling services directly to clients on an average of at least _____ hours per week, during the period of time he / she was in my employment.

Address(es) of where the above-named applicant provided the majority of his / her clinical addiction counseling services:

_____

_____

I swear that the above information is true and correct to the best of my knowledge and belief.

SEAL OF NOTARY PUBLIC

_____
Signature of employer

_____
Printed name of employer and title

( )
Cellular telephone number

( )
Work telephone number

_____
E-mail address

_____
Date (*month, day, year*)

RETURN THIS FORM TO:
Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, IN 46204

FORM EE

VERIFICATION OF EXPERIENCE FOR LICENSURE AS A CLINICAL ADDICTION COUNSELOR (LCAC) *(cont.)*

Part of State Form 54089 (R3 / 1-13)

TO BE USED ONLY IF YOU ARE APPLYING BY EXEMPTION FROM EXAMINATION.

SECTION C / AFFIRMATION OF EXPERIENCE

To be completed by applicant if the applicant was in private practice or if your previous employer is no longer able to complete ***SECTION B.*** *Please indicate below why your previous employer is no longer able to complete SECTION B. If you are affirming experience acquired through more than one previous employer this form may be duplicated but you must submit one notarized AFFIRMATION OF EXPERIENCE for each previous employer that is no longer able to complete SECTION B.*

I acquired this experience through private practice. ☐ Yes ☐ No

If you answered yes, then please proceed to Section C-2.
If you answered no, then please proceed to Section C-1.

SECTION C-1

I am unable to have my previous employer complete SECTION B for the following reason:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please briefly explain:

_____

_____

SECTION C-2

Total number of months that you have been providing addiction counseling services directly to clients at the address below on an average of at least _____ hours per week: _____ Total number of hours served at the address below: _____

Period of time in which you provided these services: _____ (*month / year*) to _____ (*month / year*)

Name of facility and address where clinical addiction counseling services were provided:

_____

_____

Provide the name of a professional colleague who can attest to the validity of the above statements:

_____ ( ) _____

Name of colleague (*last, first, middle, maiden*) Daytime telephone number of colleague

_____

Address of colleague

_____

List all graduate degrees, credentials and / or state board issued licenses / certifications held by this colleague

APPLICANT'S AFFIRMATION

(*To be completed only if applicant is unable to complete SECTION B*)

_____ _____

Signature of applicant (*Sign only in the presence of the Notary Public*) Date (*month, day, year*)

Before me, the undersigned, a Notary Public for _____ County, State of _____

_____, personally appeared and acknowledged in the foregoing
(*Name of applicant*)

statements as true and correct to the best of his / her knowledge and belief this _____ day of _____, 20 _____.

_____, Notary Public.
(*Signature of Notary Public*)

County of Residence: _____ My Commission Expires: _____