SUPPLEMENTAL FORMS FOR ADDICTION COUNSELOR APPLICATION FOR LICENSURE (LAC)

BEHAVIORAL HEALTH AND HUMAN SERVICES LICENSING BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2054
E-mail: pla8@pla.IN.gov
www.pla.IN.gov

FORM C – VERIFICATION OF ADDICTION COUNSELOR COURSEWORK

Name of Applicant:	Date of Birth:

ALL INFORMATION ON THIS FORM MUST BE TYPED OR CLEARLY PRINTED.

Please list the course titles in the areas indicated below, or 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 supporting documentation, such as course descriptions from your college or university's catalog. Once complete, you will submit the form to the PLA for processing.

Forty (40) semester hours or sixty (60) quarter hours of eligible postsecondary coursework that must include course credits with material in at least the following content areas. Please indicate whether these are semester or quarter hours below.

Addictions Theory				
Name of educational institution	Course number	Course Title	Credit hours	Semester/Quarter Year
Psychoactive Drugs				
Name of educational institution	Course number	Course Title	Credit hours	Semester/Quarter Year
Addictions Counseling Skills				
Name of educational institution	Course number	Course Title	Credit hours	Semester/Quarter Year
Theories of Personality				
Name of educational institution	Course number	Course Title	Credit hours	Semester/Quarter Year
Developmental Psychology				
Name of educational institution	Course number	Course Title	Credit hours	Semester/Quarter Year
Abnormal Psychology				
Name of educational institution	Course number	Course Title	Credit hours	Semester/Quarter Year
Treatment Planning				
Name of educational institution	Course number	Course Title	Credit hours	Semester/Quarter Year
Cultural Competency				
Name of educational institution	Course number	Course Title	Credit hours	Semester/Quarter Year
Ethics and Professional Development				
Name of educational institution	Course number	Course Title	Credit hours	Semester/Quarter Year
Family Education				
Name of educational institution	Course number	Course Title	Credit hours	Semester/Quarter Year
Group Work				
Name of educational institution	Course number	Course Title	Credit hours	Semester/Quarter Year

FORM P – VERIFICATION OF PRACTICUM FOR LICENSURE AS AN ADDICTION COUNSELOR (LAC)

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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)*	Date of Birth *(month, day year)*
My minimum three hundred fifty (350) 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 THREE HUNDRED FIFTY (350) HOUR PRACTICUM	
As an official of the school named above, I certify that the above-named applicant has completed a minimum of three hundred fifty (350) hours of addiction counseling services as described in IC 25-23.6-10.5-5 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. 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 described in 839 IAC 1-5.5-3 or 839 IAC 1-5.5-1.	
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 AN ADDICTION COUNSELOR (LAC)

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Complete **SECTION A** and then forward this form to your previous employer(s) for completion of **SECTION B.** You must submit proof that you have acquired at least two (2) years of post-graduate experience as described in IC 25-23.6-10.5-7 and 839 IAC 1-5.5-2. **This form may be duplicated if your experience has been completed at more than one (1) place of employment.** If you are no longer able to contact your previous employer(s), you may complete **SECTION C** for each previous place of employment. Sign the form(s) and return to the form to the Professional Licensing Agency.

SECTION A - APPLICANT INFORMATION

Name of Applicant (*last, first, middle, maiden or previous)*	Date of Birth *(month, day year)*
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 and sent directly to the Professional Licensing Agency.
All experience documented in this form is to be specific to addiction counseling.

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

Total number of hours served at the address below: _____.

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

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

_____.

_____.

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

Signature of employer: _____

Printed name of employer and title: _____

Cellular telephone number: _____

Work Telephone number: _____

E-mail address: _____

Date *(month, day, year)*: _____

FORM E2 – VERIFICATION OF EXPERIENCE FOR LICENSURE AS AN ADDICTION COUNSELOR (LAC) *(continued)*

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 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 addiction counseling services directly to clients on an average of at least _____ at the address below.

Total number of hours served at the address below: _____.

Total number of hours served at the address below: _____ to _____.
(month/year) *(month/year)*

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

_____.

_____.

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

_____ _____
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

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

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

FORM S2 – VERIFICATION OF SUPERVISION FOR LICENSURE AS AN ADDICTION COUNSELOR (LAC)

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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 acquired at least one hundred fifty (150) hours of post-graduate face-to-face supervision, with one hundred (100) hours under individual supervision and fifty (50) hours must be under group supervision as described in IC 25-23.6-10.5-7. The supervision must have been provided by a qualified supervisor as described in 839 IAC 1-5.5-2 or 839 IAC 1-5.5-4. **This form may be duplicated if your face-to-face supervision has been completed through multiple supervisors.** If you are no longer able to contact your previous employer(s), you may complete **SECTION C** for each previous place of employment. Sign the form(s) and return to the form to the Professional Licensing Agency.

SECTION A - APPLICANT INFORMATION

Name of Applicant (*last, first, middle, maiden or previous)*	Date of Birth *(month, day year)*
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 and sent directly to the Professional Licensing Agency.
All experience documented in this form is to be specific to addiction counseling.

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

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

The above-named applicant was providing 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 an addiction

counselor supervisor: _____.

. _____.

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

Signature of supervisor: _____

Printed name of supervisor: _____

Cellular telephone number: _____

Work Telephone number: _____

E-mail address: _____

Date *(month, day, year)* _____

FORM S2 – VERIFICATION OF SUPERVISION FOR LICENSURE AS AN ADDICTION COUNSELOR (LAC)

SECTION C - AFFIRMATION OF SUPERVISION

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 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 AFFIRMATION OF SUPERVISION for each previous supervisor that is no longer able to complete SECTION B.**

Please indicate 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 addiction counseling services directly to clients: _____.

Date of supervision: _____ to _____.
(month/year) *(month/year)*

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

_____.

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

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