

COMMONWEALTH OF VIRGINIA  
Department of Health Professions  
Board of Counseling

Perimeter Center  
9960 Mayland Drive, Suite 300  
Henrico, VA 23233-1463

Email: [coun@dhp.virginia.gov](mailto:coun@dhp.virginia.gov)  
Phone: (804) 367-4610 Fax: (804) 527-4435  
Website: [www.dhp.virginia.gov/counseling](http://www.dhp.virginia.gov/counseling)

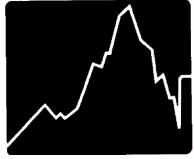
**PAPER APPLICATION INSTRUCTIONS FOR  
CERTIFIED SUBSTANCE ABUSE ASSISTANT (CSAC-A) COUNSELOR  
BY EXAMINATION**

**Completed Application:** The application must be notarized. To avoid delays, please provide a complete application packet. Incomplete packets will not be reviewed by the Credential Reviewer.

**Application Fee:** A fee of **\$115.00** is required for an application to be processed. All fees paid by check or money order must be made payable to the “Treasurer of Virginia”. This fee is non-refundable. The application is valid for one year from date of receipt.

**The below supplemental documentation must accompany your application and fee in one packet:**

- Verification of Education:** An official high school transcript or general education development (GED) certification is required.
- Verification of Experience While Under Supervision Form:** The Verification form should be completed by your supervisor, verifying the completion of your educational tasks.
- Didactic Training Verification Form:** In addition to the form, official school transcript(s) or certificates must be submitted to verify completion of a minimum of 120 hours of didactic training in substance abuse counseling. Each certificate must show your name, course name, number of clock hours, date of training and the approved providers/programs name. Training not approved or affiliated with one of the approved providers will not be considered.
- Name Change:** Documentation must be provided if your name has legally changed through marriage, divorce, or a court order and is different on any of your documentation. A photocopy of your marriage license or a copy of the court order must be provided.



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**CERTIFIED SUBSTANCE ABUSE COUNSELOR ASSISTANT (CSAC-A) BY EXAMINATION**

Military/Military Spouse:

Yes  No

Are you active duty military personnel?

Are you the spouse of a member of the U.S. military who has been transferred to

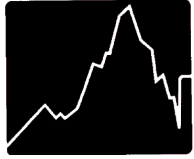
Virginia and who had to leave employment to accompany your spouse to Virginia?

Yes  No

INSTRUCTIONS				PLEASE TYPE OR PRINT CLEARLY			
<b><u>Applicant must complete all sections.</u></b>							
<b>GENERAL INFORMATION</b>							
Legal Name (Last, First)			(Middle Initial)		(Maiden)		(Suffix)
Social Security Number or Virginia DMV Control Number*					Date of Birth (MM/DD/YY)		
Public Address (Street and/or Box Number, City, State, Zip Code) **					Home Telephone Number		
Mailing Address (Street and/or Box Number, City, State, Zip Code)					Alternate Telephone Number		
E-mail Address							
<b>EDUCATION:</b> List in chronological order each graduate school or other institution where course work has been completed.							
Institution Name				Type of Degree Received			
Institution Name				Type of Degree Received			

\*In accordance with § 54.1-116 of the *Code of Virginia*, you are required to submit your Social Security Number or your control number issued by the Virginia Department of Motor Vehicles.

\*\*Licensure Address is Public Information and Published on the Internet.



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**CERTIFIED SUBSTANCE ABUSE COUNSELOR ASSISTANT (CSAC-A) BY EXAMINATION- PAGE 2**

**ANSWER THE FOLLOWING QUESTIONS:**

1. Have you ever been denied the privilege of taking an occupational licensure or certification examination? If yes, explain in detail on a separate sheet of paper.	Yes	No
2. Have you ever had any disciplinary action taken against an occupational license to practice or are any such actions pending? If yes, explain in detail on a separate sheet of paper.	Yes	No
3. Have you ever been convicted of a violation of or pled nolo contendere to any federal, state, or local statute, regulation or ordinance or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations and driving under the influence.) If yes, explain in detail on a separate sheet of paper and provide court documents.	Yes	No
4. In the last twelve (12) months, have you been unable to practice Counseling by reason of excessive use of alcohol, drugs, chemicals or any other type of material or as a result of any mental or physical condition? If yes, please provide an explanation on a separate sheet of paper.	Yes	No
5. Have you ever been censured, warned, or requested to withdraw from your employment, terminated from any health care facility, agency, or practice? If yes, provide an explanation on a separate sheet of paper.	Yes	No
6. Are you the respondent in any pending or unresolved board action in another jurisdiction or in a malpractice claim?	Yes	No

**The following statement must be executed by a Notary Public. This form is not valid unless properly notarized.  
AFFIDAVIT**

**(To be completed before a notary public)**

State of \_\_\_\_\_ County/City of \_\_\_\_\_

Name \_\_\_\_\_, being duly sworn, says that he/she is the person who is referred to in the foregoing application for licensure as a certified substance abuse counselor in the Commonwealth of Virginia; that the statements herein contained are true in every respect, that he/she has complied with all requirements of the law; and that he/she has read and understands this affidavit.

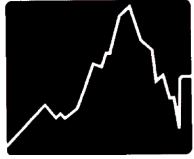
\_\_\_\_\_  
Signature of Applicant

Subscribed to and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of Notary Public

My commission expires \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

**SEAL**



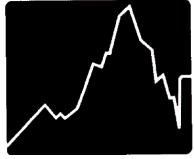
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**CSAC-A VERIFICATION OF EXPERIENCE WHILE UNDER SUPERVISION**

<b>GENERAL INFORMATION</b>		<b>PLEASE TYPE OR PRINT CLEARLY</b>	
Name of Applicant (Last, First, Middle)		Applicants Email Address	
<b>SUPERVISOR'S EVALUATION:</b>			
Supervisor's Name (Last, First)		Supervisor's License or Certification Number	Supervisor's Telephone Number
Worksite Name and Address where substance abuse tasks were performed:			
Dates of supervision: From: _____ to _____			
Did the applicant complete a minimum of 180 hours of experience performing the following tasks with substance abuse clients with <u>at least eight hours</u> for each task?			<b>(Circle Yes or No)</b>
a. Screening clients and gathering information used in making the determination for the need for additional professional assistance;	Yes	No	
b. Intake of clients by performing the administrative and initial assessment tasks necessary for admission to a program;	Yes	No	
c. Orientation of new clients to program's rules, goals, procedures, services, costs and the rights of the client;	Yes	No	
d. Assisting the client in identifying and ranking problems to be addressed, establish goals, and agree on treatment processes;	Yes	No	
e. Implementation of substance abuse treatment plan as directed by the supervisor;	Yes	No	
f. Implementation of case management activities that bring services, agencies, people and resources together in a planned framework of action to achieve established goals;	Yes	No	
g. Assistance in identifying appropriate crisis intervention responses to clients; needs during acute mental, emotional or physical distress;	Yes	No	
h. Education of clients by providing information about drug abuse and available services and resources;	Yes	No	
i. Facilitating the client's utilization of available support systems and community resources to meet needs identified in clinical valuation or treatment planning;	Yes	No	
j. Reporting and charting information about client's treatment, progress, and other client-related data; and	Yes	No	
k. Consultation with other professionals to assure comprehensive quality care for the client	Yes	No	
In your opinion has the applicant demonstrated competency sufficient for certification of substance abuse counseling?			Yes      No
I declare that, to the best of my knowledge, the foregoing is true and correct.			
_____		_____	
Supervisor's Signature		Date	



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**CSAC-A DIDACTIC TRAINING VERIFICATION**

<b>INSTRUCTIONS</b>		<b>PLEASE TYPE OR PRINT CLEARLY</b>	
Name of Applicant (Last, First, Middle)			
Applicants Email Address		Home and/or Cell Telephone Number	
<b>EACH APPLICANT SHALL HAVE RECEIVED A <u>MINIMUM OF 10 CLOCK HOURS</u> IN EACH OF THE EIGHT CONTENT AREAS:</b>			
<b>CONTENT AREA</b>	<b>COURSE TITLE</b>	<b>NUMBER OF CLOCK HOURS</b>	<b>UNIVERSITY/AGENCY IN WHICH TRAINING WAS PROVIDED</b>
Understanding the dynamics of human behavior			
Signs and symptoms of substance abuse			
Treatment approaches			
Case management skills and continuum of care			
Recovery process and relapse prevention methods			
Ethics			
Professional identity in the provision of substance abuse services			
Crisis intervention			
Total Clock Hours _____ (minimum 120)			