



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
Phone: (804) 367-4610 Fax: (804) 527-4435
Website: www.dhp.virginia.gov/counseling

**APPLICATION FOR REINSTATEMENT OF A CSAC or CSAC-A
FOLLOWING REVOCATION OR SUSPENSION**

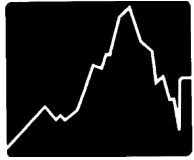
Completed Application: The application must be notarized. To avoid delays, please provide a complete application packet. Incomplete packets will not be reviewed by the Credential Reviewer.

Application Fee: A fee of **\$600.00** 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:

- Out-of-State Licensure Verification:** If you have ever held or hold a licensure or certification as a mental health or health professional, whether current or expired, you must submit license verification. Please send the enclosed verification form to the issuing jurisdiction. This verification is to be completed by the issuing jurisdiction and mailed back to you and included in your application packet, or you can provide an online verification printed from your licensure jurisdiction website if the verification indicates that you have no disciplinary actions.

- Continuing Education (CE) Certificates:** Provide evidence of having met all applicable continuing competency requirements by providing 20 CE certificates in substance abuse education to demonstrate continued ability to perform the functions within the scope of practice of this certificate. The board may require the applicant for reinstatement to submit further evidence regarding the continued ability to perform the functions within the scope of practice of the license.



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
Phone: (804) 367-4610 Fax: (804) 527-4435
Website: www.dhp.virginia.gov/counseling

**APPLICATION FOR REINSTATEMENT OF A CSAC or CSAC-A
FOLLOWING REVOCATION OR SUSPENSION**

I hereby submit an application for reinstatement of my Virginia certification number _____.

**Board of
Counseling**

Complete All
Sections

Application
Fee of \$600.00 is
Non-Refundable

Application forms
lacking a Social
Security or VA DMV
number will not be
processed.

Mail all required
documentation and
fee to:

**Board of Counseling
9960 Mayland Dr.,
Suite 300,
Henrico,
Virginia 23233**

Legal Name (First, Middle, Last)

Other Names Used on Official Documents (i.e. transcripts)

Sex (Circle)

Male Female

Public Address (Street/Box Number, City, State, Zip)

Mailing Address (Street/Box Number, City, State, Zip)

Home Phone

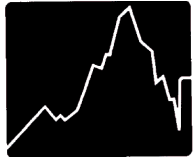
Cell Phone

Business Phone with extension

Email

Social Security Number (or VA DMV #)

Date of Birth



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
 Phone: (804) 367-4610 Fax: (804) 527-4435
 Website: www.dhp.virginia.gov/counseling

**APPLICATION FOR REINSTATEMENT OF A CSAC or CSAC-A FOLLOWING REVOCATION OR
 SUSPENSION – PAGE 2**

Ethics Attestation: Please answer the five questions below. **If you answer yes to any question, include a detailed explanation or supporting documentation. Refer to Guidance Document 115-2 for detailed information on the requirements with a criminal conviction.**

1. Have you ever been denied the privilege of taking an occupational license or certification examination? Yes No
 If yes, state what type of occupational examination and where: _____
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 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). Yes No
 If yes, explain in detail on a separate sheet of paper and provide court documents.
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 censored, 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 malpractice claim? Yes No

Licenses / Certifications: List all mental health or health professional licenses or certificates that you hold or have ever held.

State/License #	Current License Status	Issue Date	Type of License

Attestation of Accuracy & Review of Virginia Regulations & Statutes: *By signing this document, I hereby certify that the information provided in this application is true, accurate and complete to the best of my knowledge and belief. I also certify that I have carefully reviewed and agree to apply the Statutes and Board of Counseling Regulations. I understand that my signature below must be notarized.*

Signature of Applicant: _____

Date: _____

AFFIDAVIT: The following statement must be executed by a Notary Public.

State of _____, County of _____

Name _____, being duly sworn, says that he/she is the person who is referred to in the foregoing application for licensure as a professional 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.

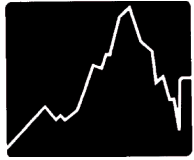
Subscribed to and sworn to before me this _____ day of _____, 20_____.

Signature of Notary: _____.

My commission expires on _____.

My Commission # (if applicable): _____.

SEAL



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
Phone: (804) 367-4610 Fax: (804) 527-4435
Website: www.dhp.virginia.gov/counseling

APPLICANT OUT-OF-STATE LICENSURE/CERTIFICATION VERIFICATION

Part I. To be completed by the applicant:

PLEASE TYPE OR PRINT CLEARLY	
Name of Applicant (Last, First)	
Mailing Address (Street and/or Box Number, City, State, Zip)	
Applicants Email Address	Home and/or Cell Telephone Number

Part II. To be completed by state Licensing Authority:

PLEASE TYPE OR PRINT CLEARLY			
Title of License		License Number	
Issue Date		Expiration Date	
Obtained by Method <input type="checkbox"/> <u>By Examination</u> Date taken: Name of Exam: Score:	<input type="checkbox"/> <u>By Waiver</u>	<input type="checkbox"/> <u>By Endorsement</u>	<input type="checkbox"/> <u>By Reciprocity</u>
Is there any public information relating to this license? Yes (specify details on a separate sheet) _____ No _____			
Certification by the authorized Licensure Official of the State of _____ I certify that the information is correct. Authorized Licensure Official Name and Title _____			
State Seal		Title of Board _____ Telephone Number _____ Email Address _____ Date _____	