Virginia Department of Health Professions
Board of Counseling

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
www.dhp.virginia.gov/counseling

Email: csac@dhp.virginia.gov
(804) 367-4610 (Tel)
(804) 767-6225 (Fax)

APPLICATION INSTRUCTIONS CSAC AND CSAC-A REINSTATEMENT FOLLOWING REVOCATION OR SUSPENSION

☐ Completed Application: The application must have an *original signature*. To avoid delays, please provide a complete application packet. Incomplete packets will not be evaluated by the Credential Reviewer.

☐ Application Fee: A fee of $600.00 is required for an application to be processed. All fees must be paid by check or money order 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 hold or have ever held a licensure, certification, or registration as a mental health or health professional, whether current or expired, you must submit a license verification from 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 can be provided through an online verification printed from the issuing jurisdiction's website if the verification indicates that you have no disciplinary actions listed.

☐ NPDB Self-Query: A current report from the U.S. Department of Health and Human Services National Practitioners Data Bank (NPDB) must be included. A self-query request can be obtained at https://www.npdb.hrsa.gov. Copies of the completed self-report result can be considered.

☐ Name Change: If applicable, documentation must be provided if your name has legally changed by marriage, divorce, or a court order. A photocopy of your marriage license or a copy of the court order must be provided.

☐ Continuing Education (CE) Certificates: Submit evidence of a **minimum of 20 hours of substance abuse education** that is consistent with course content specified in 18VAC115-30-50(B) for substance abuse counselors and 18VAC115-30-62 for substance abuse counseling assistants to demonstrate the continued ability to perform the functions within the scope of practice of the certificates. Courses shall be offered or approved by a provider listed in 18VAC115-30-50 A or 18VAC115-30-62 A.

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CSAC AND CSAC-A REINSTATEMENT FOLLOWING REVOCATION OR SUSPENSION– Page 1

Military/Military Spouse

Are you active duty military personnel? ☐ Yes ☐ No

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

FIRST NAME	MIDDLE NAME	LAST NAME AND SUFFIX
DATE OF BIRTH _____ _____ _____ MM DD YY	SOCIAL SECURITY NO. OR VA CONTROL NO.*	

ADDRESS OF RECORD**: STREET	CITY	STATE	ZIP CODE
ALTERNATE PUBLIC ADDRESS***: STREET	CITY	STATE	ZIP CODE

HOME PHONE:	WORK PHONE:	MOBILE PHONE:
E-MAIL ADDRESS		

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

STATE	LICENSE #	CURRENT LICENSE STATUS	ISSUE DATE	TYPE OF LICENSE

*In accordance with §54.1-116 Code of Virginia, you are required to submit your Social Security Number or your control number issued by the Virginia Department of Motor Vehicles. If you fail to do so, the process of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other state agencies for child support enforcement activities. NO LICENSE WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FAILED TO DISCLOSE ONE OF THESE NUMBERS.

**The address information you provide is your address of record with the Board. Please be advised that all notices from the board, to include renewal notices, licenses, and other legal documents, will be sent to the address of record provided. If you provided a different public address, this information is not subject to public disclosure under the Freedom of Information Act and will not be sold or distributed for any other purpose.

***This address is subject to public disclosure under the Freedom of Information Act. You may provide an address other than a residence, such as a Post Office Box or a practice location if you wish.

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CSAC AND CSAC-A REINSTATEMENT FOLLOWING REVOCATION OR SUPSENSION– Page 2

If you answer "yes" to any question, **include a detailed explanation AND supporting documentation.**

Refer to Guidance Document 115-2 for detailed information on the requirements with a criminal conviction, past actions or possible impairment.

1. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? If yes, please provide a full explanation. ☐ Yes ☐ No

   (A) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? ☐ Yes ☐ No

2. Have you ever been censored, warned, terminated, or requested to withdraw from your employment with any health care facility, agency, or practice? If yes, provide a full description of the circumstances and any supporting documentation. ☐ Yes ☐ No

3. Within the past five years, have you been disciplined by any entity? Please provide a full explanation and any associated orders or letters from the entity. ☐ Yes ☐ No

   (A) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? ☐ Yes ☐ No

4. Have you voluntarily surrendered your license, certification or registration while under investigation? If yes, provide detail(s), jurisdiction(s), date(s), and supporting documentation. ☐ Yes ☐ No

5. Have you ever been denied the issuance of a license, certification, or registration, or denied the privilege of taking an occupational examination by a licensing agency. If yes, provide detail(s), jurisdiction(s) and date(s). ☐ Yes ☐ No

6. Have you ever been convicted of, pled Nolo Contendere to, or entered into a plea agreement for a violation of any federal, state or local statute, regulation, or ordinance? (This includes convictions for driving under the influence, but does not include other traffic violations). Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, does not have to be disclosed. If yes, include an explanation of the charges/convictions, and attach documentation required in the Board's Guidance Document #115-2. ☐ Yes ☐ No

7. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing LPC. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.) ☐ Yes ☐ No

8. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing LPC. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.) ☐ Yes ☐ No

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CSAC AND CSAC-A REINSTATEMENT FOLLOWING REVOCATION OR SUPSENSION – Page 3

9. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing LPC. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.)

☐ Yes ☐ No

10. Within the past 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? If yes, please provide a full explanation and any associated orders or letters from the entity. (NOTE: The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application, or have the program send this documentation directly to the Board.)

☐ Yes ☐ No

I ATTEST THAT THE INFORMATION CONTAINED WITHIN THE APPLICATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE:	DATE:

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APPLICANT OUT-OF-STATE LICENSURE VERIFICATION

PART I. TO BE COMPLETED BY THE APPLICANT:

NAME OF APPLICANT (LAST, FIRST, MIDDLE)

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:

TITLE OF LICENSE	LICENSE NUMBER
ISSUE DATE	EXPIRATION DATE

OBTAINED BY METHOD			
☐ BY EXAMINATION	☐ BY WAIVER	☐ BY ENDORSEMENT	☐ BY RECIPROCITY
DATE TAKEN: _____			
NAME OF EXAM: _____			
SCORE: _____			

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 _____