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

PAPER APPLICATION INSTRUCTIONS FOR CERTIFIED SUBSTANCE ABUSE 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 transcript with conferral date of your Bachelor's degree is required.
- If you have been previously approved by the Board for supervision, a duplicate transcript is not required.

☐ **Verification of Clinical Supervision**: This form should be completed by your supervisor, verifying 100 hours of face-to-face clinical supervision and 2,000 hours of supervised experience in clinical substance abuse services.

☐ **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.

☐ **Didactic Training Verification**: In addition to the form, official school transcript(s) or certificates must be submitted to verify completion of a minimum of 220 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. .

☐ **Supervisor Qualifications**: Unless your supervisor was pre-approved for supervision, a LPC, LCP, LCSW, LMFT, MD or RN must have a minimum of one year of experience in substance abuse counseling and provide certificates of *at least 100 hours of substance abuse didactic training as required by 18VAC115-30-50(B)(1).*

☐ **Verification of Out-of-State Supervisor**: If your supervision did not take place in Virginia, you must submit a verification of your supervisor's license. You may submit an online Verifications printed form the issuing license jurisdiction website or you may submit the enclosed verification form. The supervisor's license verification must be included in your application packet.

☐ **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.

☐ **National Practitioners Data Bank Report (NPDB)**: You must provide a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank. An online self-query can be processed at https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp.

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CERTIFIED SUBSTANCE ABUSE COUNSELOR (CSAC) 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**		
Applicant must complete all sections.			
GENERAL INFORMATION			
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			

LICENSURE/CERTIFICATION – List in order of attainment all the states in which you now hold or have ever held a health or mental health license or certificate in order of attainment.

STATE	LICENSE/CERTIFICATE NUMBER	ISSUE DATE	TYPE OF LICENSE/CERTIFICATE

*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 (CSAC) BY EXAMINATION- PAGE 2

EDUCATION: List in chronological order each graduate school or other institution where course work has been completed.

Institution Name	Type of Degree Received

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 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 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_____.

_____ SEAL
Signature of Notary Public

My commission expires _____ day of _____, 20_____.

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CSAC VERIFICATION OF CLINICAL SUPERVISION

GENERAL INFORMATION	**PLEASE TYPE OR PRINT CLEARLY**	**USE BLUE OR BLACK INK**
Name of Applicant (Last, First, Middle)	Applicants Email Address	

SUPERVISOR'S EVALUATION:

Supervisor's Name (Last, First)	Supervisor's Telephone Number

Supervisor's License/Certification Type	Supervisor's License/Certification Number	Does supervisor have 1 year of experience in substance abuse counseling? Yes No

Business Name and Address of Work Site Where Clinical Hours Were Obtained (ONE LOCATION ONLY)

Dates of supervision: From: _____ to _____	**(Circle Yes or No)**
Did the applicant receive a minimum of one (1) hour and a maximum of four (4) hours of face-to-face supervision per week while under your direct supervision?	Yes No If not, explain on separate page
Did the applicant receive a minimum of 100 total hours of supervision, with no more than 50 of the 100 hours obtained in group supervision while under your direct supervision?	Yes No If not, how many? _____
Did applicant complete a minimum of 2,000 hours of supervised experience in the delivery of clinical substance abuse counseling services?	Yes No If not, how many? _____
Did the applicant demonstrate minimum competencies of applying a counseling process, treatment strategies and rehabilitative services to help an individual to: a. Understand his substance abuse use, abuse or dependency? b. Change his drug-taking behaviors so that it does not interfere with effective physical, psychological, social or vocational functioning?	 Yes No Yes No
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? a. Screening clients to determine eligibility and appropriateness for admission to a particular program b. Intake of clients by performing the administrative and initial assessment tasks necessary for admission to a program; c. Orientation of new clients to program's rules, goals, procedures, services, costs and the rights of the client; d. Assessment of client's strengths, weaknesses, problems, and needs for the development of a treatment plan; e. Treatment planning with the client to identify and rank problems to be addressed, establish goals, and agree on treatment processes;	 Yes No Yes No Yes No Yes No Yes No

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CSAC VERIFICATION OF CLINICAL SUPERVISION – Page 2	**(Circle Yes or No)**
f. Counseling the client utilizing specialized skills in both individual and group approaches to achieve treatment goals and objectives;	Yes No
g. Case management activities which bring services, agencies, people and resources together in a planned framework of action to achieve established goals;	Yes No
h. Crisis intervention responses to clients' needs during acute mental, emotional or physical distress;	Yes No
i. Education of clients by providing information about drug abuse and available services and resources;	Yes No
j. Referral of clients in order to meet identified needs unable to be met by the counselor and assisting the client in effectively utilizing those resources;	Yes No
k. Reporting and charting information about client's assessment, treatment plan, progress, discharge summaries and other client-related data; and	Yes No
l. 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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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 ☐ By Examination **Date taken:** **Name of Exam:** **Score:**	☐ By Waiver	☐ By Endorsement	☐ By Reciprocity
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 _____	

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CSAC DIDACTIC TRAINING VERIFICATION

INSTRUCTIONS **PLEASE TYPE OR PRINT CLEARLY** **USE BLUE OR BLACK INK**

Name of Applicant (Last, First)	
Applicants Email Address	Home and/or Cell Telephone Number

EACH APPLICANT SHALL HAVE RECEIVED A MINIMUM OF 10 CLOCK HOURS IN EACH OF THE FIRST EIGHT CONTENT AREAS:

CONTENT AREA	COURSE TITLE	NUMBER OF CLOCK HOURS	UNIVERSITY/AGENCY IN WHICH TRAINING WAS PROVIDED
Understanding the dynamics of human behavior			
Signs and symptoms of substance abuse			
Treatment approaches			
Continuum of care and case management skills			
Recovery process and relapse prevention methods			
Ethics			
Professional identity in the provision of substance abuse services			
Crisis intervention			
Substance abuse counseling treatment planning and substance abuse research **(20 clock hours)**			
Group counseling **(20 clock hours)**			

Total Clock Hours (minimum 220) _____

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SUPERVISOR OUT-OF-STATE LICENSURE VERIFICATION

Part I. To be completed by the applicant:

INSTRUCTIONS	**PLEASE TYPE OR PRINT CLEARLY**
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. Supervisor's information to be verified:

Last Name _____ First Name _____ M.I. _____

Part III. To be completed by state Board where supervisor is licensed:

INSTRUCTIONS	**PLEASE TYPE OR PRINT CLEARLY**
Title of License/Certification	License Number/Certification
Issue Date	Expiration Date
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 _____