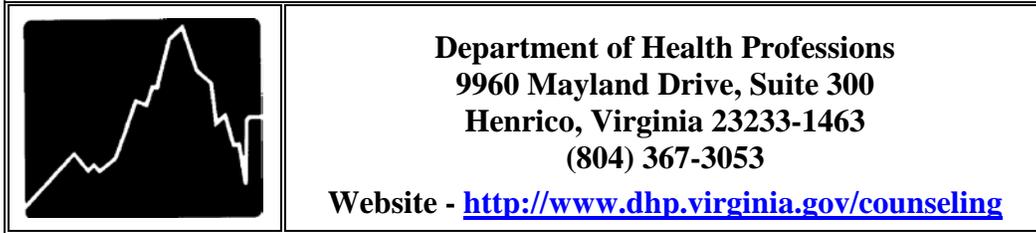


COMMONWEALTH OF VIRGINIA
BOARD OF COUNSELING



PAPER APPLICATION INSTRUCTIONS FOR
CERTIFIED SUBSTANCE ABUSE COUNSELOR BY EXAMINATION

Application:

Fee: A \$90.00 application fee must be paid by check or money order made payable to the “Treasurer of Virginia”. This fee is non-refundable. The application can be used for one year from date of receipt.

Supporting Documentation:

Upon completion of the application you will be required to submit to the Board office the following items:

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: The Verification of Clinical Supervision form should be completed by your supervisor, verifying 100 hours of face-to-face clinical supervision.

Out-of-State Licensure Verification: If you have ever held a health or mental health license or certificate in another jurisdiction, whether current or expired, 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. We will accept license/certification verifications on another jurisdictions’ forms.

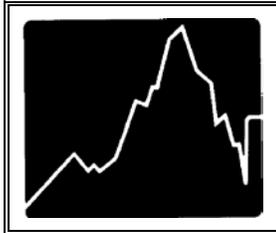
Didactic Training Verification: Official transcripts or certificates must be submitted to verify completion of a minimum of 220 hours of didactic training in substance abuse counseling.

Verification of Out-of-State Supervisor: If applicable, you must provide an official verification of license of your supervisor if they are licensed in another state and supervision occurred in another state.

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>.

**COMMONWEALTH OF VIRGINIA
BOARD OF COUNSELING**



Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
(804) 367-3053

Website - <http://www.dhp.virginia.gov/counseling>

CERTIFIED SUBSTANCE ABUSE COUNSELOR BY EXAMINATION

INSTRUCTIONS		PLEASE TYPE OR PRINT CLEARLY		USE BLUE OR BLACK INK	
<u>Applicant must complete all sections.</u>					
GENERAL INFORMATION					
Name (Last, First)			(Middle Initial)	(Maiden*)	(Suffix)
Social Security Number or Virginia DMV Control Number**				Date of Birth (MM/DD/YY)	
Mailing Address (Street and/or Box Number, City, State, Zip Code)				Home Telephone Number	
Public Address (Street and/or Box Number, City, State, Zip Code)***				Alternate Telephone Number	
E-mail Address					
Are you the spouse of a member of the U. S. military who has been transferred to Virginia and did you leave employment to accompany your spouse to Virginia? Yes No					
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.

EDUCATION: 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

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

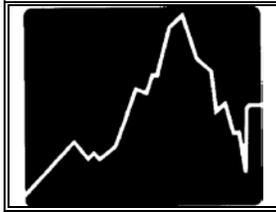
Subscribed to and sworn to before me this _____ day of _____, 20_____.

Signature of Notary Public

My commission expires _____ day of _____, 20_____.

SEAL

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VERIFICATION OF CLINICAL SUPERVISION

GENERAL INFORMATION	PLEASE TYPE OR PRINT CLEARLY	USE BLUE OR BLACK INK
Name of Applicant (Last, First)	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:	
Business Name and Address of Supervision Applicant's Work Site (ONE LOCATION ONLY)		
Dates of supervision: From: _____ to _____		
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:	Yes	No
a. Understand his substance abuse use, abuse or dependency?	Yes	No
b. Change his drug-taking behaviors so that it does not interfere with effective physical, psychological, social or vocational functioning?	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> under supervision for each task?	Yes	No
a. Screening clients to determine eligibility and appropriateness for admission to a particular program	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. Assessment of client's strengths, weaknesses, problems, and needs for the development of a treatment plan;	Yes	No
e. Treatment planning with the client to identify and rank problems to be addressed, establish goals, and agree on treatment processes;	Yes	No

VERIFICATION OF CLINICAL SUPERVISION – PAGE 2

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

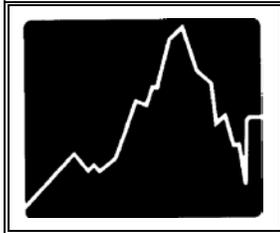
In your opinion has the applicant demonstrated competency sufficient for certification of substance abuse counseling?	Yes	No
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I declare that, to the best of my knowledge, the foregoing is true and correct.

Supervisor's Signature

Date

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APPLICANT OUT-OF-STATE LICENSURE VERIFICATION

Part I. To be completed by the applicant:

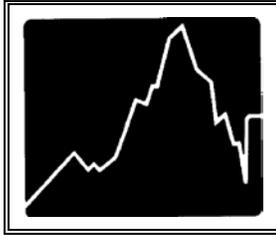
INSTRUCTIONS	PLEASE TYPE OR PRINT CLEARLY	USE BLUE OR BLACK INK
Name of Applicant (Last, First)		
Mailing Address (Street and/or Box Number, City, State, Zip)		
Applicants Email Address	Home and/or Cell Telephone Number	

Part II. To be completed by state Board of Counseling:

INSTRUCTIONS	PLEASE TYPE OR PRINT CLEARLY	USE BLUE OR BLACK INK
Title of License/Certification	License/Certification Number	
Issue Date	Expiration Date	
Obtained by Method		
By Examination	By Waiver	By Endorsement
		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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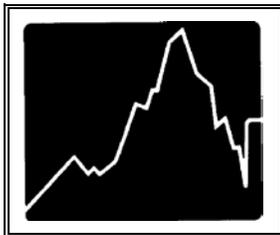
Website: <http://www.dhp.virginia.gov/counseling>

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 <u>MINIMUM OF 10 CLOCK HOURS</u> IN EACH OF THE FIRST EIGHT CONTENT AREAS:				
CONTENT AREA	COURSE TITLE	NUMBER OF CLOCK HOURS	INSTITUTION/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 120)				

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SUPERVISOR OUT-OF-STATE LICENSURE VERIFICATION

Part I. To be completed by the applicant:

INSTRUCTIONS	PLEASE TYPE OR PRINT CLEARLY	USE BLUE OR BLACK INK
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. Supervisor's information to be verified:

Last Name _____	First Name _____	M.I. _____
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Part III. To be completed by state Board where supervisor is licensed:

INSTRUCTIONS	PLEASE TYPE OR PRINT CLEARLY	USE BLUE OR BLACK INK
Title of License/Certification	License/Certification Number	
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 _____	