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

Licensed Substance Abuse Treatment Practitioners (LSATP) by Endorsement

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 **$175.00** 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(s)**: 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. (Virginia licenses or certifications do not require verification.)

- ☐ **Verification of a National Certification in Substance Abuse Treatment** – If applicable, submit a verification of holding a The Master Addiction Counselor (MAC), The National Certified Addiction Counselor Level II (NCAC II) or The Advanced Alcohol & Drug Counselor (AADC) certification.

- ☐ **Clinical Scores**: Clinical scores can be accepted by one of the following: (1) A notation on your official license verification form. (2)Transferring your official MAC exam scores to VA by contacting NAADAC. (3) Holding a current and unrestricted license as a Virginia LPC, for whom the exam is waived.

- ☐ **NPDB Self-Query**: A current report from the U.S. Department of Health and Human Services National Practitioners Data Bank (NPDB) must be included. You may request a self-query at https://www.npdb.hrsa.gov.

- ☐ **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.

- ☐ **Verification of Education**: An official graduate transcript with conferral date is required. Master's degree must be in mental health with at least 60 semester credit hours.

- ☐ **Verification of Clinical Active Practice**: Provide evidence of post-licensure independent clinical active practice in substance abuse treatment services or clinical supervision of such services for 24 of the last 60 months immediately preceding your application in Virginia.

- ☐ **Original Application**: Provide certified copy of your application materials from the jurisdiction where you were originally licensed.

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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**

LSATP

Licensed Substance Abuse Treatment Practitioners

Complete All Sections

Application Fee of $175.00 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

All signatures must be original.

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

Education/Training (List in chronological order all graduate schools attended. Include transcripts.)

Degree Earned	Date Degree Received	Major	Attendance Dates-mm/yr	Institution Name/State

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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? If yes, state what type of occupational examination and where: _____ □ **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 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 of 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 read, understand and agree to apply the Statutes and Regulations Governing the Practice of Licensed Substance Abuse Treatment Practitioners. 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

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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, 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:

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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VERIFICATION OF CLINICAL PRACTICE FOR 24 OF THE LAST 60 MONTHS IN SUBSTANCE ABUSE TREATMENT SERVICES IMMEDIATELY PRECEDING SUBMISSION OF APPLICATION FOR LICENSURE

The Virginia Board of Counseling, in its consideration of a candidate for licensure, depends on information from persons and institutions regarding the candidate's clinical independent practice for twenty-four of the last sixty months immediately preceding their licensure application in Virginia. Please complete this form to the best of your ability so the information you provide can be given consideration in the processing of this candidate's application in a timely manner.

By providing this form to references, the applicant authorizes past and present employers, businesses, professional associates and personal references to release to the Virginia Board of Counseling any information requested by the Board in connection with the processing of the application for licensure**.**

TO BE COMPLETED BY THE APPLICANT:

Last Name	First Name	M.I.
Street Address		
City	State	Zip Code
Email Address:	Phone Number:	

TO BE COMPLETED BY THE REFERENCE:

Last Name	First Name	M.I.
Street Address		
City	State	Zip Code
Email Address:	Phone Number:	

Relationship to Applicant:	

I certify that the above applicant for licensure in the Commonwealth of Virginia, was in active practice at:

Business Name of Agency or Private Practice:		
Street Address		
City	State	Zip Code
From: (mm/dd/yyyy)	To: (mm/dd/yyyyy)	
Reference Signature:		Date: