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

LSATP APPLICATION INSTRUCTIONS
Licensed Substance Abuse Treatment Practitioners 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 **$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:

- ☐ **Verification of Education**: An official graduate transcript with conferral date is required. If you were previously approved for residency, a duplicate transcript is not required.
- ☐ **Verification of Required Coursework and Internship**: To be completed by your graduate program and sent to the Board within your application packet. If you were previously approved for residency, a duplicate Verification of Coursework and Internship is not required.
- ☐ **Verification of Supervision**: The Verification of Supervision form should be completed by your supervisor, verifying hours obtained during your supervised residency. Original signatures are required. Note: *A separate verification of supervision form must be submitted for each supervisor and/or location.*
- ☐ **Quarterly Evaluations**: The Quarterly Evaluation forms should be completed by your supervisor, verifying hours obtained during your supervised residency each quarter. Original signatures are required. Note: *A separate quarterly evaluation form must be submitted for each supervisor and/or location.*
- ☐ **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.
- ☐ **Licensure 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 from the issuing license jurisdiction's website or you may submit the enclosed verification form. The supervisor's license verification must be included in your application packet.
- ☐ **Clinical Scores***:* If you have passed the Master Addiction Counselor (MAC) exam administered through the National Certification Commission for Addiction Professionals (NCC AP) with the Association for Addiction Professionals (NAADAC), please have your scores transferred to Virginia. The exam is waived for an applicant who holds a current and unrestricted license as a Virginia LPC.
- ☐ **NPDB Self-Query**: a current report from the U.S. Department of Health and Human Services National Practitioners Data Bank (NPDB) must be submitted. 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 through marriage, divorce, or a court order. A photocopy of your marriage license or a copy of the court order must be provided.

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Licensed Substance Abuse Treatment Practitioners (LSATP) by Examination Application

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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Licensed Substance Abuse Treatment Practitioners (LSATP) Examination Application – 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? 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 reviewed 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 SUPERVISION FOR LSATP LICENSURE

GENERAL INFORMATION - PLEASE TYPE OR PRINT CLEARLY	
Name of Applicant (Last, First, Middle)	Applicant's Email Address

SUPERVISOR'S EVALUATION:

Supervisor's Name (Last, First)	License Number:	License Type:	Supervisor's Telephone Number

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

Dates of supervision: From (mm/dd/yy): _____ To (mm/dd/yy): _____ Total Months:_____

Did the resident receive a minimum of one (1) hour and a maximum of four (4) hours of in-person supervision per 40 hours of work experience while under your **direct supervision**?	Yes No If no, explain on separate page	
Total amount of in-person hours of supervision with the resident.	Individual Hours:	Group Hours:
Did the applicant complete a minimum of 3,400 hours of supervised residency in substance abuse treatment working with various populations, clinical problems and theoretical approaches under your **direct supervision**? If not, how many? _____	Yes No	
Did the resident complete at least 2,000 hours of face-to face client contact in providing clinical substance abuse treatment services while under your **direct supervision**? If not how many? _____	Yes No	
Did the applicant demonstrate minimum competencies of **clinical evaluation** while under your direct supervision?	Yes No	
Did the applicant demonstrate minimum competencies of **treatment planning, documentation and implementation** while under your direct supervision?	Yes No	
Did the applicant demonstrate minimum competencies of **referral and service coordination** while under your direct supervision?	Yes No	
Did the applicant demonstrate minimum competencies of **individual and group counseling and case management** while under your direct supervision?	Yes No	
Did the applicant demonstrate minimum competencies of **client family and community education** while under your direct supervision?	Yes No	
Did the applicant demonstrate minimum competencies **professional and ethical responsibility** while under your direct supervision?	Yes No	
In your opinion has the applicant demonstrated competency sufficient for licensing and the independent practice in clinical substance abuse treatment services? If not, explain on separate page.	Yes No	

I declare that, to the best of my knowledge, the foregoing is true and correct. This evaluation has been discussed with the resident and a copy has been provided to the resident.

Supervisor Signature:_____ Date:_____

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LICENSED SUBSTANCE ABUSE TREATMENT PRACTITIONER (LSATP)

VERIFICATION OF REQUIRED COURSEWORK AND INTERNSHIP FORM

TO BE COMPLETED BY THE APPLICANT

Applicant's Name (Last, First, Middle)
Institution where internship took place (include city and state)
Name of Program
Applicant's Student ID Number — Applicant's Social Security Number or VA DMV Number

TO BE COMPLETED BY GRADUATE SCHOOL PROGRAM OFFICIAL OR ADMINISTRATION OFFICE

Please verify in the table below that the required coursework was successfully completed by the applicant by listing the relevant required core courses taken. All courses must be graduate level from a college or university approved by a regional accrediting agency or CACREP. Do not list courses that are not directly related to counseling. If a course title is not clearly indicative on the transcript, please attach college catalog description(s) or course syllabi. All information provided is subject to Board review and approval. **The applicant must have three (3) graduate semester hours or four (4) graduate quarter hours in core courses 1-9 listed below. The applicant must have completed twelve (12) graduate semester credit hours or eighteen (18) graduate quarter hours in course cores 10-14 listed below. One course may satisfy study in more than one content area.**

DESIGNATE SEMESTER HOURS WITH AN "S" AND QUARTER HOURS WITH A "Q"

1. **Professional Identity, Functions and Ethics**.

Course Code	Course Title	S/Q Hours	College/University

2. **Theories of Counseling and Psychotherapy.**

Course Code	Course Title	S/Q Hours	College/University

3. **Counseling and Psychotherapy Techniques.**

Course Code	Course Title	S/Q Hours	College/University

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4. **Group Counseling and Psychotherapy, Theories and Techniques**.

Course Code	Course Title	S/Q Hours	College/University

5. **Appraisal, Evaluation and Diagnostic Procedures.**

Course Code	Course Title	S/Q Hours	College/University

6. **Abnormal Behavior and Psychopathology.**

Course Code	Course Title	S/Q Hours	College/University

7. **Multicultural Counseling, Theories and Techniques.**

Course Code	Course Title	S/Q Hours	College/University

8. **Research.**

Course Code	Course Title	S/Q Hours	College/University

9. **Marriage and Family Systems Theory.**

Course Code	Course Title	S/Q Hours	College/University

10. **Assessment, Appraisal, Evaluation and Diagnosis Specific to substance abuse.**

Course Code	Course Title	S/Q Hours	College/University

11. **Treatment Planning Models, Client Case Management, Interventions and Treatments to Include Relapse Prevention, Referral Process, Step Models and Documentation Process.**

Course Code	Course Title	S/Q Hours	College/University

12. **Understanding Addictions: The Biochemical, Sociocultural and Psychological Factors of Substance Use and Abuse.**

Course Code	Course Title	S/Q Hours	College/University

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13. **Addictions and Special Populations Including, but Not Limited to, Adolescents, Women, Ethnic Groups and the Elderly.**

Course Code	Course Title	S/Q Hours	College/University

14. **Client and Community Education.**

Course Code	Course Title	S/Q Hours	College/University

15. **Supervised Internship.** This course provides students with a minimum of 600 hours of experience in a clinical field placement including (but not limited to) 240 hours of face-to-face client contact of which 200 hours in treating substance abuse-specific treatment problems.

Course Code	Course Title	S/Q Hours	College/University

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VERIFICATION OF INTERNSHIP FOR LSATP LICENSURE

USE THIS FORM TO DOCUMENT YOUR REQUIRED INTERNSHIP HOURS

Applicant's Name (Last, First, Middle)	
Applicant's Student ID Number	Applicant's Social Security Number or VA DMV Number

Is the college or university approved by a regional accrediting agency?	Yes	No
Is the college or university CACREP accredited?	Yes	No
Did internship begin after completion of 30 graduate semester hours?	Yes	No
Total number of supervised internship hours:		
Total **direct client** contact internship hours:		
Total **direct client contact hours** treating **substance abuse-specific** treatment problems		
What type of licensure did the supervisor hold?		
Number of **individual** supervision hours during internship?		
Number of **group** supervision hours during internship?		
If applicable, total direct client contact hours with **couples and/or families**:		

Name of School	
Name of Program Official	Title
Email Address of School Official	Phone Number of School Official
Signature of School Official	Date

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SUPERVISOR OUT-OF-STATE LICENSURE/CERTIFICATION VERIFICATION

Part I. To be completed by the applicant:

INSTRUCTIONS	**PLEASE TYPE OR PRINT CLEARLY**
Name of Applicant (Last, First)	
Mailing Address (Street and/or Box Number, City, State, Zip	
Applicant's 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 Licensing Authority:

INSTRUCTIONS	**PLEASE TYPE OR PRINT CLEARLY**
Title of License	License 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 _____

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QUARTERLY EVALUATION FOR LSATP LICENSURE

Section 115-60-80-E-3 of the Virginia LSATP regulations requires that the applicant's supervisor provide quarterly evaluations to the resident. This form must be signed and dated by the supervisor. **This form is to be completed by the supervisor each quarter and provided to the resident to be held in their possession until they are ready to submit their licensure application.**

Name of Applicant (Last, First, Middle)	Applicant's Email Address

SUPERVISOR'S EVALUATION:

Supervisor's Name (Last, First)	License Number:	License Type:
Business Name and Address of Residency Work Site Where Clinical Hours Were Obtained (ONE LOCATION ONLY)		
Dates of supervision: From (mm/dd/yy): _____	To (mm/dd/yy): _____	

All Columns Must Be Completed	Hours per week	Total hours	Hours are duplicated on another supervisor's quarterly form
Total hours of supervised residency (face-to-face client contact hour + ancillary hours)			Yes No
How many Face-to-face Client Contact hours did the resident provide?			Yes No
Total number of face-to-face client contact hours in providing clinical substance abuse treatment services.			Yes No
How many Individual Supervision hours did the resident receive?			
How many Group Supervision hours did the resident receive?			
If applicable, Total number of face-to-face client contact with Couples and Families or both.			Yes No

These areas are outlined in Section 18 VAC 115-60-80 of the LSATP Regulations. The resident must have supervised residency in a supervised residency in substance abuse treatment **with various populations, clinical problems, and theoretical approaches** in the below areas.

Did the applicant provide **clinical evaluations** while under your direct supervision?	Yes No
Did the applicant provide **treatment planning, documentation and implementation** while under your direct supervision?	Yes No
Did the applicant provide **referral and service coordination** while under your direct supervision?	Yes No
Did the applicant provide **individual and group counseling and case management** while under your direct supervision?	Yes No
Did the applicant demonstrate minimum competencies of **client family and community education** while under your direct supervision?	Yes No
Did the applicant demonstrate minimum competencies **professional and ethical responsibility** while under your direct supervision?	Yes No
Do you have any concerns about the competency of the resident? If yes, explain on separate page.	Yes No
Supervisor's Signature:_____	Date:_____

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SUPERVISION SUMMARY FORM FOR LSATP LICENSURE

Applicant's Name (Last, First, Middle)

		Supervisor One	Supervisor Two	Supervisor Three	Supervisor Four	Internship Hours towards Residency *	Totals
1.	**Name of Supervisor**						
2.	**Dates of Supervision**						
3.	**Total Hours (client contact + ancillary hours)**						
4.	**Total Hours of Face-to-Face Client Contact**						
5.	**Total Face-To-Face Contact Hours providing clinical substance abuse treatment services**						
6.	**Total hours of Individual supervision**						
7.	**Total Hours of Group Supervision**						
8.	**Are hours duplicated under another supervisor? If so, how many? (Circle yes or no)**	**Yes No** _____	**Yes No** _____	**Yes No** _____	**Yes No** _____	**Yes No** _____	

*A graduate-level internship in excess of 600 hours, which was completed in a program that meets the requirements set forth in 18VAC115-60-70 may count for up to an additional 300 hours towards the requirements of a residency. Only internship hours earned after completion of 30 graduate semester hours may be counted towards residency hours. Up to 20 hours of the supervision received during the supervised internship may be counted towards the 200 hours of in-person supervision if the supervision was provided by a licensed professional counselor or a licensed marriage and family therapist.

Revision date: 2/2017