Virginia Department of Health Professions
Board of Counseling

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

Email: coun@dhp.virginia.gov
(804) 367-4610 (Tel)
(804) 527-4435 (Fax

LSATP APPLICATION INSTRUCTIONS
Initial Registration of Supervision for a Resident in Substance Abuse Treatment

Completed Application: The application must be signed by the resident and supervisor. To avoid delays, please provide a complete application packet. Incomplete packets will not be reviewed by the Credential Reviewer.

Application Fee: A fee of **$65.00** 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.
- ☐ **Verification of Required Coursework and Internship**: To be completed by your graduate program and sent to the Board within your application packet.
- ☐ **Supervisor must be a LSATP or LPC with Evidence of Supervision Training**: If your supervisor is not listed on the Supervisor Registry, you must submit evidence that your supervisor received professional training in supervision, consisting of three credit hours or 4.0 quarter hours in graduate-level coursework in supervision or at least 20 hours of continuing education in supervision offered by a provider approved under 18VAC115-20-106. Additionally, all supervisors must have two year of post-licensure substance abuse treatment experience and at provide evidence of having at least 100 hours of didactic instruction in substance abuse treatment.
- ☐ **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.

Please note:

In order to be considered for residency, all requirements outlined in Regulations 18VAC115-60-60 and 18VAC115-60-70 must be met.

Supervised work experience occurring in Virginia, in any setting, must be registered and approved by the Board prior to beginning that supervision. An applicant may not count hours towards licensure unless that supervised experience has been registered with the Board. Supervision that is not concurrent with a residency will not be accepted, nor will residency hours be accrued in the absence of board-approved supervision.

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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**

Resident in Substance Abuse Treatment toward

LSATP

Licensed Substance Abuse Treatment Practitioners

Complete All Sections

Application Fee of $65.00 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)

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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Initial Registration of Supervision for a Resident in Substance Abuse Treatment – Page 2

Ethics Attestation: Please answer the ten questions below. **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.**

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? Yes No
   Please provide a full explanation and any associated orders or letters from the entity.

   (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? Yes No
   If yes, provide detail(s), jurisdiction(s), date(s), and supporting documentation.

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? Yes No
   (This includes convictions for driving under the influence, but does not include other traffic violations).
   If yes, include an explanation of the charges/convictions, and attach documentation required in the Board's Guidance Document #115-2.

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? Yes No
   "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing LSATP. 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.)

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 LSATP. 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

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 LSATP. 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

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Initial Registration of Supervision for a Resident in Substance Abuse Treatment – Page 3

SUPERVISOR'S INFORMATION: **The Board can only consider qualified LPCs or LSATPs to supervise a resident in counseling.** **(To register an additional supervisor, please submit the add/change of supervision application.)**		
Supervisor's Legal Name: (Last, First)	License Number:	License Type:
Business Name and Address of Supervisor's worksite:		
Email Address:	Business Phone Number:	

WORKSITE: **Please indicate the NAME and ADDRESS of the location where the RESIDENT will provide clinical counseling services.** **(To register an additional worksite, please submit the add/change of supervision application.)**
Worksite Name:
Worksite Mailing Address (Street and/or Box Number, City, State, Zip

RESIDENCY REQUIREMENTS:	
Will the residency in substance abuse treatment provide clinical services to various populations, clinical problems and theoretical approaches in the following areas? If not, explain on separate page. • Clinical evaluation • Treatment planning, documentation and implementation • Referral and service coordination • Individual and group counseling and case management • Client family and community education • Professional an ethical responsibility	Yes No
Will the supervisor be on-site in the same facility where the resident is providing services?	Yes No

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Statement of Assurance

- I have read, understand and intend to comply with the regulations that govern the Virginia Board of counseling licensees and applicants.
- I understand that the Supervisor is prohibited from providing supervision to any individual whose relationship with the Supervisor would compromise objectivity.
- I understand that the Supervisor assumes full responsibility for the clinical activities of the Resident at the worksite listed for the duration of the residency. The Supervisor is responsible for ensuring that the Resident does not practice outside of the scope of his/her education.
- I understand that the Supervisor shall complete evaluation forms to be given to the Resident at the end of each three-month period.
- I understand that the Supervisor shall report the total hours of residency by completing the verification of supervision form at the end of the residency.
- I understand that the Supervisor must immediately report to the Board any unethical practice performed by the Resident, in accordance with regulation 18VAC115-60-130.
- I understand that the Supervisor must ensure that all clients of the Resident are informed of the Resident's status and the Supervisor's contact information.
- I understand that the residency must be completed in no less than 21 months and no more than four years.
- I understand that the Resident may only use the title "Resident in Substance Abuse Treatment" and shall not present himself/herself in a way that may appear to be independent practice.
- I understand that the Supervisor will ensure that the Resident does not bill directly for services and that all payments, both cash and insurance, are paid to the Supervisor, or the Resident's employer.
- I understand that any violations of the regulations by the Supervisor or the Resident, including but not limited to allowing unlicensed practice, misrepresenting the Resident's status to clients, allowing the Resident to bill directly, may result in disciplinary action before the Board of Counseling.

I attest that the information contained within the application is true and accurate to the best of my knowledge and belief.

Resident Signature: (original signature)	Date:
Supervisor Signature: (original 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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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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REQUEST FOR TERMINATION OF SUPERVISION

This form should be used to notify the Virginia Board of Counseling of the termination of a board-approved supervisory contract between a supervisor and resident. At the conclusion of the supervised residency, the supervisor shall provide the resident with a completed the Verification of Clinical Supervision form to be held in their possession until they are ready to submit their licensure application.

Resident Information:	
Resident's Name (Last, First)	Resident's Telephone Number
Resident's Email Address	
Supervisor's Information:	
Supervisor's Name (Last, First)	Supervisor's Telephone Number
Supervisor's Email Address	Supervisor's License Number:
Supervised Residency Worksite Information:	
Name of Supervision Work Site:	
Address of Supervision Work Site (Street, City, State, Zip):	
Date of Termination:	
Signature and date of individual submitting form: Signature:_____ Date:_____	

Please email, fax or mail this completed form to:

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