



APPLICATION FOR LICENSURE AS A CLINICAL ADDICTION COUNSELOR (LCAC)

State Form 54089 (1-10)

Approved by State Board of Accounts, 2010

BEHAVIORAL HEALTH & HUMAN SERVICES LICENSING BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2064
Website: www.pla.IN.gov

INSTRUCTIONS: Answer all questions. All information must be typed or clearly printed.

* Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it. Social Security Numbers are available to the Indiana Department of Revenue.

FOR OFFICE USE ONLY	
APPLICATION FEE:	
DATE FEE PAID (month, day, year):	
RECEIPT NUMBER:	
REGISTRATION NUMBER:	
DATE ISSUED (month, day, year):	

Attach
One
Passport
Quality
Photograph
Here

DO NOT WRITE ABOVE THIS LINE

Type of application (check one)

Option 1 Option 2 Option 3

APPLICANT INFORMATION		
Name (last, first, middle, maiden or previous)		
Current address (number and street or rural route)		
City	State	ZIP code
Permanent address (if different from address above)		
City	State	ZIP code
Work telephone number (include area code) ()	Home telephone number (include area code) ()	
Social Security number *	Date of birth (month, day, year)	Place of birth (city, state)
E-mail address		
Please indicate exactly how you wish your name to appear on your license.		

CERTIFICATIONS			
PROVIDER OF CERTIFICATION	CERTIFICATION NUMBER	DATE OF ISSUE (month, day, year)	DATE OF EXPIRATION (month, day, year)

EDUCATION

Name of academic institution		Department	Program title
Location (<i>city and state</i>)		Dates attended (<i>month, year to month, year</i>)	Degree earned
Name of academic institution		Department	Program title
Location (<i>city and state</i>)		Dates attended (<i>month, year to month, year</i>)	Degree earned
Name of academic institution		Department	Program title
Location (<i>city and state</i>)		Dates attended (<i>month, year to month, year</i>)	Degree earned

EMPLOYMENT HISTORY FOR THE PAST TEN (10) YEARS*Please list all places of professional employment, including self-employment.*

Name of employer		Position or title	Name of supervisor
Location (<i>city and state</i>)		Dates employed (<i>month, year to month, year</i>)	Average hours per week
Duties or responsibilities			
Name of employer		Position or title	Name of supervisor
Location (<i>city and state</i>)		Dates employed (<i>month, year to month, year</i>)	Average hours per week
Duties or responsibilities			
Name of employer		Position or title	Name of supervisor
Location (<i>city and state</i>)		Dates employed (<i>month, year to month, year</i>)	Average hours per week
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Duties or responsibilities			
Name of employer		Position or title	Name of supervisor
Location (<i>city and state</i>)		Dates employed (<i>month, year to month, year</i>)	Average hours per week
Duties or responsibilities			

OTHER STATE LICENSURE / CERTIFICATION

Do you now hold, or have you ever held, a license / certification / registration / permit to practice any regulated health profession by a state licensing board?

Yes No

If yes, list all states below, including Indiana, in which you have held a license / certification / registration / permit to practice any state regulated health occupation.

TYPE OF LICENSE / CERTIFICATE / REGISTRATION / PERMIT	STATE	LICENSE NUMBER	DATE ISSUED	STATUS
1.				
2.				
3.				
4.				
5.				

If you answer "Yes" to any question below, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. Include all relevant court documents, if applicable. Letters from attorneys are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been denied a license, certificate, registration or permit to practice any regulated health occupation in any state (including Indiana) or country?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you now being, or have you ever been treated for drug or alcohol abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever been convicted of, pled guilty or <i>nolo contendere</i> to: A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? B. Any offense, misdemeanor or felony in any state?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever had a malpractice judgment against you or settled any malpractice action?	<input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date signed (month, day, year)
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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, corporation, association, organization or institution to release to the Professional Licensing Agency, or the Behavioral Health and Human Services Licensing Board, any files, documents, records or other information pertaining to the undersigned requested by the Agency, or the Board, or any of their authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency, or the Behavioral Health and Human Services Licensing Board, to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency, and the Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm, that I have read the above statements and agree to same.

Signature of applicant	Date signed (month, day, year)
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FORM E2**VERIFICATION OF EXPERIENCE FOR LICENSURE AS A CLINICAL ADDICTION COUNSELOR (LCAC)**

Part of State Form 54089 (1-10)

Return this form to the Professional Licensing Agency, 402 West Washington Street, Room W072, Indianapolis, IN 46204.

Complete **SECTION A** and then forward this form to your previous or current employer(s) for completion of **SECTION B**. You must submit proof that you have acquired at least five (5) years of experience for Option 2 or twenty (20) years of experience for Option 3. **This form may be duplicated if your experience has been completed at more than one place of employment.** If you are no longer able to contact your previous employer(s), you may complete **SECTION C** (*on the reverse side of this form*) for each previous place of employment. Sign the form(s) in the presence of the Notary Public and have your signature notarized, then return the form to the Professional Licensing Agency at the address listed above.

SECTION A - APPLICANT INFORMATION

Name of applicant (<i>last, first, middle, maiden</i>)	Social Security number *
Name of employer	Dates of employment (<i>month/year to month/year</i>)
Location of place of employment or place of practice	

SECTION B - EMPLOYER / EMPLOYMENT INFORMATION

This section is to be completed by the applicant's previous or current employer, notarized and sent directly to the Professional Licensing Agency at the address listed above.

Total number of months the above-named applicant served in the practice of clinical addiction counseling: _____

Total number of months served at the address below: _____

The above-named applicant was providing clinical addiction counseling services directly to clients on an average of at least _____ hours per week, during the period of time he / she was in my employment.

Address(es) of where the above-named applicant provided the majority of his / her clinical addiction counseling services:

I hereby swear or affirm that the above information is true and correct to the best of my knowledge and belief.

Signature of employer		Date (<i>month, day, year</i>)
Printed name of employer	Title	Daytime telephone number ()

CERTIFICATION OF NOTARY PUBLIC

STATE OF _____

SS:

SEAL

COUNTY OF _____

Before me, a notary public, in and for the state and county above named, _____,
Printed name of employer

personally appeared and acknowledged in the foregoing statements as true and correct to the best of his/her knowledge and belief

this _____ day of _____, 20_____.

Signature of notary public		Printed name of notary public
County of residence	State of residence	Date commission expires (<i>month, day, year</i>)

THIS IS A TWO-SIDED FORM

FORM E2 (continued)

VERIFICATION OF EXPERIENCE FOR LICENSURE AS A CLINICAL ADDICTION COUNSELOR (LCAC)

Part of State Form 54089 (1-10)

SECTION C / AFFIRMATION OF EXPERIENCE

This section is to be completed by applicant only if the applicant's previous employer is no longer able to complete SECTION B (on reverse side of this form). Please indicate below the reason why your previous employer is no longer able to complete SECTION B (on the reverse side of this form). If you are affirming experience acquired through more than one previous employer this form may be duplicated but you must submit one notarized AFFIRMATION OF EXPERIENCE for each previous employer that is no longer able to complete SECTION B (on the reverse of this form).

I am unable to have my previous employer(s) complete SECTION B for the following reason:

- Deceased
- Unable to be located
- Other reason

If you have checked "Other reason", please briefly explain:

Total number of months that you have been providing clinical addiction counseling services directly to clients on an average of at least _____ hours per week, at the address below:

Total number of months served at the address below: _____

Period of time in which you provided these services: _____ to _____
(month / year) (month / year)

Name of facility and address where clinical addiction counseling services were provided:

Provide the name of a professional colleague who can attest to the validity of the above statements:

Name of colleague (last, first, middle, maiden)	Daytime telephone ()
Address of colleague (number and street, city, state, and ZIP code)	
List all graduate degrees, credentials and / or state board issued licenses / certifications held by this colleague	

APPLICANT'S AFFIRMATION (To be completed only if applicant is unable to complete SECTION B)

I hereby swear or affirm that the above information is true and correct to the best of my knowledge and belief.

Signature of applicant (Sign only in the presence of the Notary Public)	Date (month, day, year)
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CERTIFICATION OF NOTARY PUBLIC

STATE OF _____

SS:

SEAL

COUNTY OF _____

Before me, a notary public, in and for the state and county above named, _____,
Printed name of applicant

personally appeared and acknowledged in the foregoing statements as true and correct to the best of his/her knowledge and belief

this _____ day of _____, 20_____.

Signature of notary public	Printed name of notary public
County of residence	State of residence
Date commission expires (month, day, year)	