Reset Form

FORM E2 – VERIFICATION OF EXPERIENCE FOR LICENSURE AS A CLINICAL ADDICTION COUNSELOR (LCAC)

Part of State Form 52957 (R1 / 8-24)

BEHAVIORAL HEALTH AND HUMAN SERVICES LICENSING BOARD
PROFESSIONAL LICENSING AGENCY
402 W Washington Street, Room W072
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GENERAL INSTRUCTIONS: *All information on this form must be typed or clearly printed. You are authorized to photocopy this form as necessary. Sign the form and upload to your (the applicant's) online application as applicable or mail them to the address provided in the top right-corner above.*

SECTION A - APPLICANT INFORMATION

SECTION A INSTRUCTIONS FOR APPLICANT: *Complete this section and then forward this form to your direct supervisor(s) of your previous or current employer(s) for completion of* ***SECTION B****. You must submit proof that you have acquired at least two (2) years of post-graduate clinical experience as described in IC 25-23.6-10.5-8. This post-graduate experience must be completed in no less than twenty-one (21) months and no more than forty-eight (48) months. If you obtained your hours in another state or jurisdiction, it will be reviewed by the Board. This form may be duplicated if your experience was completed at more than one place of employment. If you are no longer able to contact your direct supervisor(s) of your previous employer(s), a professional colleague of your previous employer(s) should complete* ***SECTION C*** *(on the reverse side of this form) for each previous direct supervisor.*

Name of Applicant (*last, first, middle, maiden or previous*)		Date of Birth *(month, day year)*
Name of Employer	Date of employment begin *(month, day, year)*	Date of employment end *(month, day, year)*
Location of place of employment or place of practice		

SECTION B - EMPLOYER/EMPLOYMENT INFORMATION

SECTION B INSTRUCTIONS FOR APPLICANT'S DIRECT SUPERVISOR: *Complete this section. All experience documented in this form is to be specific to clinical addiction counseling.*

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

Total number of hours served at the address below:_____.

The above-named applicant provided clinical addiction counseling services directly to clients on an average of at least _____hours per week during the time the applicant was in my employment.

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

_____

_____

_____

_____

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

Signature of employer: _____

Printed name of employer and title: _____

Cellular telephone number: _____

Work Telephone number: _____

E-mail address: _____

Date *(month, day, year)*: _____

FORM E2 – VERIFICATION OF EXPERIENCE FOR LICENSURE AS A CLINICAL ADDICTION COUNSELOR (LCAC) *(continued)*

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SECTION C - AFFIRMATION OF EXPERIENCE [UNABLE TO CONTACT DIRECT SUPERVISOR(S)]

SECTION C INSTRUCTIONS FOR PROFESSIONAL COLLEAGUE OF APPLICANT'S EMPLOYER: *This section is to be completed by a professional colleague of the applicant's previous employer, if the applicant's previous direct supervisor is no longer able to complete* ***SECTION B*** *(on reverse side of this form). Please indicate below the reason why the applicant's previous direct supervisor is no longer able to complete* ***SECTION B*** *(on the reverse side of this form).* ***If you are affirming experience received from more than one previous direct supervisor of a previous employer, this form may be duplicated but you must submit one AFFIRMATION OF EXPERIENCE for each previous direct supervisor that is no longer able to complete SECTION B (on the reverse side of this form).***

The applicant's direct supervisor is unable to 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 the applicant been providing clinical addiction counseling services directly to clients on an average of at least _____ at the address below.

Total number of hours served at the address below: _____.

Total number of hours served at the address below: _____ to _____.
(month / year) *(month / year)*

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

_____

_____

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

_____

_____

_____ _____

Name of colleague *(last, first, middle, maiden)* Daytime telephone number of colleague

_____

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

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

Signature of applicant	Date *(month, day, year)*