



APPLICATION INSTRUCTIONS
FOR TEMPORARY LICENSURE AS A RESIDENT IN
SUBSTANCE ABUSE TREATMENT

- Completed Application:** The application must have an *original signature*. To avoid delays, please provide a complete application packet. Incomplete packets will not be evaluated by the Credential Reviewer.
- Application Fee:** A fee of \$65.00 is required for an application to be processed. All fees must be paid by check or money order 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 degree transcript with conferral date is required. Electronic transcripts must be emailed directly to the Board from the school
- Verification of Required Coursework and Internship:** To be completed by your graduate program and sent to the Board within your application packet.
- Supervisor Contract:** A signed contract that outlines the expectations and responsibilities of the supervisor and resident in accordance with the regulations of the Board. (Supervisor contract example can be found on the Board's website)
- Supervisor must be a LSATP and 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 18VAC115-60-116. Additionally, all supervisors must have two year of post-licensure substance abuse treatment experience and provide evidence of receiving 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 by marriage, divorce, or a court order. A photocopy of your marriage license or a copy of the court order must be provided.
- NPDB Self-Query:** A current report from the U.S. Department of Health and Human Services National Practitioners Data Bank (NPDB) must be included. A self-query request can be obtained at <https://www.npdb.hrsa.gov>. Copies of the completed self-report result can be considered.
- Out-of-State Licensure Verification(s):** If you hold or have ever held a licensure, certification, or registration as a mental health or health professional, whether current or expired, you must submit a license verification from 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 can be provided through an online verification printed from the issuing jurisdiction's website if the verification indicates that you have no disciplinary actions listed.
- Degree Information:** **Degree Information:** If applicable, you will need to submit the following information if your degree is **not** CACREP accredited or your degree is **not** specifically in the practice substance abuse treatment or related counseling discipline:
 1. Evidence (letter or printed information from website) that degree program had the express intent to prepare counselors.
 2. Evidence that degree program had an identifiable counselor training faculty (licensed LPC faculty) with an identifiable body of students.
 3. Degree program had clear authority and primary responsibility for the core and specialty areas.

Please note:

In order to be considered for residency, all education requirements outlined in Regulations 18VAC115-60-60 and 18VAC115-60-70 must be met. Once approved you will be required to renew the Resident in Substance Abuse Treatment License each year and complete the continuing education requirements.



**INITIAL APPLIATION FOR TEMPORARY LICENSURE AS A RESIDENT IN
SUBSTANCE ABUSE TREATMENT - PAGE 1**

Military/Military Spouse	
Are you active duty military personnel?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

(PLEASE PRINT IN BLUE OR BLACK INK)

FIRST NAME		MIDDLE NAME		LAST NAME AND SUFFIX	
DATE OF BIRTH ____ / ____ / ____ MM DD YY		SOCIAL SECURITY NO. OR VA CONTROL NO.*			
ADDRESS OF RECORD**: STREET			CITY	STATE	ZIP CODE
ALTERNATE PUBLIC ADDRESS***: STREET			CITY	STATE	ZIP CODE
HOME PHONE:		WORK PHONE:		MOBILE PHONE:	
E-MAIL ADDRESS					
DEGREE EARNED	DATE DEGREE RECEIVED	MAJOR	INSTITUTION NAME/STATE		

*In accordance with §54.1-116 Code of Virginia, you are required to submit your Social Security Number or your control number issued by the Virginia Department of Motor Vehicles. If you fail to do so, the process of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other state agencies for child support enforcement activities. **NO LICENSE WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FAILED TO DISCLOSE ONE OF THESE NUMBERS.**

**The address information you provide is your address of record with the Board. Please be advised that all notices from the board, to include renewal notices, licenses, and other legal documents, will be sent to the address of record provided. If you provided a different public address, this information is not subject to public disclosure under the Freedom of Information Act and will not be sold or distributed for any other purpose.

***This address is subject to public disclosure under the Freedom of Information Act. You may provide an address other than a residence, such as a Post Office Box or a practice location if you wish.



**INITIAL APPLIATION FOR TEMPORARY LICENSURE AS A RESIDENT IN
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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, past actions or possible impairment.

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? Please provide a full explanation and any associated orders or letters from the entity. Yes No
 (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? If yes, provide detail(s), jurisdiction(s), date(s), and supporting documentation. Yes No
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? (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. Yes No
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? “Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing LPC. 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



**INITIAL APPLIATION FOR TEMPORARY LICENSURE AS A RESIDENT IN
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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 LPC. 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 LPC. 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

SUPERVISOR’S INFORMATION		
<u>The Board can only consider qualified LSATPs or LPCs to supervise a resident in substance abuse treatment.</u>		
SUPERVISOR’S NAME (LAST, FIRST)	LICENSE NUMBER	LICENSE TYPE
BUSINESS NAME OF SUPERVISOR’S WORKSITE	ADDRESS OF SUPERVISOR’S WORKSITE	
E-MAIL ADDRESS		
BUSINESS PHONE NUMBER		



**INITIAL APPLIATION FOR TEMPORARY LICENSURE AS A RESIDENT IN
SUBSTANCE ABUSE TREATMENT - PAGE 4**

WORKSITE INFORMATION

Please indicate the NAME and ADDRESS of the location where the RESIDENT will provide clinical counseling services.

1st WORKSITE NAME

1st WORKSITE ADDRESS (Street and/or Box Number, City, State, Zip)

2nd WORKSITE NAME (if applicable)

2nd WORKSITE ADDRESS (Street and/or Box Number, City, State, Zip)(if applicable)

3rd WORKSITE NAME (if applicable)

3rd WORKSITE ADDRESS (Street and/or Box Number, City, State, Zip)(if applicable)

STATEMENT OF ASSURANCE AND ATTESTATION

- I have read, understand and intend to comply with the Regulations Governing the Practice of Licensed Substance Abuse Treatment Practitioners.
- I understand that as a Licensed Resident in Substance Abuse Treatment, I must have a signed and executed supervisory contract for supervision before providing clinical substance abuse treatment services and before counting hours toward LSATP licensure.
- I attest that I will provide clinical substance abuse treatment services as defined in the regulation during my residency.
- I acknowledge that the Board will conduct random audits to ensure that I am practicing in accordance with the regulations.
- I understand that as a Licensed Resident in Substance Abuse Treatment, I must renew my license each year and complete three hours of continuing education hours that emphasize ethics, standards of practice, or laws governing behavioral science professions in Virginia.
- I understand that I must complete all required residency requirements and pass the MAC examination, administered by NAADAC, within six years of the date of issuance of my resident in substance abuse treatment license.

I ATTEST THAT THE INFORMATION CONTAINED WITHIN THE APPLICATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

APPLICANTS'S SIGNATURE:

DATE:



**VERIFICATION OF REQUIRED COURSEWORK AND INTERNSHIP FOR
LSATP LICENSURE**

TO BE COMPLETED BY THE APPLICANT

APPLICANT'S NAME (LAST, FIRST, MIDDLE)

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.**

1. Professional identity, functions and ethics.

Course Code	Course Title	Semester or Quarter Hours	College/University

2. Theories of Counseling and Psychotherapy.

Course Code	Course Title	Semester or Quarter Hours	College/University

3. Counseling and Psychotherapy Techniques.

Course Code	Course Title	Semester or Quarter Hours	College/University

4. Group Counseling and Psychotherapy, Theories and Techniques.

Course Code	Course Title	Semester or Quarter Hours	College/University

5. Appraisal, Evaluation and Diagnostic Procedures.

Course Code	Course Title	Semester or Quarter Hours	College/University



6. **Abnormal Behavior and Psychopathology.**

Course Code	Course Title	Semester or Quarter Hours	College/University

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

Course Code	Course Title	Semester or Quarter Hours	College/University

8. **Research.**

Course Code	Course Title	Semester or Quarter Hours	College/University

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

Course Code	Course Title	Semester or Quarter Hours	College/University

10. **Assessment, Appraisal, Evaluation and Diagnosis Specific to Substance Abuse.**

Course Code	Course Title	Semester or Quarter 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	Semester or Quarter Hours	College/University

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

Course Code	Course Title	Semester or Quarter Hours	College/University

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

Course Code	Course Title	Semester or Quarter Hours	College/University



14. **Client and Community Education.**

Course Code	Course Title	Semester or Quarter 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	Semester or Quarter Hours	College/University



VERIFICATION OF DEGREE AND INTERNSHIP FOR LSATP LICENSURE

TO BE COMPLETED BY STUDENT	
APPLICANT'S NAME (LAST, FIRST, MIDDLE)	
APPLICANT'S STUDENT ID NUMBER	APPLICANT'S SOCIAL SECURITY NUMBER OR VA DMV NUMBER
TO BE COMPLETED BY GRADUATE PROGRAM	
1. Is the college or university approved by a regional accrediting agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Did the graduate degree program prepare individuals to practice substance abuse treatment or related counseling discipline?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Was the applicant's graduate degree program CACREP accredited at the time of the applicant's graduation? (If yes, skip to question #7)	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Did the graduate degree program have a sequence of academic study with the expressed intent to prepare counselors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Did the degree program have identifiable counselor training faculty and an identifiable body of students who completed a counseling academic study?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Did the academic unit have clear authority and primary responsibility for the core and specialty areas?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Did internship begin after completion of 30 graduate semester hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Total number of supervised internship hours:	
9. Total direct client contact internship hours:	
10. Total direct client contact hours treating substance abuse-specific treatment problems:	
11. What type of licensure did the internship supervisor hold?	
12. Number of individual supervision hours during internship?	
13. Number of group supervision hours during internship?	
14. If applicable, total direct client contact hours with couples and/or families : (For LMFT licensure)	
NAME OF SCHOOL	
NAME OF PROGRAM OFFICIAL	TITLE
EMAIL ADDRESS OF SCHOOL OFFICIAL	PHONE NUMBER OF SCHOOL OFFICIAL
SIGNATURE OF SCHOOL OFFICIAL	DATE



APPLICANT OUT-OF-STATE LICENSURE VERIFICATION/CERTIFICATION

PART I. TO BE COMPLETED BY THE APPLICANT:

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:

TITLE OF LICENSE/CERTIFICATION

LICENSE/CERTIFICATION NUMBER

ISSUE DATE

EXPIRATION DATE

OBTAINED BY METHOD

BY EXAMINATION

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 _____



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 OF RESIDENCY WORK SITE WHERE CLINICAL HOURS WERE OBTAINED (ONE LOCATION ONLY)		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		AVG HOURS PER WEEK	TOTAL HOURS (For this quarter only)	ARE HOURS DUPLICATED ON ANOTHER FORM	
Total hours of supervised residency (Face-to-face client contact hour + ancillary hours)				<input type="checkbox"/> Yes	<input type="checkbox"/> No
How many <u>face-to-face client contact</u> hours in providing substance abuse treatment services did the resident provide?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
How many <u>individual supervision</u> hours did the resident receive?				MUST HAVE A MIN. OF 1 AND MAX. OF 4 HOURS PER 40 HOURS OF EXPERIENCE.	
How many <u>group supervision</u> hours did the resident receive?					
If applicable, total number of face-to-face client contact with couples and families or both.				<input type="checkbox"/> Yes	<input type="checkbox"/> 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?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did the applicant provide treatment planning, documentation and implementation while under your direct supervision?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did the applicant provide referral and service coordination while under your direct supervision?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did the applicant provide individual and group counseling and case management while under your direct supervision?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did the applicant demonstrate minimum competencies in client family and community education while under your direct supervision?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did the applicant demonstrate minimum competencies in professional and ethical responsibility while under your direct supervision?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any concerns about the competency of the resident? If yes, explain on separate page.				<input type="checkbox"/> Yes	<input type="checkbox"/> No
COMMENTS:					
Resident's Signature:			Date:		
Supervisor's Signature:			Date:		



TERMINATION OF SUPERVISION FOR A LICENSED RESIDENT

This form should be used to document termination of a supervisory contract between a supervisor and resident. At the conclusion of the supervised residency, the supervisor must provide the resident with a completed the Verification of 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 AND ADDRESS OF RESIDENCY WORKSITE(S):	
DATE OF TERMINATION:	
NAME AND SIGNATURE AND DATE OF INDIVIDUAL INITIATING TERMINATION OF SUPERVISION:	
PRINTED NAME: _____	
SIGNATURE: _____	DATE: _____