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) 767-6225 (Fax)

# 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.

Revised 12/2019

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

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

**(PLEASE PRINT IN BLUE OR BLACK INK)**

| FIRST NAME | MIDDLE NAME | LAST NAME AND SUFFIX |
|---|---|---|
| DATE OF BIRTH<br>_____ _____ _____<br>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.

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# INITIAL APPLIATION FOR TEMPORARY LICENSURE AS A RESIDENT IN SUBSTANCE ABUSE TREATMENT - PAGE 2

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

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# INITIAL APPLIATION FOR TEMPORARY LICENSURE AS A RESIDENT IN SUBSTANCE ABUSE TREATMENT - PAGE 3

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**

**The Board can only consider qualified LSATPs or LPCs to supervise a resident in substance abuse treatment.**

| 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 | | |

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

| **WORKSITE INFORMATION**<br><br>**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: |
|---|---|
| | |

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# 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 |
|---|---|---|---|
| | | | |

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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 |
|---|---|---|---|
| | | | |

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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 |
|---|---|---|---|
| | | | |

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# 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? | ☐ Yes ☐ No |
| 2. Did the graduate degree program prepare individuals to practice substance abuse treatment or related counseling discipline? | ☐ Yes ☐ 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) | ☐ Yes ☐ No |
| 4. Did the graduate degree program have a sequence of academic study with the expressed intent to prepare counselors? | ☐ Yes ☐ No |
| 5. Did the degree program have identifiable counselor training faculty and an identifiable body of students who completed a counseling academic study? | ☐ Yes ☐ No |
| 6. Did the academic unit have clear authority and primary responsibility for the core and specialty areas? | ☐ Yes ☐ No |
| 7. Did internship begin after completion of 30 graduate semester hours? | ☐ Yes ☐ 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 |

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# 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 _____

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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** 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) | | | ☐ Yes | ☐ No |
| How many face-to-face client contact hours in providing substance abuse treatment services did the resident provide? | | | ☐ Yes | ☐ No |
| How many individual supervision hours did the resident receive? | | | **MUST HAVE A MIN. OF 1 AND MAX. OF 4 HOURS PER 40 HOURS OF EXPERIENCE.** | |
| 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 in **client family and community education** while under your direct supervision? | ☐ Yes | ☐ No |
| Did the applicant demonstrate minimum competencies in **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 |

COMMENTS:

| | |
|---|---|
| Resident's Signature: | Date: |
| Supervisor's Signature: | Date: |

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# 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 SUPERVSION:<br><br>PRINTED NAME: _____<br><br>SIGNATURE:_____ DATE:_____ | |