



**COMMONWEALTH OF VIRGINIA**

**BOARD OF COUNSELING**  
Department of Health Professions  
9960 Mayland Drive, Suite 300  
Richmond, Virginia 23233-1463  
(804) 367-4697

**Licensed Substance Abuse Treatment Practitioner  
APPLICATION FOR REINSTATEMENT OF A LAPSED LICENSE**

I hereby make application for reinstatement of my substance abuse treatment practitioner number \_\_\_\_\_. The following evidence of my qualifications is submitted with a check or money order in the amount of \$165.00 made payable to the Treasurer of Virginia. I understand that the application fee is non-refundable.

INSTRUCTIONS		PLEASE TYPE OR PRINT		USE BLACK INK
1. Applications lacking a Social Security Number or Virginia Department of Motor Vehicles control number will not be processed.				
2. Applications lacking all supporting documentation (including verification of subsequent licensure(s)) will not be processed.				
<b>I. GENERAL INFORMATION</b>				
Full Name (Last, First, Middle, Suffix, Maiden Name)		Degree	Social Security/Virginia DMV Control Number <input type="checkbox"/>	Date of Birth
Mailing Address (Street and/or Box Number, City, State, ZIP Code)			Home Telephone Number	
Business Name and Address (if different from above)			Business Telephone Number	
Fax Number		E-Mail Address		
<b>LICENSURE/CERTIFICATION</b> - List all the states in which you now hold or have ever held an occupational license or certificate to practice as mental health care practitioner. A verification form must from each jurisdiction in which licensure was ever held.				
STATE	LICENSE/CERTIFICATE NUMBER	ISSUE DATE	TYPE OF LICENSE/CERTIFICATE	

In accordance with Section 54.1-116 of the *Code of Virginia* you are required to submit your Social Security Number or your *Virginia* control number. Refer to instruction sheet.

**ANSWER THE FOLLOWING QUESTIONS:**

- |   |            |           |
|---|------------|-----------|
|   | <b>YES</b> | <b>NO</b> |
| 1. Have you ever had any disciplinary action taken against an occupational license issued outside Virginia or are any such actions pending? *If yes, see below.   | [ ]        | [ ]       |
| 2. Have you ever been convicted of a violation of or pled nolo contendere to any federal, state, or local statute, regulation or ordinance or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except for driving under the influence.) *If yes, see below. | [ ]        | [ ]       |
| 3. Have you ever been censored, warned, or requested to withdraw from your employment, terminated from any health care facility, agency, or practice? *If yes, see below.   | [ ]        | [ ]       |

**\*If you answered "YES", please provide an explanation on a separate sheet of paper and any supporting documentation.**

**II. PROFESSIONAL EXPERIENCE (subsequent to expiration of Virginia certification)**

Dates of Employment		Employer	Address	Hours per week	Supervisor (if applicable)	Duties
From	To					

**III. ADDITIONAL INFORMATION:** Provide any additional information to document continued competency to resume practice in the Commonwealth of Virginia by providing evidence of having met all applicable continuing competency requirements not to exceed a maximum of 80 hours.

The following statement must be executed by a Notary Public. This form is not valid unless properly notarized.

**AFFIDAVIT**  
(To be completed before a notary public)

State of \_\_\_\_\_ County/City of \_\_\_\_\_

Name \_\_\_\_\_, being duly sworn, attests that he/she has read and agrees to comply with the Standards of Practice and laws governing the practice of substance abuse treatment in Virginia and says that he/she is the person who is referred to in the foregoing application of licensure for substance abuse treatment practitioner in the Commonwealth of Virginia; that the statements herein contained are true in every respect, that he/she has complied with all requirements of the law; and that he/she has read and understands this affidavit.

\_\_\_\_\_  
Signature of Applicant

Subscribed to and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

My commission expires on \_\_\_\_\_.

\_\_\_\_\_  
Signature of Notary Public

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