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.		

I. GENERAL INFORMATION

Full Name (Last, First, Middle, Suffix, Maiden Name)	Degree	Social Security/Virginia DMV Control Number 🕮	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

LICENSURE/CERTIFICATION - 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:

	YES	NO
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

SEAL

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