Reset Form

SUPPLEMENTAL FORMS FOR CLINICAL ADDICTION COUNSELOR (LCAC) AND CLINICAL ADDICTION COUNSELOR ASSOCIATE (LCACA) APPLICATION FOR LICENSURE

State Form 52957 (R1 / 8-24)

BEHAVIORAL HEALTH AND HUMAN SERVICES LICENSING BOARD
PROFESSIONAL LICENSING AGENCY
402 W Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 234-2054
E-mail: pla8@pla.IN.gov
www.pla.IN.gov

FORM C – VERIFICATION OF CLINICAL ADDICTION COUNSELOR COURSEWORK

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

Name of Applicant:	Date of Birth:

ALL INFORMATION ON THIS FORM MUST BE TYPED OR CLEARLY PRINTED.

Please list the course titles in the areas indicated below, or courses, as they appear on your transcript, that in your opinion, meet the following requirements. If two or more courses combined meet the criteria, list all courses that may apply. Once complete, you will submit the form to the PLA for processing.

Name of educational institution	Course number	Course Title	Credit hours	Semester / Quarter Year
Addiction Counselling Theories and Techniques				
Clinical Problems				
Psychopharmacology				
Psychopathology				
Clinical Appraisal and Assessment				
Theory and Practice of Group Addiction Counselling				
Counselling Addicted Family Systems				
Multicultural Counselling				
Research Methods in Addictions				
Human Development				

FORM P – VERIFICATION OF PRACTICUM FOR LICENSURE AS A CLININAL ADDICTION COUNSELOR (LCAC) AND CLINICAL ADDICTION COUNSELOR ASSOCIATE (LCACA)

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

BEHAVIORAL HEALTH AND HUMAN SERVICES LICENSING BOARD
PROFESSIONAL LICENSING AGENCY
402 W Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 234-2054
E-mail: pla8@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS: 1. *The applicant must complete Section A, then forward to the educational institution at which the practicum was completed.*
2. *Section B must be completed by an official of the institution that has granted the academic credit for this supervised clinical experience.*

SECTION A - APPLICANT INFORMATION

Name of Applicant (*last, first, middle, maiden or previous)*	Date of Birth *(month, day year)*
My minimum seven hundred (700) hour practicum was completed under the auspices of the following educational institution:	
Name of Institution	
Location of educational institution *(city and state)*	
Date practicum began *(month, year)*	Date practicum was completed *(month, year)*
I completed the practicum at the following location:	
Specific location of field experience	

SECTION B - SCHOOL OFFICIAL

As an official of the school named above, I certify that the above-named applicant has completed a minimum of seven hundred (700) hours of clinical addiction counseling services which incorporated at least two hundred eighty (280) hours of face-to-face client contact hours and thirty-five (35) supervision hours as described in IC 25-23.6-10.5-6 for the purpose of enabling the student to develop basic theory skills and to integrate professional knowledge and skills during the completion of the practicum, internship, or field experience. The required practicum, internship, or field experience listed in this section must have been primarily in the provision of direct clinical addiction counseling services. This includes knowledge, skill, or experience derived from direct observations of, and participation in, the practice of clinical addiction counseling.

I certify that the supervision for this practicum, internship, or field experience was conducted by an individual who is supervising within his / her scope of experience and training and holds an active license at the time of the supervision as described in 839 IAC 1-5.5-3 or 839 IAC 1-5.5-1.

Signature of school official	Date *(month, day year)*
Printed name of school official	Title of school official
Name of program faculty member	Name of alternate supervisor
Name of site supervisor	Position held at the institution
Name of Institution	
Name of Applicant *(last, first, middle, maiden or previous)*	

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
Indianapolis, IN 46204
Telephone: (317) 234-2054
E-mail: pla8@pla.IN.gov
www.pla.IN.gov

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)*

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

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)*

FORM S2 – VERIFICATION OF SUPERVISION 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
Indianapolis, IN 46204
Telephone: (317) 234-2054
E-mail: pla8@pla.IN.gov
www.pla.IN.gov

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 hundred (200) hours of post-graduate face-to-face supervision, which must be comprised of one hundred (100) hours of individual supervision and one hundred (100) hours of group supervision as described in IC 25-23.6-10.5-8. This supervision must be completed while employed for no less than twenty-one (21) months and no more than forty-eight (48) months. The supervision must have been provided by a "qualified supervisor" as defined in 839 IAC 1-5.5-4. If you obtained your hours in another state or jurisdiction, it will be reviewed by the Board. 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 Supervisor (please also provide supervisors	Employment of Supervisor

Applicant's employer during the time of supervision	

Dates of supervision began *(month, day, year)*	Dates of supervision ends *(month, day, year)*

SECTION B - SUPERVISOR INFORMATION

SECTION B INSTRUCTIONS FOR APPLICANT'S DIRECT SUPERVISOR: *Complete this section. All supervision documented in this form is to be specific to clinical addiction counseling. All supervision may be completed either in person or virtual. However, any completed virtual supervision is required to meet the definition of "virtual supervision" provided under IC 25-23.6-10.5-8.*

Total number of months of face-to-face supervision you provided to the above-named applicant: _____

Total number of supervision hours you provided to the above-named applicant: _____

Total number of individual supervision hours you provided to the above-named applicant: _____

Total number of group supervision hours you provided to the above-named applicant: _____

The above-named applicant was providing clinical addiction counseling services directly to clients at the time of my supervision?

Yes No If No, please explain: _____.

I hold the following graduate degree(s), credential(s), and / or state board issued license(s) / certification(s) that qualify me to serve as a clinical addiction counselor supervisor:

_____

_____

I affirm that the above information is true and correct to the best of my knowledge and belief. I affirm that any virtual supervision completed met the definition of "virtual supervision" under IC 25-23.6-10.5-8.

Signature of supervisor, [please provide your professional credential (i.e., LCAC)]: _____

Printed name of supervisor, [please provide your professional credential (i.e., LCAC)]: _____

Cellular telephone number: _____

Work Telephone number: _____

E-mail address: _____

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

FORM S2 – VERIFICATION OF SUPERVISION FOR LICENSURE AS A CLINICAL ADDICTION COUNSELOR (LCAC) *(continued)*

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

SECTION C - AFFIRMATION OF SUPERVISION [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 supervision received from more than one previous direct supervisor of a previous employer, this form may be duplicated but you must submit one AFFIRMATION OF SUPERVISION for each previous direct supervisor that is no longer able to complete SECTION B (on the reverse side of this form).***

Please indicate the reason why the applicant's direct supervisor is no longer able to complete SECTION B:

The applicant's supervisor named below is:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please briefly explain:

_____

_____

_____

Supervision was provided by: _____.
(Name of supervisor / last, first, middle, maiden)

Total number of hours of face-to-face supervision the applicant received from this supervisor while providing clinical addiction counseling services directly to clients: _____.

Total number of supervision hours completed by the applicant: _____

Total number of individual supervision hours completed by the applicant: _____

Total number of group supervision hours completed by the applicant: _____

Date of supervision: _____ to _____.
(month / year) *(month / year)*

List all graduate degrees, credentials and/or state board issued licenses / certifications that qualified this individual to serve as a clinical addiction counselor supervisor: _____

_____

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

Signature of professional colleague	Date *(month, day, year)*