Reset Form

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

# SUPPLEMENTAL FORMS FOR ADDICTION COUNSELOR (LAC) OR ADDICTION COUNSELOR ASSOCIATE (LACA) APPLICATION FOR LICENSURE

State Form 52956 (R / 8-22)

## FORM C – VERIFICATION OF ADDICTION COUNSELOR COURSEWORK

| 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.

**Addictions Theory**

| Name of educational institution | Course number | Course Title | Credit hours | Semester / Quarter<br>Year |
|---|---|---|---|---|
| | | | | |

**Psychoactive Drugs**

| Name of educational institution | Course number | Course Title | Credit hours | Semester / Quarter<br>Year |
|---|---|---|---|---|
| | | | | |

**Addictions Counseling Skills**

| Name of educational institution | Course number | Course Title | Credit hours | Semester / Quarter<br>Year |
|---|---|---|---|---|
| | | | | |

**Theories of Personality**

| Name of educational institution | Course number | Course Title | Credit hours | Semester / Quarter<br>Year |
|---|---|---|---|---|
| | | | | |

**Developmental Psychology**

| Name of educational institution | Course number | Course Title | Credit hours | Semester / Quarter<br>Year |
|---|---|---|---|---|
| | | | | |

**Abnormal Psychology**

| Name of educational institution | Course number | Course Title | Credit hours | Semester / Quarter<br>Year |
|---|---|---|---|---|
| | | | | |

**Treatment Planning**

| Name of educational institution | Course number | Course Title | Credit hours | Semester / Quarter<br>Year |
|---|---|---|---|---|
| | | | | |

**Cultural Competency**

| Name of educational institution | Course number | Course Title | Credit hours | Semester / Quarter<br>Year |
|---|---|---|---|---|
| | | | | |

**Ethics and Professional Development**

| Name of educational institution | Course number | Course Title | Credit hours | Semester / Quarter<br>Year |
|---|---|---|---|---|
| | | | | |

**Family Education**

| Name of educational institution | Course number | Course Title | Credit hours | Semester / Quarter<br>Year |
|---|---|---|---|---|
| | | | | |

**Group Work**

| Name of educational institution | Course number | Course Title | Credit hours | Semester / Quarter<br>Year |
|---|---|---|---|---|
| | | | | |

# FORM P – VERIFICATION OF PRACTICUM FOR LICENSURE AS AN ADDICTION COUNSELOR (LAC) OR ADDICTION COUNSELOR ASSOCIATE (LACA)

**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 or site supervisor 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 three hundred fifty (350) hour practicum was completed under the auspices of the following educational institution:

Name of Institution:_____

Location *(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 - VERIFICATION OF COMPLETION OF THREE HUNDRED FIFTY (350) HOUR PRACTICUM

As an official of the school named above, I certify that the above-named applicant has completed a minimum of three hundred fifty (350) hours of addiction counseling services as described in IC 25-23.6-10.5-5 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 addiction counseling services. This includes knowledge, skill, or experience derived from direct observations of, and participation in, the practice of 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 ANADDICTION COUNSELOR (LAC)

**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

Complete **SECTION A** and then forward this form to your previous employer(s) for completion of **SECTION B.** You must submit proof that you have acquired at least two (2) years of post-graduate experience as described in IC 25-23.6-10.5-7 and 839 IAC 1-5.5-2. This post-baccalaureate experience must be completed in no less than twenty-one (21) months and no more than forty-eight (48) months. **This form may be duplicated if your experience has been completed at more than one (1) place of employment.** If you are no longer able to contact your previous employer(s), you may complete **SECTION C** for each previous place of employment. Sign the form(s) and return to the form to the Professional Licensing Agency.

## SECTION A - APPLICANT INFORMATION

| Name of Applicant (*last, first, middle, maiden or previous*) | Date of Birth *(month, day year)* |
|---|---|
| | |

| Name of Employer | Dates of employment begin *(month, day, year)* | Dates of employment end *(month, day, year)* |
|---|---|---|
| | | |

Location of place of employment or place of practice

## SECTION B - EMPLOYER/EMPLOYMENT INFORMATION

*This section is to be completed by the applicant's previous or current employer.*
*All experience documented in this form is to be specific to addiction counseling.*

Total number of months the above-named applicant served in the practice of addiction counseling:_____

Total number of hours served at the address below:_____

The above-named applicant was providing addiction counseling services directly to client on an average of at least____hours per week during the time he / she was in my employment.

Address(es) of where the above-named applicant provided the majority of his / her addiction counseling services:

_____

_____

_____

**I swear 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 AN ADDICTION COUNSELOR (LAC) *(continued)*

**SECTION C - AFFIRMATION OF EXPERIENCE**

To be completed by applicant if the applicant's previous employer is no longer able to complete **SECTION B.** Please indicate below the reason why your previous employer is no longer able to complete **SECTION B. If you are affirming experience acquired through more than one previous employer this form may be duplicated but you must submit one AFFIRMATION OF EXPERIENCE for each previous employer that is no longer able to complete SECTION B.**

I am unable to have my previous employer(s) 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 you have been providing 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 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 swear 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 ANADDICTION COUNSELOR (LAC)

**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

Complete **SECTION A** and then forward this form to your previous or current supervisor(s) for completion of **SECTION B.** You must submit proof that you have acquired at least one hundred fifty (150) hours of post-baccalaureate face-to-face supervision while employed in no less than twenty-one (21) months and no more than forty-eight (48) months. Your one hundred fifty (150) hours must be comprised of one hundred (100) hours of individual supervision and fifty (50) hours of group supervision as described in IC 25-23.6-10.5-7. The supervision must have been provided by a qualified supervisor as described in 839 IAC 1-5.5-2 or 839 IAC 1-5.5-4. **This form may be duplicated if your face-to-face supervision has been completed through multiple supervisors.** If you are no longer able to contact your previous employer(s), you may complete **SECTION C** for each previous place of employment. Sign the form(s) and return to the form to the Professional Licensing Agency.

## SECTION A - APPLICANT INFORMATION

| Name of Applicant (*last, first, middle, maiden or previous*) | Date of Birth (*month, day year*) |
|---|---|
| | |

| Name of Supervisor | Employment of Supervisor |
|---|---|
| | |

Applicant's employer during the time of supervision

| Dates of supervision began (*month, day, year*) | Dates of supervision end (*month, day, year*) |
|---|---|
| | |

## SECTION B - SUPERVISOR INFORMATION

*This section is to be completed by the applicant's previous or current supervisor and sent directly to the Professional Licensing Agency. All experience documented in this form is to be specific to addiction counseling.*

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 applicant's virtual supervision was no more than fifty percent (50%) of the total supervision. ☐ True ☐ False

The above-named applicant was providing 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 an addiction counselor supervisor:

_____

_____

_____

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

Signature of supervisor:_____

Printed name of supervisor:_____

Cellular telephone number:_____

Work Telephone number:_____

E-mail address:_____

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

# FORM S2 – VERIFICATION OF SUPERVISION FOR LICENSURE AS AN ADDICTION COUNSELOR (LAC)

## SECTION C - AFFIRMATION OF SUPERVISION

To be completed by applicant if the applicant's previous employer is no longer able to complete **SECTION B.** Please indicate below the reason why your previous supervisor is no longer able to complete **SECTION B. If you are affirming supervision received from more than one previous supervisor, this form may be duplicated but you must submit one AFFIRMATION OF SUPERVISION for each previous supervisor that is no longer able to complete SECTION B.**

Please indicate the reason why your previous supervisor is no longer able to complete SECTION B:

My previous 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 you have received from this supervisor while providing 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 an addiction counselor supervisor: _____

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

Signature of applicant: _____

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