



# APPLICATION FOR LICENSURE AS AN ADDICTION COUNSELOR (LAC)

State Form 54088 (R7 / 8-16)

Approved by State Board of Accounts, 2016

BEHAVIORAL HEALTH AND HUMAN SERVICES LICENSING BOARD

PROFESSIONAL LICENSING AGENCY

402 West Washington Street, Room W072

Indianapolis, Indiana 46204

Telephone: (317) 234-2054

E-mail: [pla8@pla.IN.gov](mailto:pla8@pla.IN.gov)

[www.pla.IN.gov](http://www.pla.IN.gov)

- INSTRUCTIONS:**
1. The fee for this application is \$50.00, payable to the Indiana Professional Licensing Agency, in accordance with 839 IAC 1-2-5.
  2. If applying for a temporary permit, please include your fee of \$25.00 in accordance with 839 IAC 1-2-5.
  3. All fees are non-refundable and non-transferable.
  4. Please refer to the instructions on our website, [www.pla.in.gov](http://www.pla.in.gov), for the licensing requirements.

\* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

### FOR OFFICE USE ONLY

APPLICATION FEE:	
DATE FEE PAID (month, day, year):	
RECEIPT NUMBER	
LICENSE NUMBER ISSUED:	
PERMIT NUMBER ISSUED:	
DATE LICENSE ISSUED (month, day, year):	

Attach one passport quality photograph here. (See instructions.)

### DO NOT WRITE ABOVE THIS LINE

### APPLICANT INFORMATION

Name of applicant (last, first, middle, maiden or previous) \_\_\_\_\_

Current address (number and street, city, state, and ZIP code) \_\_\_\_\_

Permanent address (if different from above) \_\_\_\_\_

Work telephone number ( ) ( )	Home telephone number ( ) ( )	E-mail address
Social Security number *	Date of birth (month, day, year)	Place of birth (city and state)
Are you the spouse of a member of the military who is assigned to a duty station in Indiana? (Optional) <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you an active duty member of the military? (Optional) <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please indicate exactly how you wish your name to appear on your license. \_\_\_\_\_ Are you applying for a temporary permit?  
 Yes  No

**Please check all that apply:**

- I am applying for licensure by examination and will be taking:
- The International Examination for Alcohol & Drug Counselors through IC & RC
- OR**
- The National Certified Addiction Counselor II through NAADAC
- I am applying for licensure by exemption from examination (ENDORSEMENT).
- I have passed the (name of examination) \_\_\_\_\_

Date (month, day, year): \_\_\_\_\_ State taken in: \_\_\_\_\_

### GRADUATE EDUCATION (Master's or Doctoral)

Name of academic institution	Department	Program title
Location (city and state)	Dates attended (mm/yy - mm/yy)	Degree earned
Name of academic institution	Department	Program title
Location (city and state)	Dates attended (mm/yy - mm/yy)	Degree earned
Name of academic institution	Department	Program title
Location (city and state)	Dates attended (mm/yy - mm/yy)	Degree earned

**OTHER STATE LICENSURE / CERTIFICATION**

Do you hold, or have you ever held, a license / certification / registration / permit to practice any regulated health profession by a state licensing board?  Yes  No

(If yes, list all states below, including Indiana, in which you have held a license / certification / registration / permit to practice any state regulated occupation.)

Type of License / Certificate / Registration / Permit	State	Number	Date Issued (month, day, year)	Status
1.				
2.				
3.				
4.				
5.				

**ALL APPLICANTS MUST ANSWER THE FOLLOWING QUESTIONS**

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held?  Yes  No
2. Have you ever been denied license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state (including Indiana) or country?  Yes  No
3. Do you have any condition or impairment (including a history of alcohol or substance abuse) that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner?  Yes  No
4. Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,
  - (1) have you ever been arrested;  Yes  No
  - (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;  Yes  No
  - (3) have you ever been convicted of any offense, misdemeanor, or felony in any state;  Yes  No
  - (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or  Yes  No
  - (5) have you ever pled *nolo contendere* to any offense, misdemeanor, or felony in any state?  Yes  No
5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?  Yes  No
6. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?  Yes  No
7. Have you ever had a malpractice judgment against you or settled any malpractice action?  Yes  No

**APPLICATION AFFIRMATION**

I hereby swear or affirm under the penalties perjury that the above statements are true, complete and correct.

Signature of applicant	Date (month, day, year)
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**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency, or the Behavioral Health and Human Services Licensing Board, any files, documents, records or other information pertaining to the undersigned requested by the Agency, or the Board, or any of their authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency, or the Behavioral Health and Human Services Licensing Board, to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency, and the Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

**AFFIRMATION**

I hereby swear or affirm, that I have read the above statements and agree to same.

Signature of applicant	Date signed (month, day, year)
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**FORM C  
VERIFICATION OF ADDICTION COUNSELOR COURSEWORK**

Part of State Form 54088 (R7 / 8-16)

**All information on this form must be typed or clearly printed.**

Please list the course titles in the areas indicated below, or the courses, as they appear on your transcript, that in your opinion, meet the following requirements. If the title of the course you are wishing to apply towards these requirements does not clearly reflect these content areas, you should also submit additional supporting documentation, such as course descriptions from your college or university's catalog.

Forty (40) semester hours or sixty (60) quarter hours of eligible postsecondary coursework that must include course credits with material in at least the following content areas. Please indicate whether these are semester or quarter hours below.

**Addictions Theory**

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter
				Year

**Psychoactive Drugs**

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter
				Year

**Addictions Counseling Skills**

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter
				Year

**Theories of Personality**

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter
				Year

**Developmental Psychology**

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter
				Year

**Abnormal Psychology**

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter
				Year

**Treatment Planning**

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter
				Year

**Cultural Competency**

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter
				Year

**Ethics and Professional Development**

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter
				Year

**Family Education**

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter
				Year

**FORM P****VERIFICATION OF PRACTICUM FOR LICENSURE AS AN ADDICTION COUNSELOR (LAC)**

Part of State Form 54088 (R7 / 8-16)

- 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 ( <i>last, first, middle, maiden or previous</i> )		Social Security number *
My minimum three hundred fifty (350) hour practicum was completed under the auspices of the following educational institution:		
Name of institution		
Location ( <i>city and state</i> )		
Date practicum began ( <i>month, year</i> )	Date practicum was completed ( <i>month, year</i> )	
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 three hundred fifty (350) hours of addiction counseling services 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.

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 an addiction counselor, clinical addiction counselor, mental health counselor, clinical social worker, marriage and family therapist, a physician with training in psychiatric medicine, a psychologist, clinical nurse specialist in psychiatric medicine or a mental health nursing, another state-regulated addiction counseling professional or if the experience was gained in a state where no regulation exists by an addictions or behavioral health professional of equivalent status. I further certify that the supervising individual has at least three (3) years of experience in providing addiction services.

Signature of school official		Date ( <i>month, day, year</i> )
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 ( <i>last, first, middle, maiden or previous</i> )		

**FORM E2****VERIFICATION OF EXPERIENCE FOR LICENSURE AS AN ADDICTION COUNSELOR (LAC)**

Part of State Form 54088 (R7 / 8-16)

Complete **SECTION A** and then forward this form to 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 past-graduate experience. **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) in the presence of the Notary Public and have your signature notarized, then return the form to the Professional Licensing Agency at the address listed in the lower left hand corner of this form.

**SECTION A / APPLICANT INFORMATION**

Name of applicant ( <i>last, first, middle, maiden</i> )	Social Security number *
Name of employer	Dates of employment ( <i>month/year to month/year</i> )
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, notarized and sent directly to the Professional Licensing Agency at the address listed in the lower left hand corner of this form.

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

Total number of hours served at the address below: \_\_\_\_\_

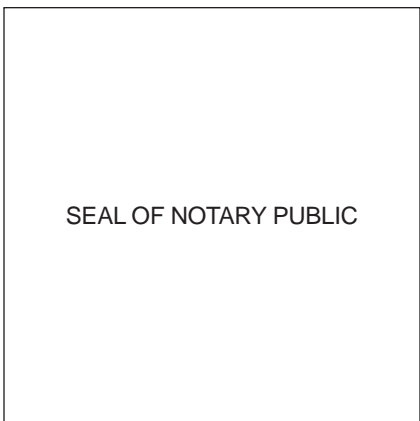
The above-named applicant was providing addiction counseling services directly to clients on an average of at least \_\_\_\_\_ hours per week, during the period of time he / she was in my employment.

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*)

RETURN THIS FORM TO:  
Professional Licensing Agency  
402 West Washington Street, Room W072  
Indianapolis, IN 46204

**FORM E2**

**VERIFICATION OF EXPERIENCE FOR LICENSURE AS AN ADDICTION COUNSELOR (LAC) (continued)**

Part of State Form 54088 (R7 / 8-16)

**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 notarized **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:

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Total number of months that you have been providing addiction counseling services directly to clients on an average of at least \_\_\_\_\_ hours per week, at the address below: \_\_\_\_\_

Total number of hours served at the address below: \_\_\_\_\_

Period of time in which you provided these services: \_\_\_\_\_ to \_\_\_\_\_  
(month / year) (month / year)

Name of facility and address where addiction counseling services were provided:

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Provide the name of a professional colleague who can attest to the validity of the above statements:

\_\_\_\_\_  
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.

**APPLICANT'S AFFIRMATION**  
**(To be completed only if applicant is unable to complete SECTION B.)**

\_\_\_\_\_  
Signature of applicant (Sign only in the presence of the Notary Public.) Date (month, day, year)

Before me, the undersigned, a Notary Public for \_\_\_\_\_ County, State of \_\_\_\_\_

\_\_\_\_\_, personally appeared and acknowledged in the foregoing  
(Name of applicant)

statements as true and correct to the best of his / her knowledge and belief this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

\_\_\_\_\_, Notary Public.  
(Signature of Notary Public)

County of Residence: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_  
(month, day, year)

**FORM S2**

**VERIFICATION OF SUPERVISION FOR LICENSURE AS AN ADDICTION COUNSELOR (LAC)**

Part of State Form 54088 (R7 / 8-16)

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 received at least one hundred fifty (150) hours of past-graduate face-to-face supervision, with one hundred (100) hours under individual supervision and fifty (50) hours must be under group supervision that was provided by an approved addiction counseling professional. **This form may be duplicated if your one hundred fifty (150) hours of face-to-face supervision have been completed through multiple supervisors.** If you are no longer able to contact your previous supervisor(s), you may complete **SECTION C** for each previous supervisor. Sign the form(s) in the presence of the Notary Public and have your signature notarized, then return the form to the Professional Licensing Agency at the address listed in the lower left hand corner of this form.

**SECTION A / APPLICANT INFORMATION**

Name of applicant (last, first, middle, maiden)	Social Security number *
Name of supervisor	Dates of supervision (month/year to month/year)

**SECTION B / SUPERVISOR INFORMATION**

This section is to be completed by the applicant's previous or current supervisor, notarized and sent directly from the applicant's previous or current supervisor to the Professional Licensing Agency at the address listed in the lower left hand corner of this form.

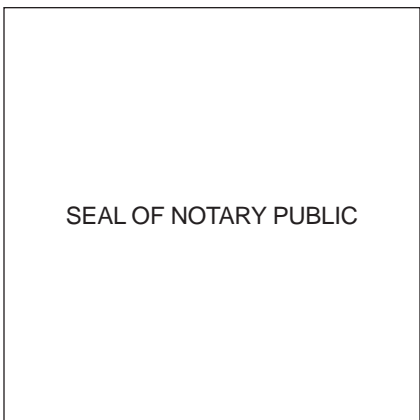
Total number of hours of face to face supervision you provided to the above-named applicant: \_\_\_\_\_

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)

RETURN THIS FORM TO:  
Professional Licensing Agency  
402 West Washington Street, Room W072  
Indianapolis, IN 46204

**FORM S2**

**VERIFICATION OF SUPERVISION FOR LICENSURE AS AN ADDICTION COUNSELOR (LAC) (continued)**

Part of State Form 54088 (R7 / 8-16)

**SECTION C / AFFIRMATION OF SUPERVISION**

To be completed by applicant if your previous supervisor 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 notarized **AFFIRMATION OF SUPERVISION** for each previous supervisor that 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**.

My previous supervisor named below is:

- Deceased
- Unable to be located
- Other reason

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

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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: \_\_\_\_\_

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 mental health counselor supervisor: \_\_\_\_\_  
\_\_\_\_\_

**APPLICANT'S AFFIRMATION**  
**(To be completed only if applicant is unable to complete SECTION B.)**

\_\_\_\_\_  
Signature of applicant (Sign only in the presence of the Notary Public.) Date (month, day, year)

Before me, the undersigned, a Notary Public for \_\_\_\_\_ County, State of \_\_\_\_\_

\_\_\_\_\_, personally appeared and acknowledged in the foregoing  
(Name of applicant)

statements as true and correct to the best of his / her knowledge and belief this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

\_\_\_\_\_, Notary Public.  
(Signature of Notary Public)

County of Residence: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_  
(month, day, year)

**ALL INFORMATION ON THIS FORM SHOULD BE TYPED OR CLEARLY WRITTEN.**



**FORM EE**

**VERIFICATION OF EXPERIENCE FOR LICENSURE AS AN ADDICTION COUNSELOR (LAC)**

Part of State Form 54088 (R7 / 8-16)

**TO BE USED ONLY IF YOU ARE APPLYING BY EXEMPTION FROM EXAMINATION.**

Complete **SECTION A** and then forward this form to your previous or current employer(s) for completion of **SECTION B**. You must submit proof that you have been engaged in the practice of addiction counseling for not less than three (3) of the previous five (5) years. **This form may be duplicated if your three (3) years of experience have been completed at more than one place of employment.** If you are no longer able to contact your previous employer(s), or you have been in private practice, you may complete **SECTION C** for each previous place of employment. Sign the form(s) in the presence of the Notary Public and have your signature notarized, then return the form to the Professional Licensing Agency at the address listed in the lower left hand corner of this form.

**SECTION A / APPLICANT INFORMATION**

Name of applicant ( <i>last, first, middle, maiden</i> )	Social Security number *
Name of employer	Dates of employment or practice ( <i>month/year to month/year</i> )
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, notarized and sent directly from the applicant's previous or current employer to the Professional Licensing Agency at the address listed in the lower left hand corner of this form.*

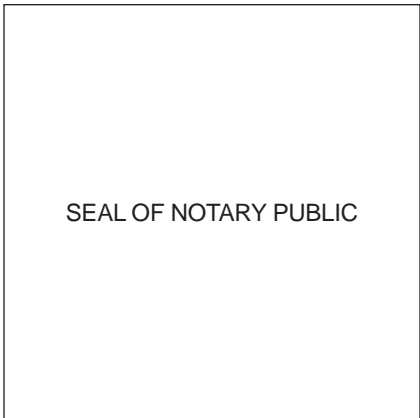
Total number of months the above-named applicant served in the practice of addiction counseling: \_\_\_\_\_

Total number of hours served under my employment: \_\_\_\_\_

The above-named applicant was providing addiction counseling services directly to clients on an average of at least \_\_\_\_\_ hours per week, during the period of 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*)

RETURN THIS FORM TO:  
Professional Licensing Agency  
402 West Washington Street, Room W072  
Indianapolis, IN 46204

**FORM EE**

**VERIFICATION OF EXPERIENCE FOR LICENSURE AS AN ADDICTION COUNSELOR (LAC) (continued)**

Part of State Form 54088 (R7 / 8-16)

**TO BE USED ONLY IF YOU ARE APPLYING BY EXEMPTION FROM EXAMINATION.**

**SECTION C / AFFIRMATION OF EXPERIENCE**

To be completed by applicant if the applicant was in private practice or if your previous employer is no longer able to complete **SECTION B**. Please indicate below 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 notarized **AFFIRMATION OF EXPERIENCE** for each previous employer that is no longer able to complete **SECTION B**.

I acquired this experience through private practice.  Yes  No

If you answered yes, then please proceed to Section C-2.

If you answered no, then please proceed to Section C-1.

**SECTION C-1**

I am unable to have my previous employer complete **SECTION B** for the following reason:

Deceased  Unable to be located  Other reason

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

\_\_\_\_\_

**SECTION C-2**

Total number of months that you have been providing addiction counseling services directly to clients at the address below on an average of at least \_\_\_\_\_ hours per week: \_\_\_\_\_ Total number of hours served at the address below: \_\_\_\_\_

Period of time in which you provided these services: \_\_\_\_\_ to \_\_\_\_\_  
(month / year) (month / year)

Name of facility and address where addiction counseling services were provided:

\_\_\_\_\_

Provide the name of a professional colleague who can attest to the validity of the above statements:

\_\_\_\_\_ ( ) \_\_\_\_\_  
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.

**APPLICANT'S AFFIRMATION**

**(To be completed only if applicant is unable to complete SECTION B.)**

\_\_\_\_\_ Signature of applicant (Sign only in the presence of the Notary Public.) \_\_\_\_\_ Date (month, day, year)

Before me, the undersigned, a Notary Public for \_\_\_\_\_ County, State of \_\_\_\_\_

\_\_\_\_\_, personally appeared and acknowledged in the foregoing  
(Name of applicant)

statements as true and correct to the best of his / her knowledge and belief this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

\_\_\_\_\_, Notary Public.  
(Signature of Notary Public)

County of Residence: \_\_\_\_\_ My Commission Expires: \_\_\_\_\_  
(month, day, year)