



**APPLICATION FOR LICENSURE AS A
CLINICAL ADDICTION COUNSELOR (LCAC),
AN ADDICTION COUNSELOR (LAC), OR
ASSOCIATE (LACA OR LCACA)**

State Form 54089 (R9 / 9-21)

Approved by State Board of Accounts, 2017

**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
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. Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.
 4. All fees are non-refundable and non-transferable.
 5. Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.

FOR OFFICE USE ONLY	
Application Fee	Permit fee
Date fee paid (month, day, year)	Date fee paid (month, day, year)
Receipt number	Receipt number
License number issued	Permit number issued
License issuance date (month, day, year)	Permit issuance date (month, day, year)

* 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.
 ** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

BASIS FOR LICENSURE	
License Type (check only one): <input type="checkbox"/> Licensed Clinical Addiction Counselor (LCAC) <input type="checkbox"/> Licensed Addiction Counselor (LAC) <input type="checkbox"/> Licensed Clinical Addiction Counselor Associate (LCACA) <input type="checkbox"/> Licensed Addiction Counselor Associate (LACA)	Obtained by Method: Associate applicants must apply by examination. <input type="checkbox"/> Examination <input type="checkbox"/> Reciprocity
Do you wish to apply for a Temporary Permit? Only Examination applicants are eligible to request the temporary permit. One permit allowed per applicant. <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you have passed an addiction counselor examination, provide the following information for the most recent examination passed: Date (month, day, year): _____ State: _____ Level of the Examination (select one): <input type="checkbox"/> IC & RC <input type="checkbox"/> NAADAC <input type="checkbox"/> Other (Specify): _____	

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION			
Name of applicant (last, first, middle)		Social Security number*	
Date of birth (month, day, year)	Gender** <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone number (daytime) ()	E-mail address
Address of applicant (number and street or rural route)		City, state, and ZIP code	
Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: (Please select one of the following.) <input type="checkbox"/> I am a United States Citizen. <input type="checkbox"/> I am a qualified alien (as defined under 8 U.S.C. § 1641). <input type="checkbox"/> I am authorized by the federal government to work in the United States.			
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	

EDUCATION: MASTER'S OR DOCTORAL (LCAC OR LCACA), BACHELOR'S OR HIGHER (LAC, LACA)

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
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Location (city and state)	Dates attended (mm/yy - mm/yy)	Degree earned

STATES LICENSED

List all states and territories, **including Indiana**, in which you have been licensed to practice any regulated health occupation. Verification of all listed licenses must be submitted directly to the board from the state/territory that issued each license. *Licenses issued by the Indiana Professional Licensing Agency will not need verifications.*

Type of License / Certificate / Registration / Permit	State	Number	Date Issued (month, day, year)	Status

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, 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.

- Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? Yes No
- Have you ever been denied license, certificate, registration or permit to practice any regulated health occupation in any state (including Indiana), country or U.S. Territory? Yes No
- 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
- Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,
 - have you ever been arrested; Yes No
 - have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; Yes No
 - have you ever been convicted of any offense, misdemeanor, or felony in any state; Yes No
 - have you ever pled guilty to any offense, misdemeanor, or felony in any state; or Yes No
 - have you ever pled *nolo contendere* to any offense, misdemeanor, or felony in any state? Yes No
- 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
- 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

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 any files, documents, records or other information pertaining to the undersigned requested by the Agency or any of its 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 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 affirm, under penalties for perjury, that the foregoing representations are true.

Signature of applicant	Date (month, day, year)
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