Reset Form

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

State Form 54089 (R11 / 3-25)
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)*

DO NOT WRITE ABOVE THIS LINE

BASIS FOR LICENSURE

License Type (check only one):
☐ Licensed Clinical Addition Counselor (LCAC)
☐ Licensed Addiction Counselor (LAC)
☐ Licensed Clinical Addiction Counselor Associate (LCACA)
☐ Licensed Addiction Counselor Associate (LACA)

Obtained by Method: *Associate applicants must apply by examination.*
☐ Examination ☐ Reciprocity

Do you wish to apply for a temporary permit?*
**One permit allowed per applicant. Temporary permit applicants are required to meet and are subject to the requirements provided under:*
(1) IC 25-23.6-10.5-1.5, for addiction counselor associate (LACA) and clinical addiction counselor associate (LCACA) license applicants.
(2) IC 25-23.6-10.5-10 and 839 IAC 1-5.5-6, for addiction counselor (LAC) and clinical addiction counselor (LCAC) license applicants.

☐ Yes ☐No

APPLICANT INFORMATION

* 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.

Name of applicant (*last, first, middle*)			Social Security number*
Date of birth (*month, day, year*)	Gender** ☐Male ☐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.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 1641). ☐ 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)* ☐ Yes ☐No	Are you an active-duty member of the military? *(Optional)* ☐ Yes ☐No

ORGAN & TISSUE DONOR

In 2022, the Indiana State Legislature passed a law (SEA 260) allowing Indiana residents to sign up as organ donors when seeking or renewing professional licenses via the Indiana Professional Licensing Agency. More than 100,000 people are awaiting a lifesaving transplant, and more than 1,000 of those waiting are Hoosiers, so your decision to say "yes" can truly help save lives.

By selecting "yes", I affirm that I wish to be an organ donor upon my death. I would like to donate all organs for transplant, research, and education. At the time of my death, I understand that my family cannot override my decision. I understand this online sign-up is binding and is a legal document of gift. I do solemnly swear, affirm or certify that I am the applicant described in this application and that the information entered herein is true and correct.

Do you want to sign up to be an organ and tissue donor? ☐ Yes ☐ Not Today

EXAMINATION INFORMATION

ELIGIBILITY FOR EXAMINATION PRIOR TO GRADUATION
[ADDICTION COUNSELOR ASSOCIATE (LACA) AND CLINICAL ADDICTION COUNSELOR ASSOCIATE (LCACA) APPLICANTS ONLY]

Pursuant to IC 25-23.6-10.5-9, addiction counselor associate (LACA) and clinical addiction counselor associate (LCACA) applicants who are:

(1) Enrolled in the last "term" of the last year of their program leading to their degree that meets the requirements of IC 25-23.6-10.5-1.5 (for LACAs) or IC 25-23.6-10.5-2.5 (for LCACAs); and

(2) provide a "Letter of Good Standing" from the director of the addiction counselor department or the director's designee;

may take the examinations provided by the Behavioral Health and Human Services Board (the "ADC" or the "NCAC – Level II" Examinations for LACAs, or the "AADC" or "MAC" Examinations for LCACAs) prior to graduation.

The "Letter of Good Standing" provided by the director or the director's design must include the follow information:

(1) The applicant's first and last name.
(2) The type of degree and program in which the applicant is enrolled.
(3) A statement confirming that the applicant is currently in the final term of the program.
(4) The anticipated date of completion of the program.
(5) A statement confirming that the applicant is in good academic standing.

LACA or LCACA applicants who meet these eligibility requirements and are interested in being approved to register and take one of the examinations referenced above during their last "term" prior graduation should indicate their interest by "checking" (✓) the box below and supply their "Letter of Good Standing" with this application.

☐ I affirm that I meet the eligibility requirements provided above, and I would like to be approved to register and take the Behavioral Health and Human Services Board's examination, towards my LACA or LCACA license. I affirm that I am including my "Letter of Good Standing" with this application.

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):* ☐ IC & RC ☐ NAADAC ☐ Other (Specify):

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
Name of academic institution		Department	Program title
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.

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 any regulated health occupation in any state (*including Indiana*), country or U.S. Territory?	Yes	No
3. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice in a competent, ethical, 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 contendre* 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 of 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

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*)