KENTUCKY BOARD OF ALCOHOL AND DRUG COUNSELORS

P.O. Box 1360, Frankfort, Kentucky 40602 ~ 500 Mero St., 2 SC 32, Frankfort, Kentucky 40601
Phone (502) 782-8814 ~ http://adc.ky.gov

APPLICATION FOR:

TEMPORARY REGISTRATION AS PEER SUPPORT SPECIALIST	**( )**
REGISTRATION AS PEER SUPPORT SPECIALIST	**( )**
CERTIFIED ALCOHOL AND DRUG COUNSELOR ASSOCIATE I	**( )**
CERTIFIED ALCOHOL AND DRUG COUNSELOR ASSOCIATE II	**( )**
TEMPORARY CERTIFICATION AS AN ALCOHOL AND DRUG COUNSELOR	**( )**
CERTIFICATION AS AN ALCOHOL AND DRUG COUNSELOR	**( )**
LICENSED CLINICAL ALCOHOL AND DRUG COUNSELOR ASSOCIATE	**( )**
LICENSED CLINICAL ALCOHOL AND DRUG COUNSELOR	**( )**
LICENSED ALCOHOL AND DRUG COUNSELOR	**( )**

SECTION 1 – APPLICANT INFORMATION

1. _____
Name: First Middle Last Maiden

_____-_____-_____
Social Security Number Date of Birth Home Phone Cell Phone

_____
Mailing Address: Street City State Zip Code

_____
Employer Business Phone

_____
Employer's Address: Street City State Zip Code

_____
Home Email Business Email

2. Have you had a credential in Kentucky or any other state that has ever been suspended or revoked?
☐ YES ☐ NO If yes, give details:

_____

3. Have you been convicted of a felony or plead guilty, including an Alford plea (other than minor traffic violations) under the laws of the United States in the last 5 years? ☐ YES ☐ NO If yes, what offense? _____(If yes, send supporting documentation.)

4. Are you credentialed as an Alcohol or Drug Counselor in any other state? ☐ YES ☐ NO
If yes, what state?_____Type of Credential? _____

5. Have you ever been discharged or forced to resign for misconduct or unsatisfactory service from any position from any professional training program, or from the program of any university? ☐ YES ☐ NO
(If yes, send supporting documentation.)

6. Have you ever been sanctioned by the Kentucky Board of Alcohol and Drug Counselors or by any other credentialing board or professional associations for ethical misconduct? ☐ YES ☐ NO
(If yes, send supporting documentation.)

7. Are you currently on active military duty? ☐ YES ☐ NO
8. Are you or your spouse a member of the United States military, Reserves, or National Guard, or are you or your spouse a veteran? ☐ YES ☐ NO

If yes, do you currently hold or recently held an equivalent credential issued by another state, the District of Columbia, or any possession or territory of the United States? ☐ YES ☐ NO

If yes, please answer the following questions:
Has your credential issued by another state, the District of Columbia, or any possession or territory of the United States been expired for more than two years? ☐ YES ☐ NO
Is your credential issued by another state, the District of Columbia, or any possession or territory of the United States in good standing? ☐ YES ☐ NO
Has your credential issued by another state, the District of Columbia, or any possession or territory of the United States been suspended for disciplinary reasons? ☐ YES ☐ NO

The United States military service member, Reserves or National Guard member, veteran, or spouse shall submit:

(1) Proof of issuance of a valid license, permit, certificate, or other document issued by another state, the District of Columbia, or any possession or territory of the United States that is active or has been expired for less than two (2) years;
(2) Proof that the valid license, permit, certificate, or other document issued by another state, the District of Columbia, or any possession or territory of the United States is in good standing or was upon the date of expiration; and
(3) His or her DD-214 form or other proof of active or prior military service with an honorable discharge, discharge under honorable conditions, or a general discharge under honorable conditions.

SECTION 2 – APPLICANT EDUCATION

School	Name and Location	Dates Attended	Date of Graduation	Number of Hours	Degree Obtained
High School/Equivalent					
Baccalaureate					
Master's					
Doctoral					

Submit proof of your highest education achieved:

- High school / equivalent - submit a copy of your diploma or certificate.
- Other higher education - submit official transcript sent from registrar of the college or university.

SECTION 3 – WORK EXPERIENCE (Attach Additional Related Experience If Needed)

Name of Employer: _____

Title or Position: _____

Employment Start Date: _____ End Date: _____

Address of Employer: _____

Clinical Supervisor: _____ Credential Number: _____

Total Number of Work Hours per Week Related to Alcohol and Drug Clients: _____

Describe Work Duties Related to Alcohol and Drug Clients: _____

_____

Name of Employer: _____

Title or Position: _____

Employment Start Date: _____ End Date: _____

Address of Employer: _____

Clinical Supervisor: _____ Credential Number: _____

Total Number of Work Hours per Week Related to Alcohol and Drug Clients: _____

Describe Work Duties Related to Alcohol and Drug Clients: _____

_____

AFFIDAVIT

I do hereby certify under penalty of law, that the information contained herein is true, correct and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose such misrepresentation or falsification, my application could be rejected or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

_____ _____

Applicant's Signature (Do not type or print) Date

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SUPERVISORY AGREEMENT

To Be Completed By Applicant and Supervisor (Please Check One)

_____ Certified Associate **_____Temporary Certification** **_____Licensed Associate**

INSTRUCTIONS

1. Forms submitted without the appropriate signatures will be returned.
2. The completed form may be submitted to the Kentucky Board of Alcohol and Drug Counselors either by mail to P.O. Box 1360, Frankfort, Kentucky 40602 or by delivery to 500 Mero St., 2 SC 32, Frankfort, Kentucky 40601.

SECTION 1
APPLICANT INFORMATION

First Name | Middle Name | Last Name

/ / | Social Security Number

( ) - | Home Telephone

( ) - | Work Telephone

Email Address

Street Address

City | State | Zip Code

SECTION 2
SUPERVISOR INFORMATION

First Name | Middle Name | Last Name

Email Address

Street Address

City | State | Zip Code

( ) - | Telephone Number

Type of License/Certification Held and Number

/ / | Date of issue (Attach a copy)

/ / | Expiration Date (Attach a copy)

Date of Board Approved Supervision Training (Attach copy of certificate of attendance)	Number of Supervisee's Currently Providing with Board Approved Supervision

SECTION 3
INFORMATION RELATED TO SUPERVISED EXPERIENCE

Applicant Name _____

Name of organization or agency where experience will be gained (complete a separate form for each setting.)

_____

_____

Street Address of Organization or Agency

_____

City State Zip Code

Average number of hours expected to be gained per week: _____

Type of Setting:

- ☐ State/Government Agency
- ☐ Non-Profit
- ☐ School
- ☐ Hospital
- ☐ DUI/Private Practice
- ☐ Rehab Center

Type of peer support/counseling experience to be gained (check all that apply):

- ☐ Rehabilitation Center
- ☐ Child & Adolescent
- ☐ Adult
- ☐ Family Treatment
- ☐ Other
- ☐ Judicial/Corrections
- ☐ Individual Counseling
- ☐ Group Counseling

_____

Describe

Describe specifically, and in detail, what work experience will be obtained to meet the criteria in the following four (4) domains: (a) Screening assessment and engagement; (b) Treatment planning, collaboration, and referral; (c) Counseling; and (d) Professional and ethical responsibilities. (201 KAR 35:070)

_____
_____
_____
_____
_____
_____
_____
_____

Describe specifically, and in detail, how supervision will focus on: (a) Screening assessment and engagement; (b) Treatment planning, collaboration, and referral; (c) Counseling; and (d) Professional and ethical responsibilities.(201KAR 35:070)

_____
_____
_____
_____
_____
_____
_____

Applicant Name _____

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VERIFICATION OF CLASSROOM TRAINING

_____**LCADCA** _____**LCADC**

In accordance with 201 KAR 35:050, Section 1 (5), an applicant seeking licensure as a licensed clinical alcohol and drug counselor or licensed clinical alcohol and drug counselor associate shall complete 180 classroom hours which are specifically related to the knowledge and skills necessary to perform the following alcohol and drug counselor domains:

1. Screening assessment and engagement;
2. Treatment planning, collaboration, and referral;
3. Counseling; and
4. Professional and ethical responsibilities

I certify, under the penalty of perjury, that I have had training or education in each of these four domains related to the practice of alcohol and drug counseling.

Signature:_____Date: _____

ETHICS TRAINING (6) – A minimum of 6 hours shall be interactive, face-to-face ethics training related to counseling. PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Applicant Name_____ **Total Number of Hours:** _____

Applicant Name _____

<u>HIV TRAINING (2)</u> – A minimum of two (2) hours of training in transmission, control, treatment and prevention of the human immunodeficiency virus. PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours: _____

<u>DOMESTIC VIOLENCE (3)</u> – A minimum of three (3) hours of training specific to domestic violence. PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours: _____

<u>ALCOHOL AND DRUG COMPETENCY TRAINING HOURS</u> All training hours shall specifically be related to the knowledge and skills necessary to perform the four alcohol and drug counseling domains: 1. Screening assessment and engagement; 2. Treatment planning, collaboration, and referral; 3. Counseling; 4. Professional and ethical responsibilities.

PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours: _____

Applicant Name_____

<u>ALCOHOL AND DRUG COMPETENCY TRAINING HOURS</u> (Make as many copies of this page as needed. Number each page.)
PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours on This Page: _____

Applicant Name_____

<u>ALCOHOL AND DRUG COMPETENCY TRAINING HOURS</u> (Make as many copies of this page as needed. Number each page.)
PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours on This Page: _____

I, as applicant, affirm that all information provided by me on this form is true and accurate and I affirm the following:

- That I have read the board Law and Regulations related to supervised experience and that all supervised experience will be completed in accordance with board rules;
- That I will meet with my supervisor at a minimum of 2 hours two (2) times a month of documentedsupervised experience;
- That I will abide by all rules of the board, including ethics requirements;
- That I understand the alcohol and drug counselor associate I certification/alcohol and drug counselor associate II certification/temporary certification/clinical alcohol and drug counselorassociate license is only valid while I practice under supervision;
- That I notify the board if this supervisory arrangement is terminated; and
- That I understand any additional supervisors and settings shall be approved by the board in advance.

Signature of Applicant

Date

Printed Name

This agreement shall not be effective until the board has issued the letter approving the agreement.

I, as the board-approved supervisor of the above-named applicant, affirm that all information provided by me on this form is true and accurate and I affirm the following:

- That all supervised experience will be completed in accordance with the Law and Regulations related to supervised experience and all subsequent board rules.
- That I will provide supervision to the above name applicant at least 2 hours two times a month of documented experience.
- That I understand the full professional responsibility for services of the supervisee shall rest with the supervisor.
- That I understand the supervisory arrangement is only valid while my credential remains in good standing.
- That I will notify the board if the supervisory arrangement is terminated.
- That I understand that I shall not serve as a supervisor of record for more than twelve persons obtaining experience for peer support/certification/licensure at the same time.

Signature of Supervisor

Date