



State of Maine

BOARD OF ALCOHOL AND DRUG COUNSELORS

**Applicant information to assist
in completing your application**

Application for Licensure by Endorsement
Certified Alcohol and Drug Counselor
Licensed Alcohol and Drug Counselor
Certified Clinical Supervisor

**Do not return the following informational pages with your
application; it is for your information only**

Department of Professional and Financial Regulation
Office of Licensing and Registration
(Mailing address) 35 State House Station, Augusta, ME 04333
(Office location) Gardiner Annex, 76 Northern Avenue, Gardiner, Maine 04345

Office Direct Line (207) 624-8689 or Main Receptionist (207) 624-8603
TTY/Hearing Impaired 1-888-577-6690
FAX (207) 624-8637

Web address: www.maine.gov/professionallicensing
Email: alcoholdrug.lic@maine.gov

APPLICATION INSTRUCTIONS

LICENSURE BY ENDORSEMENT

Information checklist for documents to be submitted to the Board in one package at time of application. (This is an abbreviated checklist and does not replace the requirements outlined in the Alcohol and Drug Counseling Laws and Rules. Please review them carefully for more detailed and clarifying information.)

Fax submissions of applications and supporting documentation will not be accepted.

- **Completed Application**
Complete and sign the application (being sure the Board-Certified Clinical Supervisor portion has been completed and signed by your Board-Certified Clinical Supervisor.) and submit with the appropriate fees and documentation.
- **Proof of age**
A copy of your official birth certificate or other official legal document is acceptable.
- **Proof of Clinically Supervised Work Experience**
Submit completed verification of clinically supervised work experience form.
CADC - see 32 MRS §6214-C
LADC - see 32 MRS §6214-D
CCS - see Board Rules, Chapter 6
- **Proof of Education**
Submit documentation highest education obtained.
- **Examination Results**
Submit proof of passing the required applicable IC&RC written examinations:
CADC - AODA Examination
LADC - AODA & Advanced AODA Examinations **or** AODA, CPM and Oral Examinations
CCS - CCS Examination
- **Motor Vehicle Report**
Submit a 10-year non certified motor vehicle report of your driving record from the Bureau of Motor Vehicles (or appropriate agency if you are from another state). This report must be containing your name and must be current. You can obtain a report from the Bureau of Motor Vehicles at <http://www.informe.org/bmv/drc/index.html> or please call 624-9000.
- **Self query results for the HIPDB and the NPDB**
In accordance with 10 MRS §8003, sub-§10, the Office of Licensing and Registration now requires all applicants to submit a NPDB/HIPDB* Self-Query Report as part of the initial application for licensure within each of the following allied health licensure programs effective 11/1/2007. The instructions to request a self-query report are available at NPDB/HIPDB's website: www.npdb-hipdb.hrsa.gov
- **Any other supporting documentation such as: verification of licensure or criminal conviction information.**
Submit verification from every state in which you currently hold or have ever held any type of professional license (except Maine).

Court judgment and decision of any criminal conviction and a written statement regarding the crime.

CONTINUING EDUCATION

As a licensee you will be required to satisfy the Continuing Education requirements identified in Chapter 7 of the Board's rules. Please be sure to review this chapter carefully.

INITIAL EACH PAGE OF YOUR APPLICATION WHERE NOTED. Be sure to initial the bottom of each page where noted on your application. This is critical to insuring that each page of your application is intact with the correlating application and will help us with expediting your application review.

The Board of Alcohol and Drug Counselors requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted.** Documents that have been modified or altered in any way will not be accepted.

NOTE: This is an abbreviated checklist and does not replace the requirements outlined in the Board of Alcohol and Drug Counseling Laws and Rules. Please review them carefully for more detailed and clarifying information.

NOTE:

If you are applying for various levels of licensure such as Alcohol and Drug Counseling Aide, Certified Alcohol and Drug Counselor (CADC), Licensed Alcohol and Drug Counselor (LADC), or Certified Clinical Supervisor (CCS). You must submit all required documentation for each license category you are currently applying for at the time you submit your application. If you believe a document was filed with a prior application and is on file attach a letter describing the document. If the document in question is on file we would be happy to retrieve it. **However, be aware it will take longer to process your application. Submitting a complete application will optimize our ability to process your application quickly.**

- ✓ Please allow approximately three (3) weeks processing time from date of receipt.
- ✓ Please do not call our office regarding the status of your application as numerous calls will delay the timeliness of processing applications. Information regarding the status of applications may be found at the Office of Licensing and Registration's website www.maine.gov/professionallicensing. We appreciate your thoughtful attention to this request.
- ✓ Once your license is issued it is immediately visible online with an "active" status. Licenses are printed off site and require at least 14 days for delivery.

VERIFICATION OF LICENSURE IN ANOTHER STATE OR JURISDICTION

If you hold or have held an alcohol and drug counselor license in another state or jurisdiction, you must submit evidence from the State of licensure in the form of a License Verification.

Please contact the state of licensure to request an official License Verification. At a minimum, the license verification must contain:

- Name of State providing the License Verification
- Your name
- License number and expiration date
- Status of your license i.e. active, inactive, lapsed, probation, restricted, suspended, revoked...
- Type of license issued to you
- Date your license was issued
- If appropriate, hours of internship completed with beginning and ending dates
- Method your license was issued i.e. Original State, Reciprocity/Endorsement, Score Transfer
- Examinations taken i.e. ICRC/AODA examinations, Jurisprudence, other
- Disciplinary action(s) against your license, if any
- Signature and title of person from the licensing jurisdiction providing License Verification
- State Seal

Please direct the licensing jurisdiction to send the License Verification report to you directly and in turn you must submit this verification with your completed Maine application.

Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035
- **Where are you located?** 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** 8:00 AM to 5:00 PM weekdays
- **Can I come to Gardiner to drop off my application?** Yes. You will not leave with a license, though.
- **Can I come to Gardiner to pick up my license?** No. Your license will be mailed to you.
- **How long does it take to process an application?** You can check our website: www.maine.gov/professionallicensing. Your license will show up as PENDING at first; as soon as your status is ACTIVE you are authorized to practice.
- **How far back do I go answering the criminal question?** Any conviction, ever.

NOTICES

BACKGROUND CHECK: Pursuant to 5 MRS §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration requires a criminal history records check as part of the application process for all applicants.

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRS §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

SOCIAL SECURITY NUMBER: The following statement is made pursuant to the Privacy Act of 1974 (§7(B)). Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 35 MRS §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(C)(2)(C)(1)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

Before you seal the envelope, did you:

- Complete every item on the application (incomplete applications may be returned)
- Answer the criminal background disclosure questions
- Sign and date your application
- Include correct amount (payable to Maine State Treasurer) or credit card information (plus signature)
- Include any required transcripts or exam results
- Make a copy of your application to keep for your records
- DO NOT SEND CASH.

SECTION 1: EDUCATION

Please check one:		
<input type="checkbox"/> High School Diploma or GED	<input type="checkbox"/> MHRT/C	
<input type="checkbox"/> Associate's Degree	<input type="checkbox"/> Substance Abuse Rehabilitation Certificate	
<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Master's Degree	<input type="checkbox"/> Other describe: _____
Name of Educational Provider		Date of Graduation
Contact Address: _____ Street or P.O. Box _____		
City	State	Zip Code
Official transcript demonstrating your education must be submitted with your application		

SECTION 2: LIST BELOW EVERY JURISDICTION IN WHICH YOU HOLD OR HAVE EVER HELD A PROFESSIONAL LICENSE. LICENSE VERIFICATION REQUIRED IF YOU HAVE EVEN HAD A ALCOHOL AND DRUG LICENSE IN ANOTHER JURISDICTION.

1. State, Territory, Country	License Number/Type	Date Issued	Expiration Date
2. State, Territory, Country	License Number/Type	Date Issued	Expiration Date
3. State, Territory, Country	License Number/Type	Date Issued	Expiration Date
4. State, Territory, Country	License Number/Type	Date Issued	Expiration Date

For each of the above, you must submit with this application an official Verification of Licensure from the licensing jurisdiction. **IMPORTANT:** Applications submitted without all of the Verification of Licensure from the licensing jurisdiction(s) will not be accepted and your application returned as incomplete.

INITIALS OF APPLICANT

SECTION 3: EXAMINATION

<p>Have you ever take a ICRC/AODA examinations?</p> <p>If yes, list the jurisdiction(s) where you took the examination, type of examination, date of examination and score:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr style="background-color: #cccccc;"> <th style="width: 25%;">Jurisdiction</th> <th style="width: 25%;">Examination Type</th> <th style="width: 25%;">Date</th> <th style="width: 25%;">Score</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Jurisdiction	Examination Type	Date	Score													<input type="checkbox"/> Yes <input type="checkbox"/> No
Jurisdiction	Examination Type	Date	Score														

SECTION 4: FOR CERTIFIED CLINICAL SUPERVISOR’S ONLY: QUALIFYING LICENSE INFORMATION

List your qualifying license i.e. LCPC, LADC, LCSW etc. See 32 MRS §6212(12) and Board Rules Chapter 6.

License Type	License Number	Expiration Date

CONTINUING EDUCATION

Submit certificate of attendance of 30 hours of didactic training in clinical supervision.

SECTION 5: CHECK APPROPRIATE RESPONSE TO THE QUESTIONS BELOW. ANY YES RESPONSE MUST BE FULLY EXPLAINED BY WRITTEN STATEMENT ON A SEPARATE SHEET OF PAPER, SIGNED AND DATED, AND SUBMITTED WITH YOUR APPLICATION.

<p>Had hospital or similar health care institution privileges ever been denied or which had previously been granted to you suspended, restricted or withdrawn involuntarily; or have you ever voluntarily surrendered privileges or resigned from staff membership while under peer review?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Have you ever received a sanction from Medicare or from a state Medicaid program?</p> <p>1. <input type="checkbox"/> Medicare <u>OR</u> <input type="checkbox"/> Medicaid Program (State) _____</p> <p>2. Submit a copy of the official action by the entity.</p> <p>3. Provide a detailed explanation in your own words on a separate sheet of paper.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

INITIALS OF APPLICANT

SECTION 6: NOTICES

Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRS §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State's website.

10 Day Notification Requirement

This applicant/licensee must report in writing to the Board the following information no later than 10 days after the change or event, as the case may be:

- a. Change of name or address of the licensee;
- b. A criminal conviction of the licensee or anyone listed on this application as having an ownership interest in the licensee;
- c. A revocation, suspension, or other disciplinary action taken in this or any other jurisdiction against any occupational or professional license held by the applicant/licensee or anyone listed on this application as having an ownership interest in the licensee; or
- d. Any material change in the conditions or qualifications set forth in the original application for licensure submitted to the Board.

Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRS section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

Healthcare Integrity and Protection Data Bank ("HIPDB") Self-Query Reports

In accordance with 10 MRS §8003(10), all applicants must submit a HIPDB Self-Query Report as part of the initial application for licensure. The instructions to request a self-query report are available at HIPDB's website: www.npdb-hipdb.hrsa.gov The website includes a Fact Sheet on self-querying, as well as FAQs to assist you in requesting a report. Customer Service Contact information: **NPDB-HIPDB Customer Service Center Tel: (800)767-6732 - TDD: (703)802-9395**

INITIALS OF APPLICANT

SECTION 7: APPLICANT’S CERTIFICATION AND SIGNATURE

Read the statement below and sign where indicated as your certification of the information provided on this application.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application I understand that the Maine Board of Alcohol and Drug Counselors will rely upon this information for issuance of my license and that this information is truthful and factual. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

By signing this application, I acknowledge that I have read, understand and agree to uphold the Alcohol and Drug Counselor Code of Ethics as it appears in the Rules of the Board and that I have been notified that my name may be reported to various disciplinary data banks if I am sanctioned by the Maine State Board of Alcohol and Drug Counselors for violating the Board’s Laws and/or Rules.

Printed Name of Applicant	Title
Signature of Applicant	Date

Applications that are incomplete, altered, defaced, or compromised will not be accepted and will be returned. This includes, but not limited to, unanswered questions, lack of appropriate signature, information is illegible, missing supporting documents, and/or missing or wrong fee.



STATE OF MAINE
 DEPARTMENT OF PROFESSIONAL
 AND FINANCIAL REGULATION
BOARD OF ALCOHOL AND DRUG COUNSELORS
 35 STATE HOUSE STATION
 AUGUSTA, MAINE 04333-0035
 TEL:(207)624-8603 – FAX:(207)624-8637

VERIFICATION OF CLINICALLY SUPERVISED EXPERIENCE

Certified Clinical Supervisor's only: Work Experience must be obtained under the Qualifying License listed in Section 4 of this application.

Name of Applicant:		
Address:		
City:	State:	Zip:
Applicant's Job Title:		Telephone #:

The following section is to be completed by employer or supervisor only

Name of Agency: _____

Clinically supervised work experience must be obtained while licensed. Please include valid

Date of employment/ Dates worked to obtain hours (Please be specific with dates).	License Type	License Number	Total number of hours of clinically supervised work experience.
From: _____ To: _____			
From: _____ To: _____			
From: _____ To: _____			

license type and number.

I, the employer or supervisor, of the above named applicant am certifying the information provided on this form is verifiable, factual and accurate.

Print Name: _____ **License #:** _____

Signature: _____ **Date:** _____

TO SUPERVISOR COMPLETING THIS FORM: Return this completed form directly to the