

# STATE OF MAINE BOARD OF ALCOHOL AND DRUG COUNSELORS

## Application for Licensure Certified Clinical Supervisor (CCS)



Department of Professional and Financial Regulation  
Office of Professional and Occupational Regulation  
(Mailing) 35 State House Station, Augusta, ME 04333  
(Physical Location) 76 Northern Ave. Gardiner, ME 04345

Office Telephone: (207) 624-8623  
Office Facsimile: (207) 624-8637  
TTY USERS CALL MAINE RELAY 711  
Internet: [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing)

## **APPLICATION INSTRUCTIONS**

### **LICENSURE**

**Helping Tool:** This is a checklist to help you identify the documents for submission with your 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.) You must submit a complete application and all required documents and information.

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

- **Completed Application**  
Complete and sign the application (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.  
CCS - see 32 MRS §6214 - E
- **Proof of Education**  
Submit documentation of the highest education you have obtained.
- **Any other supporting documentation such as: verification of licensure or disciplinary information.**
  - ◆ Submit verification from every state or jurisdiction in which you currently hold or have ever held any type of professional license (except Maine). Online or Electronic Verifications are acceptable.
  - ◆ A signed, detailed, written statement regarding any disciplinary action taken against any license or certificate that you hold or have held along with any documentation pertaining to the disciplinary action.

#### Processing Time

- ✓ Your application has greater chance of being processed expeditiously if it is complete and all supporting documents are attached. Action on this application is posted to the web in real time. Please visit our website if you wish to monitor progress. If the status appears as Pending, this means that your application was received by this office and it is pending or under review. Once reviewed and if everything about your application is complete and complies with requirements, the license will be issued and the status will show as ACTIVE. If incomplete, you will receive written correspondence by email.
- ✓ Please refrain from calling our office to “check” on your application as these calls only serve to slow our ability to review and process applications. Information regarding the status of applications may be found at the Office of Professional and Occupational Regulation’s website [www.maine.gov/professionallicensing](http://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 emailed to the address provided by you by 6AM the following day.

STATE OF MAINE DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION  
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION

**Mailing Address:** 35 State House Station, Augusta, Maine 04333 - **Courier/Delivery address:** 76 Northern Avenue, Gardiner, Maine 04345  
Phone: (207) 624-8603 Fax: (207) 624-8637 TTY users call Maine relay 711 web: [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing)

### 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?** Gardiner Annex, 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** Due to the Covid-19 pandemic, and until further notice, the Gardiner Annex that houses the Office of Professional and Occupational Regulation and other agencies is closed to the public. OPOR staff members work remotely from 8 am to 5 pm to review and process license applications. We advise you to mail paper applications to 35 State House Station, Augusta, ME 04333.
- **Can I come to Gardiner to drop off my application?** No, the Gardiner Annex is closed to the public until further notice due to the Covid-19 pandemic. Please mail your paper application to our mailing address—35 State House Station, Augusta, ME 04333.
- **Can I come to Gardiner to pick up my license?** No. Your license will be emailed to you.
- **How long does it take to process an application?** You can check our website: [www.maine.gov/professionallicensing](http://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.

**PLEASE ALSO SEE THE WEBSITE FOR THE OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION FOR ADDITIONAL QUESTIONS:** [https://www.maine.gov/pfr/professionallicensing/licensee\\_faq.html](https://www.maine.gov/pfr/professionallicensing/licensee_faq.html)

### 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 Professional and Occupational Regulation 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. Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 36 MRS §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(c)(2)(C)(i)). 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 discipline question
- 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.



**STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION  
INDIVIDUAL LICENSE APPLICATION**

APPLICANT INFORMATION (please print)			
FULL LEGAL NAME	<i>FIRST</i>	<i>MIDDLE INITIAL</i>	<i>LAST</i>
ANY OTHER NAMES EVER USED:			
DATE OF BIRTH	<i>mm / dd / yyyy</i>	SOCIAL SECURITY NUMBER	- -
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ( )	FAX # ( )	E-MAIL	

<b>State Board of Alcohol and Drug Counselors CCS Licensure</b>													
<input type="checkbox"/> <b>CCS</b> —CERTIFIED CLINICAL SUPERVISOR (CCS)  <b>Required Fees \$61.00 (Non-Refundable)</b> <b>(Includes license and criminal records check fees)</b>	<p style="text-align: right; font-size: small;">Office Use Only:</p> <table style="width: 100%;"><tr><td style="width: 50%;">SBI</td><td>2619 - \$21.00</td></tr><tr><td>CCS</td><td>1421 - \$40.00</td></tr></table> <table style="width: 100%;"><tr><td>Check #</td><td>_____</td></tr><tr><td>Amount:</td><td>_____</td></tr><tr><td>Cash #</td><td>_____</td></tr><tr><td>Lic. #</td><td>_____</td></tr></table>	SBI	2619 - \$21.00	CCS	1421 - \$40.00	Check #	_____	Amount:	_____	Cash #	_____	Lic. #	_____
SBI	2619 - \$21.00												
CCS	1421 - \$40.00												
Check #	_____												
Amount:	_____												
Cash #	_____												
Lic. #	_____												
Rev. 4/2023													

<b>PAYMENT OPTIONS:</b> Make checks payable to "Maine State Treasurer" – if you wish to pay by Mastercard, Visa, Discover or American Express fill out the following:			
NAME OF CARDHOLDER (please print)	<i>FIRST</i>	<i>MIDDLE INITIAL</i>	<i>LAST</i>
MAILING ADDRESS OF CARDHOLDER (please print)			
I authorize the Department of Professional and Financial Regulation, Office of Professional & Occupational Regulation to charge my <input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD <input type="checkbox"/> DISCOVER <input type="checkbox"/> AMERICAN EXPRESS the following amount: \$_____			
<input type="checkbox"/> <b>I understand that fees are non-refundable</b>			
Card number:	<i>XXXX-XXXX-XXXX-XXXX</i>	Expiration Date	<i>mm / yyyy</i>
<b>SIGNATURE</b>		<b>DATE</b>	

**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
A copy of your Official transcript demonstrating your education must be submitted with your application		

**SECTION 2: LIST BELOW EVERY STATE OR JURISDICTION IN WHICH YOU HOLD OR HAVE EVER HELD A PROFESSIONAL LICENSE.**

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

**Has any state or jurisdiction taken disciplinary action against any professional license you hold or have held, or denied your application for licensure? (circle one)**

**NO YES**

If yes, enclose a signed detailed explanation and copies of all documents.

**SECTION 3: EXAMINATION**

Have you ever taken an ICRC examination?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list the jurisdiction(s) where you took the examination, type of examination, date of examination and score:				
Location Site City, State	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 Number	Expiration Date

**CONTINUING EDUCATION**

Submit certificate of attendance of 24 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.**

Have you had hospital or similar health care institution privileges denied or suspended, restricted or withdrawn involuntarily; or have you ever voluntarily surrendered privileges or resigned from staff membership while under peer review?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever received a sanction from Medicare or from a state Medicaid program?  1. <input type="checkbox"/> Medicare <u>OR</u> <input type="checkbox"/> Medicaid Program (State) _____ 2. Submit a copy of the official action by the entity. 3. Provide a detailed explanation in your own words on a separate sheet of paper.  Clarification on programs: <ul style="list-style-type: none"> <li>• Medicare – Health program administered by the United States government for people that are (1) ages 65 or older, (2) under the age of 65 with certain disabilities, and/or (3) all ages with end-stage renal disease.</li> <li>• Medicaid – Health program administered by the United States government for people with limited incomes.</li> <li>• MaineCare – Health program administered by the State of Maine with similar eligibility requirements as Medicaid.</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 6: NOTICES**

**Please Note:**

Pursuant to 10 MRS §8003-G - any change in name, address, email address, criminal convictions, disciplinary actions, or any material change set forth in your original application for licensure must be reported to the Office within 10 days.

You can access this Law for your review at:

<http://www.mainelegislature.org/legis/statutes/10/title10ch901sec0.html>

## **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. Applications that are incomplete, altered (including use of any white out), defaced, or compromised will not be accepted and will be cancelled. This includes, but is not limited to, unanswered questions, lack of appropriate signature, illegible information, missing required supporting documents, and/or missing or wrong fee.

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 & 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.

### **Alcohol & Drug Counseling Board:**

**Statute Reference:** 32 MRSA Chapter 81 – Alcohol & Drug Counseling Board Link: <http://www.mainelegislature.org/legis/statutes/32/title32ch81sec0.html>

**Rules Reference:** Alcohol & Drug Counseling Board (02 384) Chapters 1-9  
<http://www.maine.gov/sos/cec/rules/02/chaps02.htm#384>

**Title 5 Administrative Procedures and Services Chapter 341**  
<http://www.mainelegislature.org/legis/statutes/5/title5ch341sec0.html>

**Title 10 Department of Business Regulation Law §§8001-8011**  
<http://legislature.maine.gov/statutes/10/title10ch901sec0.html>

**Office of Professional and Occupational Regulation Rules 02 041**  
<http://www.maine.gov/sos/cec/rules/02/chaps02.htm#041>

Chapter 10, Establishment of License Fees

Chapter 11, Late Renewals

Chapter 13, Uniform Rule for the Substantiation of Continuing Education Requirements

By my signature below, I Attest that I have read all of the above listed laws and rules and will keep current by periodically revisiting them for any changes and updates.

I agree to abide by the Maine Board of Alcohol & Drug Counselors Statutes, and Board Rules, as well as the Department of Professional and Financial Regulation's Laws and Rules, and the Office of Professional and Occupational Regulation's Laws and Rules. Above is a list of the relevant laws and rules and information to obtain these documents. This office cannot provide you with hardcopy documents, please visit the website(s) listed to obtain electronically available documents. These documents may be subject to change without notice and it is strongly advised that you periodically revisit these sites for any updates.

Printed Name of Applicant	Title
Signature of Applicant	Date



STATE OF MAINE  
 DEPARTMENT OF PROFESSIONAL  
 AND FINANCIAL REGULATION  
**STATE BOARD OF ALCOHOL AND DRUG COUNSELORS**  
 35 STATE HOUSE STATION  
 AUGUSTA, MAINE 04333-0035  
 TEL: (207)624-8623 – FAX: (207)624-8637

**VERIFICATION OF CLINICALLY SUPERVISED EXPERIENCE**

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: \_\_\_\_\_

Address: \_\_\_\_\_

**Clinically supervised work experience must be obtained while licensed. Please include the applicant's valid license type and number.**

Date of employment/ Dates worked to obtain hours (mm/yyyy)	Applicant's License Type	Applicant's License Number	Work area of practice that was Supervised in the practice of Alcohol and Drug Counseling (Check all that apply)	Number of Hours of Clinically Supervised Work Experience in the practice of Alcohol and Drug Counseling
From: _____ To: _____			<input type="checkbox"/> Screening <input type="checkbox"/> Intake <input type="checkbox"/> Orientation <input type="checkbox"/> Assessment <input type="checkbox"/> Client education <input type="checkbox"/> Referral <input type="checkbox"/> Case management <input type="checkbox"/> Crisis intervention <input type="checkbox"/> Reports and record keeping <input type="checkbox"/> Treatment planning <input type="checkbox"/> Individual, group & family counseling <input type="checkbox"/> Consultation with other Professionals	
From: _____ To: _____			<input type="checkbox"/> Screening <input type="checkbox"/> Intake <input type="checkbox"/> Orientation <input type="checkbox"/> Assessment <input type="checkbox"/> Client education <input type="checkbox"/> Referral <input type="checkbox"/> Case management <input type="checkbox"/> Crisis intervention <input type="checkbox"/> Reports and record keeping <input type="checkbox"/> Treatment planning <input type="checkbox"/> Individual, group & family counseling <input type="checkbox"/> Consultation with other Professionals	



**VERIFICATION OF CLINICALLY SUPERVISED EXPERIENCE  
(Continued)**

Date of employment/ Dates worked to obtain hours (mm/yyyy)	Applicant's License Type	Applicant's License Number	Type of Work Experience that was Supervised in the practice of Alcohol and Drug Counseling (Check all that apply)	Number of Hours of Clinically Supervised Work Experience in the practice of Alcohol and Drug Counseling
From: _____ To: _____			<input type="checkbox"/> Screening <input type="checkbox"/> Intake <input type="checkbox"/> Orientation <input type="checkbox"/> Assessment <input type="checkbox"/> Client education <input type="checkbox"/> Referral <input type="checkbox"/> Case management <input type="checkbox"/> Crisis intervention <input type="checkbox"/> Reports and record keeping <input type="checkbox"/> Treatment planning <input type="checkbox"/> Individual, group & family counseling <input type="checkbox"/> Consultation with other Professionals	
From: _____ To: _____			<input type="checkbox"/> Screening <input type="checkbox"/> Intake <input type="checkbox"/> Orientation <input type="checkbox"/> Assessment <input type="checkbox"/> Client education <input type="checkbox"/> Referral <input type="checkbox"/> Case management <input type="checkbox"/> Crisis intervention <input type="checkbox"/> Reports and record keeping <input type="checkbox"/> Treatment planning <input type="checkbox"/> Individual, group & family counseling <input type="checkbox"/> Consultation with other Professionals	
<b>TOTAL NUMBER OF HOURS OF CLINICALLY SUPERVISED ALCOHOL AND DRUG COUNSELING WORK EXPERIENCE:</b>				

Did you personally supervise the above named applicant during the timeframe indicated on this form?  Yes  No

If no, describe your relationship with the applicant and include name and license number of Certified Clinical Supervisor: \_\_\_\_\_

I, the \_\_\_\_\_ of the above named applicant, certify that the information (i.e. supervisor, human resources, etc) provided on this form is verifiable, factual and accurate.

Print Name: \_\_\_\_\_ License #: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TO SUPERVISOR COMPLETING THIS FORM: Return this completed form directly to the applicant; not the Board.**