



State of Maine

BOARD OF ALCOHOL AND DRUG COUNSELORS

Application and applicant information to assist
in completing your application

Application for Licensure Reinstatement
Certified Alcohol and Drug Counselor
Licensed Alcohol and Drug Counselor
Certified Clinical Supervisor

For licenses expired 91 days up to 2 years
from the date of expiration

Do not return the informational pages of this packet;
these are for your information.

Only submit the application you are filing

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

Note: The office location address may only be used for overnight deliveries. The office address does not accept postal deliveries. You must use the mailing address for all other regular mail deliveries.

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 REINSTATEMENT For Expired Licenses 91 days - 2 years

Helping Tool: This is a checklist to help you identify the documents required with submission of 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 (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 of the highest education you have obtained.
- **Proof of Continuing Education**
Submit documentation of completed continuing education. Refer to Board Rules Chapter 7 for specific requirements.
- **Examination Results**
Submit proof of passing the required applicable IC&RC written examinations:
CADC - ADC (AODA) Examination
LADC - ADC (AODA) & AADC (Advanced AODA) Examinations **or** ADC (AODA), CPM and Oral Examinations
CCS - CS (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 contain 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.
- **Any other supporting documentation such as: verification of licensure or criminal conviction information.**
Submit verification from every state or jurisdiction 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 signed, detailed, written statement regarding the crime.

INITIAL EACH PAGE OF YOUR APPLICATION WHERE NOTED. Be sure to initial the bottom of each page where noted on your application. All pages requiring initials must be returned to our office as part of your complete application.

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.** Applications that are incomplete, altered (including the use of any white out substance), 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.

NOTE:

If you are applying for various levels of licensure such as Alcohol and Drug Counseling Aide, (CADC), (LADC), or (CCS), you must submit all required documentation for each license category you are applying for at the time you submit your application. **Submitting a complete application will optimize our ability to process your application quickly.**

- ✓ 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 Professional and Occupational Regulation'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 a professional license in another state or jurisdiction, you must submit evidence from the state or jurisdiction of licensure in the form of a License Verification.

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

- Name of state or jurisdiction 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. IC&RC examinations, Jurisprudence, other
- Disciplinary action(s) against your license, if any
- Signature and title of person from the licensing state or jurisdiction providing License Verification
- State Seal

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

A sample license verification is available on the Board's website in the applications and forms section.

IMPORTANT: Applications submitted without all of the Verifications of Licensure from the licensing jurisdiction(s) will not be accepted and your application returned as incomplete.

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 Hearing Impaired: (888) 577-6690 web: 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?** 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 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 (§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.



**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	

CRIMINAL BACKGROUND DISCLOSURE

NOTE: Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.

1. **Have you ever been convicted by any court of any crime?**

(circle one)
NO
YES

If yes, enclose a detailed description of what happened (including dates) and a copy of the court judgment.
2. **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)**

(circle one)
NO
YES

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

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 affirm that the Office of Professional and Occupational Regulation will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.

SIGNATURE	DATE
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Board of Alcohol and Drug Counselors

Licensure Reinstatement

For licenses that have expired 91 days up to 2 years from the date of expiration.

LICENSE TYPE: (CHECK BOX)

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> CADC —CERTIFIED ALCOHOL AND DRUG COUNSELOR (CAC)
(INCLUDES APPLICATION, LICENSE, LATE FEE AND CRIMINAL RECORDS CHECK) | TOTAL REQUIRED FEES: \$161.00 |
| <input type="checkbox"/> LADC — LICENSED ALCOHOL AND DRUG COUNSELOR (LC)
(INCLUDES APPLICATION, LICENSE, LATE FEE AND CRIMINAL RECORDS CHECK) | TOTAL REQUIRED FEES: \$161.00 |
| <input type="checkbox"/> CCS —CERTIFIED CLINICAL SUPERVISOR (CCS)
(INCLUDES LICENSE, LATE FEE AND CRIMINAL RECORDS CHECK) | TOTAL REQUIRED FEES: \$121.00 |

Office Use Only:

CAC/LC	1446 - \$25.00
CAC/LC/CCS	2619 - \$21.00
CAC/LC/CCS	2090 - \$50.00
CAC	1421 - \$65.00
LC	1421 - \$65.00
CCS	1421 - \$50.00

Check # _____
Amount: _____
Cash # _____
Lic. # _____

PAYMENT OPTIONS:

Make checks payable to "Maine State Treasurer" - If you wish to pay by Mastercard or Visa, fill out the following:

NAME OF CARDHOLDER (please print)	<i>FIRST</i>	<i>MIDDLE INITIAL</i>	<i>LAST</i>
I authorize the Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation to charge my			
<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	the following amount: \$ _____	
Card number:	<i>XXXX-XXXX-XXXX-XXXX</i>	Expiration Date	<i>mm / yyyy</i>
SIGNATURE	DATE		

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 STATE OR 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 STATE OR 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 state or jurisdiction. **IMPORTANT:** Applications submitted without all of the Verification of Licensure from the licensing state(s) or jurisdiction(s) will not be accepted and your application will be returned as incomplete.

INITIALS OF APPLICANT

SECTION 3: EXAMINATION

Have you ever taken an ICRC examination? If yes, list the jurisdiction(s) where you took the examination, type of examination, date of examination and score:				<input type="checkbox"/> Yes <input type="checkbox"/> No																
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #e0e0e0;"> <th style="padding: 5px;">Location Site City, State</th> <th style="padding: 5px;">Examination Type</th> <th style="padding: 5px;">Date</th> <th style="padding: 5px;">Score</th> </tr> </thead> <tbody> <tr><td style="height: 20px;"> </td><td> </td><td> </td><td> </td></tr> <tr><td style="height: 20px;"> </td><td> </td><td> </td><td> </td></tr> <tr><td style="height: 20px;"> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Location Site City, State	Examination Type	Date		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 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.

Have you had hospital or similar health care institution privileges which have 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?	<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"> 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. Medicaid – Health program administered by the United States government for people with limited incomes. MaineCare – Health program administered by the State of Maine with similar eligibility requirements as Medicaid. 	<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.

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 (including the use of any white out substance), 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

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 valid license type and number.

Date of employment/ Dates worked to obtain hours (mm/yyyy)	License Type	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)	License Type	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	
TOTAL NUMBER OF HOURS OF CLINICALLY SUPERVISED ALCOHOL AND DRUG COUNSELING WORK EXPERIENCE:				

Did you personally supervise the above named applicant? Yes No
If no, describe your relationship with the applicant: _____

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.