State of Maine

BOARD OF ALCOHOL AND DRUG COUNSELORS

Application and applicant information to assist in completing your application

Application for Eligibility to *Qualify for the CS Examination* *for* *Certified Clinical Supervisor* *(CCS)*

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

FOR ELIGIBILITY TO QUALIFY FOR THE CS EXAMINATION FOR CERTIFIED CLINICAL SUPERVISOR

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 Clinically Supervised Work Experience**
  If currently licensed as a Psychologist, Registered Clinical Nurse Specialist, Clinical Professional Counselor, Clinical Social Worker, or any other licensed or certified mental health professional that is qualified to provide alcohol and drug services at an independent level:
  - ⇒ 1,000 hours

  If currently licensed as an LADC:
  - ⇒ 4,000 hours with high school education or GED; **or**
  - ⇒ 2,000 hours with Associate or Bachelor's degree; **or**
  - ⇒ 1,000 hours with Master's Degree

- **Proof of Education**
  Submit official documentation of highest education obtained, if applicable.

- **Continuing Education**
  Submit certificate of attendance of 30 hours of didactic training in clinical supervision.

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.

By submitting this application for eligibility to qualify for an exam if you are qualified to take an IC&RC examination the approval to take the exam does not qualify you for licensure with the Maine Board of Alcohol & Drug Counselors. You must submit a separate application for licensure once you have been notified of passing exam results. If you have any criminal convictions and prior discipline that information will be considered when an application for licensure is submitted, not with this application.

Exams are administered by the International Certification & Reciprocity Consortium (IC&RC) and are computerized. Information on registering to sit for examination and other relevant information will be provided to you by IC&RC once Maine has *qualified you to test*. Visit IC&RC's http://internationalcredentialing.org/ for assistance.

Step 1: *To QUALIFY*—This application is for the purpose of qualifying you to sit for the exam. The Board of Alcohol and Drug Counselors (Office) is the body that will qualify you.
Step 2: This Office will notify IC&RC of your qualifying eligibility.
Step 3: Once qualified, IC&RC will contact you directly using the email address you provided in your application. Submit, in writing or via email to alcoholdrug.lic@maine.gov, any email address change. IC&RC does not use any other method of contact.
Step 4: Included in the communication from IC&RC will be information on registering for a exam, payment for the examination, test location, and other relevant information.
Step 5: Once you have taken the examination, IC&RC will notify this Office of your score result. This office will notify you with the results and information to obtain an application online so you can apply for licensure if you pass the exam or re-apply to be re-qualified with IC&RC if you fail the exam. All applications must be filed with appropriate fees.

Testing dates for the CBT (Computer Based Testing) - Please note paper and pencil examinations are no longer administered by this Office. Please reference the *CBT testing dates and deadlines for submitting your application to qualify for examination*. Please visit http://internationalcredentialing.org/ or visit our website at http://www.maine.gov/pfr/professionallicensing/professions/alcohol/index.htm

Americans with Disabilities Act (ADA) Request for Reasonable Accommodation: If you require special accommodations for testing, you must complete the attached accommodation request forms and submit with your application at least 45 days prior to the examination deadline in order to qualify for the upcoming testing window. If your application is not received timely, you may be subject to a later testing window.

Study Guides: Visit the Publisher's website www.readytotest.com or call 866-471-1742.

NOTE: If you are applying for various levels of licensure such as Alcohol and Drug Counseling Aide, (CADC), (LADC), or a (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.

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 ensuring that each page of your application is intact with the correlating application and will help us with expediting your application review.

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	FIRST	MIDDLE INITIAL	LAST
ANY OTHER NAMES EVER USED:			
DATE OF BIRTH mm / dd / yyyy		SOCIAL SECURITY NUMBER - -	
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ( )	FAX # ( )	E-MAIL	
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**	

Board of Alcohol and Drug Counselors

Certified Clinical Supervisor (CCS)

Eligibility to Qualify for the CS Examination

Required Fees: $25.00

(includes examination fee)

LICENSE TYPE:

☐ CS Examination *(CCS)*

Office Use Only:	*Office Use Only:*
CCS 1447 - $ 25.00	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)	FIRST	MIDDLE INITIAL	LAST
I authorize the Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation to charge my ☐ VISA ☐ MASTERCARD the following amount: $____________			
Card number: XXXX-XXXX-XXXX-XXXX		Expiration Date mm / yyyy	
SIGNATURE		**DATE**	

SECTION 1: 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

SECTION 2: EDUCATION

Please check one:

☐ High School Diploma or GED ☐ MHRT/C

☐ Associate's Degree ☐ Substance Abuse Rehabilitation Certificate

☐ Bachelor's Degree ☐ Master's Degree ☐ 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 3: EXAMINATION

Have you ever taken an ICRC examinations?

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

☐ Yes
☐ No

_______ INITIALS OF APPLICANT

SECTION 4: 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 5: 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.

I understand that by my submitting this application for eligibility to qualify for an examination, it does not qualify me for a license with the Board of Alcohol and Drug Counselors. I must submit an application for licensure once I have been notified of passing exam results.

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: ___________			☐ Screening ☐ Intake ☐ Orientation ☐ Assessment ☐ Client education ☐ Referral ☐ Case management ☐ Crisis intervention ☐ Reports and record keeping ☐ Treatment planning ☐ Individual, group & family counseling ☐ Consultation with other Professionals	
From: _________ To: ___________			☐ Screening ☐ Intake ☐ Orientation ☐ Assessment ☐ Client education ☐ Referral ☐ Case management ☐ Crisis intervention ☐ Reports and record keeping ☐ Treatment planning ☐ Individual, group & family counseling ☐ 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: ___________			☐ Screening ☐ Intake ☐ Orientation ☐ Assessment ☐ Client education ☐ Referral ☐ Case management ☐ Crisis intervention ☐ Reports and record keeping ☐ Treatment planning ☐ Individual, group & family counseling ☐ Consultation with other Professionals	
From: _________ To: ___________			☐ Screening ☐ Intake ☐ Orientation ☐ Assessment ☐ Client education ☐ Referral ☐ Case management ☐ Crisis intervention ☐ Reports and record keeping ☐ Treatment planning ☐ Individual, group & family counseling ☐ 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.**

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

Americans with Disabilities Act (ADA)
Request for Reasonable Accommodation

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your written permission.

Name: ____

Address: ____

Telephone #: ____________________________ Social Security #: ________________

Accommodations Requested for the _____________________ Examination.

Disability: ____

Please check all that apply

☐ **Accessible Testing Site**
☐ **Separate Testing Site**
☐ **Braille**
☐ **Large Print**
☐ **Tape**
☐ **Reader as Accommodation for Visual Impairment**
☐ **Scribe/ Amanuensis as Accommodation for Visual or Motor Impairment**
☐ **Reader as Accommodation for Learning Disability**
☐ **Scribe/ Amanuensis as Accommodation for Learning Disability**
☐ **Sign Language Interpreter**
☐ **Extended Time**
    ☐ **Time-and-a-half**
    ☐ **Double time**
    ☐ **More than double time (specify):** ____________________________________
☐ **Use of computer or Other Adaptive Equipment (specify):** _________________________
☐ **Other:** ____
____

Signed and dated: ____

DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known ______________________________ **since** ____________________ **in**
(Test applicant) (Date)

my capacity as a ____.
(Professional Title)

This applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, providing the following should accommodate him/her:
(check all that apply):

☐ Accessible Testing Site
☐ Separate Testing Site
☐ Braille
☐ Large Print
☐ Tape
☐ Reader as Accommodation for Visual Impairment
☐ Scribe/Amanuensis as Accommodation for Visual or Motor Impairment
☐ Reader as Accommodation for Learning Disability
☐ Scribe/Amanuensis as Accommodation for Learning
☐ Sign Language Interpreter
☐ Extended Time
  ☐ Time-and-a-half
  ☐ Double time
  ☐ More than double time (specify): ______________________________
☐ Use of Computer or other adaptive equipment (specify): ______________________
☐ Other:____

____

Signed: ______________________________ Title: ______________________

Date: ____________________ License # (if applicable): ______________________