



# MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

## CERTIFIED SUPERVISED COUNSELOR - ALCOHOL AND DRUG

### APPLICATION INSTRUCTIONS

#### **\*\* IMPORTANT \*\***

**BEFORE** submitting your application, please:

- Retain a copy of all documents for your records. Documents **will not** be returned once received by the Board.
- All forms must be legible, complete, signed, and dated (where applicable) or processing may be delayed.
- Include a check or money order in the amount of \$150.00 payable to:  
*Board of Professional Counselors and Therapists*. Fees are **non-refundable and non-transferable**.
- Applications **may not** be submitted via fax or email. Please mail to:

*Board of Professional Counselors and Therapists*  
Attn: Janice Isaacs, Alcohol and Drug Counselor Licensing Coordinator  
4201 Patterson Avenue, Suite 316  
Baltimore, MD 21215

- \*\*\*NEW\*\*\*** Submit a copy of the receipt from your criminal history records check (CHRC) **with** your application. The form for the CHRC is included with the application. CHRC reports sent directly to the Board by CJIS.

**ELIGIBILITY/REQUIREMENTS:** *The following is a summary only. For complete requirements and definitions, see Md. Code Ann. Health Occ. II, §17-101, et. seq. and COMAR 10.58 which may be found on the Board's website, [health.maryland.gov/bopc](http://health.maryland.gov/bopc).*

- Education:** Applicant shall at a minimum:
  - 1) Hold an associate's degree from a regionally accredited educational institution in a ***health and human services counseling field***; **OR**
  - 2) Hold an associate's degree from a regionally accredited educational institution and have completed a program of studies judged by the Board to be substantially equivalent in subject matter; **AND**
  - 3) Have a minimum of 24 semester credit hours or 37 quarter credit hours including:
    - (i) A 3-semester credit hour or 5 quarter credit hour course taken at a regionally accredited educational institution **in each** of the following courses:
      1. Medical aspects of chemical dependency;





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## CERTIFIED SUPERVISED COUNSELOR - ALCOHOL AND DRUG APPLICATION

*Please type or print all information.*

### I. VETERANS AND SPOUSAL PREFERENCE

Are you an active service member or the spouse of any active service member?  Yes  No

Are you a veteran or the spouse of a veteran who was discharged from active duty under circumstances other than dishonorable within one year of filing this application?  Yes  No

### II. DEMOGRAPHIC INFORMATION

Name: \_\_\_\_\_  
*Last First MI Maiden*

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: \_\_\_\_\_  
*Street City State Zip*

Prior address: \_\_\_\_\_  
*(If less than 3 years at current address) Street City State Zip*

Mailing Address: \_\_\_\_\_  
*(If different than above) Street City State Zip*

Business: \_\_\_\_\_  
*Name Street City State Zip*

Gender and Ethnicity: *This information is optional and may be used for statistical purposes by authorized personnel.*

Gender:  Male  Female

Ethnicity: Are you of Hispanic or Latino origin?  Yes  No

*Check all that apply:*

American Indian or Alaska Native

Asian

White

Black or African American

Native Hawaiian or Pacific Islander

### III. INFORMATION REGARDING BACKGROUND

*Please answer Yes or No to each question.*

YES    NO

1. Has any state licensing or disciplinary board ever taken any disciplinary action against your license or certification, including, but not limited to, charges, admonishment, reprimand, revocation, or suspension?

*If YES, attach a separate page with a complete explanation of each occurrence (include date, time, location, disposition, etc.) and a **certified** copy of the disciplinary/court document from the issuing agency.*

**Please note:** If this question is not answered, your application will be returned and a new application and fee will be required. If you answered, “Yes”, but do not include a written explanation **AND** certified copies, your application will be returned and a new application and fee will be required.

2. Have you pled guilty, *nolo contendere*, or been convicted of, received probation before judgment, or had a conviction set aside for any criminal act (excluding traffic violations)?

*If YES, attach a separate page with a complete explanation of each occurrence (include date, time, location, disposition, etc.) and a **certified** copy of the disciplinary/court document from the issuing agency.*

**Please note:** If this question is not answered, your application will be returned and a new application and fee will be required. If you answered, “Yes”, but do not include a written explanation **AND** certified copies, your application will be returned and a new application and fee will be required.

3. Were you ever granted “Alcohol and Drug Trainee Status” prior to this application?

*If yes, when does/did it expire? \_\_\_\_/\_\_\_\_/\_\_\_\_.*

4. Are you currently (or have you ever been) licensed or certified as a:

*Check all that apply.*

- CSC-AD     CAC-AD     CPC-AD     LGADC     LCADC  
 LCPC     LGPC     LCMFT     LBMFT     LCPAT  
 LGPAT     None of the above.

5. Are you currently licensed or certified by another **Maryland** board in mental health counseling or other health occupation? *If so, specify license/certificate (Ex: LCSW-C, Psychologist, Registered Nurse, etc.) \_\_\_\_\_.*

- □ 6. Are you currently licensed or certified by a mental health or addictions counseling board *outside of Maryland*?

*If yes, please complete the “Out of State” application for certification in Alcohol and Drug Counseling which can be found on the Board’s website: [www.health.maryland.gov/bopc](http://www.health.maryland.gov/bopc).*

**V. EDUCATION:** List colleges or universities attended to satisfy academic requirements for licensure or certification. Do not list degrees unrelated to counseling. Please list the most recent colleges/universities first and provide **official** transcripts. Attach additional sheets, if necessary.

A. \_\_\_\_\_  
*Name of School* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_  
 Dates attended: From (mo./yr.) \_\_\_\_\_ To (mo./yr.) \_\_\_\_\_  
 Degree awarded: \_\_\_\_\_ Date awarded: \_\_\_\_\_  
 Major field of study: \_\_\_\_\_

B. \_\_\_\_\_  
*Name of School* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_  
 Dates attended: From (mo./yr.) \_\_\_\_\_ To (mo./yr.) \_\_\_\_\_  
 Degree awarded: \_\_\_\_\_ Date awarded: \_\_\_\_\_  
 Major field of study: \_\_\_\_\_

C. \_\_\_\_\_  
*Name of School* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_  
 Dates attended: From (mo./yr.) \_\_\_\_\_ To (mo./yr.) \_\_\_\_\_  
 Degree awarded: \_\_\_\_\_ Date awarded: \_\_\_\_\_  
 Major field of study: \_\_\_\_\_

D. \_\_\_\_\_  
*Name of School* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_  
 Dates attended: From (mo./yr.) \_\_\_\_\_ To (mo./yr.) \_\_\_\_\_  
 Degree awarded: \_\_\_\_\_ Date awarded: \_\_\_\_\_  
 Major field of study: \_\_\_\_\_

**VI. QUALIFICATIONS:** \*Complete the chart below. If the title of your course differs from those listed, you must include a catalog course description or syllabus for each course. A course applied to one topic area **may not** be used to fulfill another topic area. \* Official transcript(s) must be attached to this application.

Topic Area	Course Title and Number (Must appear on transcript)	Credits Earned	College/Univ.	Date	Grade
Medical Aspects of Chemical Dependency					

Addictions Treatment Delivery					
Ethics that includes A&D Counseling Issues (course description /syllabus must indicate alcohol/drug counseling)					
Indiv. Counseling					
Group Counseling					
Family Counseling					
Abnormal Psychology					
Topics in A&D Dependency					
Theories of Counseling					
Human Development					
Treatment of Co-occurring disorders					
Internship/Practicum/Field Placement (at least 6 semester or 10 quarter credits)					

**Total Credits Earned:** \_\_\_\_\_

**VII. AFFIDAVIT**

In making this application to the Maryland Board of Professional Counselors and Therapists (the “Board”) for the issuance of a Certified Supervised Counselor - Alcohol and Drug credential:

- I agree to abide by the rules and regulations of the Board and to take all examinations necessary for the processing of my application;
- Upon issuance of certification, I agree to abide by the Code of Ethics as set forth in COMAR;
- I understand that the fee submitted with this application is **NON-REFUNDABLE**;

- I agree to hold the Board, its members, officers, agents, and examiners free from any damage or claim of damage or complaint by reason of any action taken in connection with this application, the attendant examination, the grades with respect to any examination, and/or the failure or refusal of the Board to issue me a license or certificate.
- I grant permission to the Board to seek any information or references it deems appropriate or necessary in verifying my credentials as it pertains to this application.
- I understand, by law, it is my responsibility to notify the Board, in writing, of any change of address.

I do hereby affirm that all of the statements made herein are true and correct to the best of my knowledge and belief. I voluntarily consent to a thorough review of the information in this application and other activities for the purpose of verifying my qualifications for certification

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

ATTACH APPLICANT  
PHOTO

(Recent 2"x2")

NOTARY REQUIRED

**NOTARY**

State of \_\_\_\_\_

City/County of \_\_\_\_\_

I HEREBY CERTIFY that on this \_\_\_\_\_ day of \_\_\_\_\_, before me, a Notary Public of the State and City/County aforesaid, personally appeared \_\_\_\_\_ and made oath in due form that the contents of the foregoing Affidavit are true.

Notary Public \_\_\_\_\_

Commission Expires \_\_\_\_\_



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## NOTICE OF CRIMINAL HISTORY RECORDS CHECK

Effective January 1, 2014, the Maryland Board of Professional Counselors and Therapists (the "Board") requires that all applicants for licensure, certification, and trainee status complete a criminal history records check in accordance with §§17-501 and 17-501.1 of the Health Occupations Article, Annotated Code of Maryland.

A Criminal History Records Check includes a national and state criminal history background search. The criminal history records check requires you to be fingerprinted. In order to be fingerprinted, you will need to complete and present the LiveScan Pre-Registration Form. (Attached).

You must present this form to the fingerprinting site because it provides the Criminal Justice Information System (CJIS) authorization number **#1300005490** and the FBI ORI number **#MD920512Z** assigned specifically to the Board.

This allows the information to be forwarded directly to the Board.  
For additional information contact CJIS at 410-764-4501. For current listings of fingerprinting providers please go to <http://www.dpscs.maryland.gov/publicservs/fingerprint.shtml>.

### FOR FAST AND ACCURATE SERVICE

1. When requesting a criminal history records check for licensing purposes you must have an agency name and authorization number (Listed above).
2. Your background check is being sent to the Board.
3. You must bring a valid form of government identification. (Examples: driver's license, Certificate of Naturalization, passport, Alien Registration Card, or Military Identification).
4. Complete the LiveScan Pre-registration Application and bring it to any fingerprinting center/provider.
5. Bring payment as indicated above. The Board will receive the results from the criminal history records check directly from CJIS within 5-7 business days. The Board will contact you if it has any questions regarding the report. Please do not contact the Board to check if the report has been received.
6. Please do not send the LiveScan Pre-registration Application to the Board. You must present it at the fingerprint center/provider location.





**STATE OF MARYLAND**  
**DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES**  
**CRIMINAL JUSTICE INFORMATION SYSTEMS - CENTRAL REPOSITORY**

**LIVESCAN PRE-REGISTRATION APPLICATION**

**APPLICANT INFORMATION** (PLEASE TYPE OR PRINT CLEARLY)

Name:			
Date of birth:	SSN:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female (Please check)	
Height: ft. inches	Weight: lbs.	Eye Color:	Hair Color:
Race: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Other (Please check)			
Place of Birth:		Citizenship:	
Current address:			
City:		State:	ZIP Code: -
Daytime Phone:	Evening Phone:	Driver's License #:	

**AGENCY INFORMATION**

Agency Authorization #: 1300005490	
ORI # (if required): MD920512Z	Reason fingerprinted? License/Cert.
Position Applied for: N/A	
Request Type: (Choose one ONLY)	
<input type="checkbox"/> Adult Dependent Care	<input checked="" type="checkbox"/> Government Licensing or Certification
<input type="checkbox"/> Attorney/Client	<input type="checkbox"/> Immigration/VISA
<input type="checkbox"/> Child care	<input type="checkbox"/> Individual Challenge
<input type="checkbox"/> Criminal Justice	<input type="checkbox"/> Individual Review
<input type="checkbox"/> Gold Seal/ Adoption	<input type="checkbox"/> MSP Licensing
<input type="checkbox"/> Gold Seal/Letter/VISA	<input type="checkbox"/> Private Party Petition
<input type="checkbox"/> Government Employment	<input type="checkbox"/> Public Housing

**Mail Response to:**

(Mailing option only available for Visa Gold Seal and/or Individual Review)

Name:	_____
Address:	_____
City, State, Zip code:	_____