Virginia Department of Health Professions
Board of Counseling

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
www.dhp.virginia.gov/counseling

Email: csac@dhp.virginia.gov
(804) 367-4610 (Tel)
(804) 767-6225 (Fax)

APPLICATION INSTRUCTIONS
CERTIFIED SUBSTANCE ABUSE COUNSELOR ASSISTANT (CSAC-A)
BY EXAMINATION

☐ Completed Application: The application must have an *original signature*. To avoid delays, please provide a complete application packet. Incomplete packets will not be evaluated by the Credential Reviewer.

☐ Application Fee: An application processing and initial certification fee of $115.00 is required. All fees must be paid by check or money order made payable to the "Treasurer of Virginia". This fee is non-refundable. The application is valid for one year from date of receipt.

The below supplemental documentation must accompany your application and fee in one packet:

☐ Verification of Education: An official transcript documenting attainment of a high school diploma, a general education development (GED) certificate, or a post-secondary degree.

☐ Didactic Training Required for Certification: The didactic training form must be completed and submitted along with official transcripts or certificates verifying completion of 120 hours of didactic training in substance abuse counseling as requirement in 18VAC115-30-62. Each certificate must show your name, course name, number of clock hours, date of training and the approved provider's name. Training not approved or affiliated with one of the approved providers outlined in the Regulations will not be considered.

☐ Verification of Experience Form: The verification from should be completed by your supervisor, attesting to the completion of 180 hours of experience in a practicum, internship or under supervision performing specific tasks with substance abuse clients while under supervision.

☐ Licensure/Certification Verification: If you hold or have ever held a health or mental health licensure, certification, or registration in Virginia or any other jurisdiction, whether current or expired, you must submit a license verification. This verification is to be completed by the issuing jurisdiction and mailed back to you and included in your application packet, or you can provide an online verification printed from the licensing jurisdiction's website if the verification indicates the licensee name, license number, license type, issue and expiration date, and whether disciplinary action has ever occurred.

☐ NPDB Self-Query: A current report from the U.S. Department of Health and Human Services National Practitioners Data Bank (NPDB) must be included. A self-query request can be obtained at https://www.npdb.hrsa.gov. Copies of the completed self-report result can be considered.

☐ Name Change: If applicable, documentation must be provided if your name has legally changed by marriage, divorce, or a court order. A photocopy of your marriage license or a copy of the court order must be provided.

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Military/Military Spouse

Are you active duty military personnel? ☐ Yes ☐ No

Are you the spouse of a member of the U.S. military who has been transferred to Virginia and who had to leave employment to accompany your spouse to Virginia? ☐ Yes ☐ No

FIRST NAME	MIDDLE NAME	LAST NAME AND SUFFIX

DATE OF BIRTH _____ _____ _____ MM DD YY	SOCIAL SECURITY NO. OR VA CONTROL NO.*

ADDRESS OF RECORD**: STREET	CITY	STATE	ZIP CODE

ALTERNATE PUBLIC ADDRESS***: STREET	CITY	STATE	ZIP CODE

HOME PHONE:	WORK PHONE:	MOBILE PHONE:

E-MAIL ADDRESS

DEGREE EARNED	DATE DEGREE RECEIVED	MAJOR	INSTITUTION NAME/STATE

*In accordance with §54.1-116 Code of Virginia, you are required to submit your Social Security Number or your control number issued by the Virginia Department of Motor Vehicles. If you fail to do so, the process of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other state agencies for child support enforcement activities. NO LICENSE WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FAILED TO DISCLOSE ONE OF THESE NUMBERS.

**The address information you provide is your address of record with the Board. Please be advised that all notices from the board, to include renewal notices, licenses, and other legal documents, will be sent to the address of record provided. If you provided a different public address, this information is not subject to public disclosure under the Freedom of Information Act and will not be sold or distributed for any other purpose.

***This address is subject to public disclosure under the Freedom of Information Act. You may provide an address other than a residence, such as a Post Office Box or a practice location if you wish.

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If you answer "yes" to any question, **include a detailed explanation AND supporting documentation.**

Refer to Guidance Document 115-2 for detailed information on the requirements with a criminal conviction, past actions or possible impairment.

1. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? If yes, please provide a full explanation. ☐ Yes ☐ No

   (A) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? ☐ Yes ☐ No

2. Have you ever been censored, warned, terminated, or requested to withdraw from your employment with any health care facility, agency, or practice? If yes, provide a full description of the circumstances and any supporting documentation. ☐ Yes ☐ No

3. Within the past five years, have you been disciplined by any entity? Please provide a full explanation and any associated orders or letters from the entity. ☐ Yes ☐ No

   (A) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? ☐ Yes ☐ No

4. Have you voluntarily surrendered your license, certification or registration while under investigation? If yes, provide detail(s), jurisdiction(s), date(s), and supporting documentation. ☐ Yes ☐ No

5. Have you ever been denied the issuance of a license, certification, or registration, or denied the privilege of taking an occupational examination by a licensing agency. If yes, provide detail(s), jurisdiction(s) and date(s). ☐ Yes ☐ No

6. Have you ever been convicted of, pled Nolo Contendere to, or entered into a plea agreement for a violation of any federal, state or local statute, regulation, or ordinance? (This includes convictions for driving under the influence, but does not include other traffic violations).If yes, include an explanation of the charges/convictions, and attach documentation required in the Board's Guidance Document #115-2. ☐ Yes ☐ No

7. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing LPC. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.) ☐ Yes ☐ No

8. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing LPC. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.) ☐ Yes ☐ No

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9. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing LPC. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.) ☐ Yes ☐ No

10. Within the past 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? If yes, please provide a full explanation and any associated orders or letters from the entity. (NOTE: The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application, or have the program send this documentation directly to the Board.) ☐ Yes ☐ No

Licenses/Certifications: List all mental health or health professional licenses, certificates, or registration that you hold or have ever held.

STATE	LICENSE #	CURRENT LICENSE STATUS	ISSUE DATE	TYPE OF LICENSE

I certify that I have carefully read the laws and regulations related to the Certified Substance Abuse Counselors and Substance Abuse Counseling Assistants through the Virginia Board of Counseling, which are available at http://www.dhp.virginia.gov/counseling.

I certify by my signature below that the information provided on this application has been personally provided and reviewed by me, and that statements made on the application are true and complete. In understanding that providing false or misleading information, as well as omitting information, in response to information required in this application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing license/certificate/registration.

I agree to the above certification.

SIGNATURE:	DATE:

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APPLICANT OUT-OF-STATE LICENSURE VERIFICATION

PART I. TO BE COMPLETED BY THE APPLICANT:

NAME OF APPLICANT (LAST, FIRST, MIDDLE)

MAILING ADDRESS (STREET AND/OR BOX NUMBER, CITY, STATE, ZIP

APPLICANTS EMAIL ADDRESS	HOME AND/OR CELL TELEPHONE NUMBER

PART II. TO BE COMPLETED BY STATE LICENSING AUTHORITY:

TITLE OF LICENSE	LICENSE NUMBER
ISSUE DATE	EXPIRATION DATE

OBTAINED BY METHOD

☐ BY EXAMINATION

DATE TAKEN: _____

NAME OF EXAM: _____

SCORE: _____

☐ BY WAIVER

☐ BY ENDORSEMENT

☐ BY RECIPROCITY

IS THERE ANY PUBLIC INFORMATION RELATING TO THIS LICENSE?

☐ YES (SPECIFY DETAILS ON A SEPARATE SHEET) ☐ NO

CERTIFICATION BY THE AUTHORIZED LICENSURE OFFICIAL OF THE STATE OF

_____

☐ I CERTIFY THAT THE INFORMATION IS CORRECT.

AUTHORIZED LICENSURE OFFICIAL NAME AND TITLE

_____

STATE SEAL

TITLE OF BOARD

_____

TELEPHONE NUMBER

_____

EMAIL ADDRESS

_____

DATE

_____

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DIDACTIC TRAINING REQUIRED FOR CSAC-A CERTIFICATION

This form is used to determine the completion of the required didactic training in substance abuse counseling education for CSAC-A certification.

GENERAL INFORMATION - PLEASE TYPE OR PRINT CLEARLY	
Name of Applicant (Last, First)	
Applicants Email Address	Home and/or Cell Telephone Number

EACH APPLICANT MUST HAVE RECEIVED A TOTAL OF 120 HOURS OF DIDACTIC TRAINING IN SUBSTANCE ABUSE COUNSELING WITH A MINIMUM OF 8 CLOCK HOURS IN EACH CONTENT AREA. TRAINING MUST BE FROM AN APPROVED PROVIDER OUTLINED IN THE REGULATIONS:

CONTENT AREA	COURSE TITLE	CLOCK HOURS	APPROVED PROVIDER
UNDERSTANDING THE DYNAMICS OF HUMAN BEHAVIOR			
SIGNS AND SYMPTOMS OF SUBSTANCE ABUSE			
COUNSELING THEORIES AND TECHNIQUES			
CASE MANAGEMENT SKILLS AND CONTINUUM OF CARE			

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DIDACTIC TRAINING REQUIRED FOR CSAC-A CERTIFICATION
PAGE 2

RECOVERY PROCESS AND RELAPSE PREVENTION METHODS			
PROFESSIONAL ORIENTATION AND ETHICS			
CULTURAL COMPETENCY			
TRAUMA AND CRISIS INTERVENTION			
PHARMACOLOGY OF ABUSED SUBSTANCES			

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DIDACTIC TRAINING REQUIRED FOR CSAC-A CERTIFICATION
PAGE 3

CO-OCCURING DISORDERS			
SUBSTANCE ABUSE COUNSELING APPROACHES AND TREATMENT PLANNING			
GROUP COUNSELING			
PREVENTION, SCREENING, AND ASSESSMENT OF SUBSTANCE USE AND ABUSE			
	Total Clock Hours (minimum 120)	_____	

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CSAC-A VERIFICATION OF EXPERIENCE WHILE UNDER SUPERVISION

GENERAL INFORMATION **PLEASE TYPE OR PRINT CLEARLY**		
Name of Applicant (Last, First, Middle)	Applicants Email Address	
SUPERVISOR'S EVALUATION:		
Supervisor's Name (Last, First)	Supervisor's License or Certification Number	Supervisor's Telephone Number
Worksite Name and Address where substance abuse tasks where performed:		
Dates of supervision: From: _____ to _____		
Did the applicant complete a minimum of 180 hours of experience performing the following tasks with substance abuse clients with at least eight hours for each task?		
a. Screening clients and gathering information used in making the determination for the need for additional professional assistance;		☐ Yes ☐ No
b. Intake of clients by performing the administrative tasks necessary for admission to a program;		☐ Yes ☐ No
c. Orientation of new clients to program's rules, goals, procedures, services, costs and the rights of the client;		☐ Yes ☐ No
d. Assisting the client in identifying and ranking problems to be addressed, establishing goals, and agreeing on treatment processes;		☐ Yes ☐ No
e. Implementation of a substance abuse treatment plan as directed by the supervisor;		☐ Yes ☐ No
f. Implementation of case management activities that bring services, agencies, people, and resources together in a planned framework of action to achieve established goals;		☐ Yes ☐ No
g. Assistance in identifying appropriate crisis intervention responses to a client's needs during acute mental, emotional or physical distress;		☐ Yes ☐ No
h. Education of clients by providing information about drug abuse and available services and resources;		☐ Yes ☐ No
i. Facilitating the client's utilization of available support systems and community resources to meet needs identified in clinical valuation or treatment planning;		☐ Yes ☐ No
j. Reporting and charting information about client's treatment, progress, and other client-related data; and		☐ Yes ☐ No
k. Consultation with other professionals to assure comprehensive quality care for the client		☐ Yes ☐ No
In your opinion has the applicant demonstrated competency sufficient for certification as a substance abuse counseling - assistant?		☐ Yes ☐ No
I declare that, to the best of my knowledge, the foregoing is true and correct.		
_____ Supervisor's Signature		_____ Date