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 (CSAC)
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 coursework and attainment of a bachelor's or post-baccalaureate degree is required. If you have been previously approved by the Board for supervision, a duplicate transcript is not required.

☐ Didactic Training Required for Certification: The didactic training form must be completed and submitted along with official transcripts or certificates verifying completion of 240 hours of didactic training in substance abuse counseling as requirement in subsection B of 18VAC115-30-50. 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 Supervisor Qualifications: Supervisor must met one of the following qualifications prior to supervising your experience.

- Virginia LSATP; or
- LCP, LCP, LCSW, LMFT, medical doctor or RN and has one of the following:
  - Holds one of the following national certifications: MAC, NCACII, or AADC; or
  - Holds a Virginia CSAC Certification; or
  - Has a minimum of one year experience in substance abuse counseling and at least 100 hours of didactic training covering the areas outlined in 18VAC115-30-50 B2 through 2M by attesting to having one year experience in substance abuse counseling and at least 100 hours of didactic training in substance abuse.
- Virginia CSAC with two years of experience.

☐ Verification of Supervision: The CSAC Verification of Supervision form must be completed by the supervisor(s) verifying a minimum of 100 hours of face-to-face clinical supervision and 2,000 hours of supervised experience in the practice of substance abuse services completed in no less than 12 months and no more than 60 months.

☐ 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.

☐ Verification of Out-of-State Supervisor: If you supervision did not take place in Virginia, you must submit verification of your supervisor's license. You may submit an online verification printed from the issuing jurisdiction's website or you may submit the enclosed verification form. The supervisor's license verification must be included in your application packet.

☐ 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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CERTIFIED SUBSTANCE ABUSE COUNSELOR (CSAC)
BY EXAMINATION – Page 1

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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CERTIFIED SUBSTANCE ABUSE COUNSELOR (CSAC) BY EXAMINATION – Page 2

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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CERTIFIED SUBSTANCE ABUSE COUNSELOR (CSAC) BY EXAMINATION – Page 3

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 ☐ BY WAIVER ☐ BY ENDORSEMENT ☐ BY RECIPROCITY

DATE TAKEN: _____
NAME OF EXAM: _____
SCORE: _____

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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CERTIFIED SUBSTANCE ABUSE COUNSELOR (CSAC) VERIFICATION OF SUPERVSION FORM

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 Telephone Number
Supervisor's License/Certification Type	Supervisor's License/Certification Number	
Business Name and Address of Work Site Where Clinical Hours Were Obtained (ONE LOCATION ONLY)		
Dates of supervision: From: _____ to _____		
Did the applicant receive a minimum of one (1) hour and a maximum of four (4) hours of face-to-face supervision per 40 hours of work experience while under your direct supervision?		☐ Yes ☐ No If not, explain on separate page
Total amount of in-person hours of supervision with the supervisee.	Individual Hours:	Group Hours:
How many hours of supervised experience in the practice of clinical substance abuse counseling services did the supervisee provide under your **direct supervision**? (Do not include hours obtained under another supervisor)		_____ hours
Did the applicant demonstrate minimum competencies of applying a counseling process, treatment strategies and rehabilitative services to help an individual to:		
a. Understand his substance abuse use, abuse or dependency?		☐ Yes ☐ No
b. Change his drug-taking behaviors so that it does not interfere with effective physical, psychological, social or vocational functioning?		☐ Yes ☐ No
Did the applicant complete a minimum of **160 hours** of experience performing the following tasks with substance abuse clients with at least eight hours for each task?		
a. Screening clients to determine eligibility and appropriateness for admission to a particular program;		☐ Yes ☐ No
b. Intake of clients by performing the administrative and initial assessment 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. Assessment of client's strengths, weaknesses, problems, and needs for the development of a treatment plan;		☐ Yes ☐ No
e. Treatment planning with the client to identify and rank problems to be addressed, establish goals, and agree on treatment processes;		☐ Yes ☐ No

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VERIFICATION OF SUPERVSION FORM – Page 2

f. Counseling the client utilizing specialized skills in both individual and group approaches to achieve treatment goals and objectives;	☐ Yes ☐ No
g. Case management activities which bring services, agencies, people and resources together in a planned framework of action to achieve established goals;	☐ Yes ☐ No
h. Crisis intervention responses to clients' needs during acute mental, emotional or physical distress;	☐ Yes ☐ No
i. Education of clients by providing information about drug abuse and available services and resources;	☐ Yes ☐ No
j. Referral of clients in order to meet identified needs unable to be met by the counselor and assisting the client in effectively utilizing those resources;	☐ Yes ☐ No
k. Reporting and charting information about the client's treatment, progress, and other client related data; and	☐ Yes ☐ No
l. 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 of substance abuse counseling?	☐ Yes ☐ No

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 form has been personally provided and reviewed by me, and that statements made on the form are true and complete.

Further, I attest that I meet the supervisor qualifications as set forth in 18VAC115-30-60.

I agree to the above certification.

_____ _____

Supervisor's Signature Date

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CSAC DIDACTIC TRAINING REQUIRED FOR CERTIFICATION

This form is used to determine the completion of the required didactic training in substance abuse counseling education for CSAC 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 240 HOURS OF DIDACTIC TRAINING IN SUBSTANCE ABUSE COUNSELING WITH A MINIMUM OF 16 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
DYNAMICS OF HUMAN BEHAVIOR			
SIGNS AND SYMPTOMS OF SUBSTANCE ABUSE			
COUNSELING THEORIES AND TECHNIQUES			
CONTINUUM OF CARE AND CASE MANAGEMENT SKILLS			

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CSAC DIDACTIC TRAINING REQUIRED FOR CERTIFICATION
PAGE 2

RECOVERY PROCESS AND RELAPSE PREVENTION METHODS			
PROFESSIONAL ORIENTATION AND ETHICS			
PHARMACOLOGY OF ABUSED SUBSTANCES			
CRISIS INTERVENTION			
CO-OCCURRING DISORDERS			

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CSAC DIDACTIC TRAINING REQUIRED FOR CERTIFICATION
PAGE 3

CULTURAL COMPETENCY			
SUBSTANCE ABUSE COUNSELING APPROACHES AND TREATMENT PLANNING			
GROUP COUNSELING			
PREVENTION, SCREENING, AND ASSESSMENT OF SUBSTANCE USE AND ABUSE			
	Total Clock Hours (minimum 240)	_____	

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LICENSURE/CERTIFICATION VERIFICATION OF OUT-OF-STATE SUPERVISOR

PART I. TO BE COMPLETED BY THE APPLICANT:

INSTRUCTIONS	**PLEASE TYPE OR PRINT CLEARLY**
NAME OF APPLICANT (LAST, FIRST, MIDDLE)	
MAILING ADDRESS (STREET AND/OR BOX NUMBER, CITY, STATE, ZIP	
APPLICANT'S EMAIL ADDRESS	HOME AND/OR CELL TELEPHONE NUMBER

PART II. SUPERVISOR'S INFORMATION TO BE VERIFIED:

LAST NAME _____ FIRST NAME _____ M.I. _____

PART III. TO BE COMPLETED BY STATE LICENSING AUTHORITY:

INSTRUCTIONS	**PLEASE TYPE OR PRINT CLEARLY**
TITLE OF LICENSE	LICENSE NUMBER
ISSUE DATE	EXPIRATION DATE

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 _____