



**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243
(615) 741-5735 or (800) 778-4123 (Toll Free)**

Dear Alcohol and Drug Abuse Counselor Applicant:

This packet contains information relative to achieving licensure as a Licensed Alcohol and Drug Abuse Counselor – Level I or Level II. <http://tn.gov/health/article/AD-about>

The requirements for application are supported by the rules governing Licensure of Alcohol and Drug Abuse Counselors, which can be found on the Board's website at: <http://www.state.tn.us/sos/rules/1200/1200-30/1200-30.htm>

The licensure process includes three (3) major phases, in sequence, as follows:

- a. Review of completed application and all supporting credentials and approval to sit for the written examination.
- b. Review of written examination scores and approval to take the oral examination.
- c. Review of recommendations from the oral examining committee by the licensure board and determination of eligibility for licensure.

UNDERSTANDING THE APPLICATION PROCESS

1. **All application fees are non-refundable.**
2. You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §36-5-1301(a), as authorized by 42 U.S.C. §405 (c) (2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

3. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

**Tennessee Board of Alcohol and Drug Abuse Counselors
665 Mainstream Drive
Nashville, TN 37243 (37228 for courier service only)**

4. **Allow fourteen (14) working days** for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.
5. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you by U.S. postal mail or via email (only if an email address is provided). The supporting documentation requested in the letter or email must be received in the Board office sixty (60) days from the date of the initial deficiency letter or email notification. **(Files not completed within sixty (60) days will be closed.)**
6. Absent any complicating factors, the average application processing time is eight (8) weeks. Once the application is completed, your file will be reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.
7. **If an address change occurs at any time during the application process, you must notify the Board office, in writing, immediately.**
8. It is recommended that you do not make arrangements to accept employment as an alcohol and drug abuse in Tennessee until you are granted a license number by the Board of Alcohol and Drug Abuse Counselors.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

WRITTEN EXAMINATION

A written exam is required. The exam is offered upon approval by the Board of all application documentation. The exam is scheduled three (3) times annually. Applicants will be notified of their exam.

If a candidate does not achieve the minimum score needed to pass the examination, they will be eligible to retake the **next regularly scheduled** written exam, provided the exam will be given during the twelve (12) month time period in which the applicant's application is considered active.

After successful completion of the written exam, the applicant will be notified of the date, time, and location that the oral examination will be held. The oral exam will last about one (1) hour. The oral examination is given four (4) times each year. In each case, every attempt will be made to provide the applicant with a minimum of thirty (30) days notice. Applicants who cancel their oral examination with less than seven (7) days notice or who do not appear for their oral exam on the scheduled date will be subject to pay another oral exam fee.

WRITTEN CASE PRESENTATION FOR ORAL EXAMINATION

The applicant must submit the original case presentation in narrative (story) form. Applicants must use an actual client from their case files, one who has completed treatment or is no longer obtaining services, using a fictitious name for the client in the case. If the applicant did not carry out all the eight domains with the client, the applicant must access the treatment record, gather the information, and prepare the narrative in accord with the actual details of the case. A composite case composed from different clients will not be acceptable. The applicant must be prepared to show a full understanding in the functions not directly performed and demonstrate competency in those functions. An example might be a counselor who was not directly involved in the screening or orientation of the client, but was capable of performing that function, if requested to do so.

In written case presentation, provide the information for items "a" through "k" using a narrative style. Please be sure to insert the heading name in the order in which they are listed below. The following headings must appear, in the following order, within the narrative text:

- a. Chemical Abuse History
- b. Psychological Functioning
- c. Education/Vocational/Financial
- d. Legal History
- e. Social
- f. Physical History
- g. Treatment History
- h. Assessment
- i. Treatment Plan Process
- j. Course of Treatment
- k. Discharge Summary

The case presentation should be between eight (8) and fourteen (14) typewritten pages in length. The content must be double spaced with a one inch (1") margin. The case presentation selected should address all eight (8) domains.

Inclusion of any treatment plan form must be in addition to the required 8-14 page case presentation. However, inclusion of an actual treatment plan is not required.

Applicant shall complete basic demographic information on the client and sign the demographic sheet. The completed case presentation must be reviewed by the supervisor and signed on the demographic sheet.

Applicant should keep a copy of the case presentation for their personal file. The original case presentation should be mailed with the other application materials.

Submitted case presentations which do not follow the above criteria and format will not be reviewed.

PHILOSOPHY OF TREATMENT OUTLINE

An original three (3) page, single spaced philosophy of treatment paper should be submitted along with the written case presentation. The outline below is a guideline. Use actual case examples in the paper when appropriate.

1. What is your definition of substance abuse?
2. What is your definition of addiction?
3. How do you see treatment impacting on these problems?
4. What issues are of primary importance in making an initial assessment regarding treatment?
5. What are your treatment goals in working with clients?
6. Describe how you utilize the treatment process, including assessment, treatment planning and goal setting, family involvement, referral systems, aftercare, etc.
7. What factors are important in dealing with the client is ready for terminating treatment?
8. How do you know when a client is ready for terminating treatment?
9. Describe your understanding of confidentiality and client rights as it related to treatment.
10. Describe your view of yourself as a therapist in the treatment process including strengths, weaknesses and any particular orientation to the process (client-centered, behavior modification, 12 steps, etc).

Applications are screened for clerical errors, omissions, and appropriate content and format. The applicant will be contacted by letter for corrections or additions.

APPLICATION CHECKLIST

1. _____ Application signed and notarized
2. _____ The fee submitted with the application includes an application fee of Two Hundred Fifty Dollars (\$250.00); the state regulatory fee of Ten Dollars (10.00); the oral examination fee of Seventy-Five Dollars (\$75.00); and the license fee of Fifty Dollars (\$50.00) for a total of Three Hundred Eighty-Five Dollars (\$385.00). The application and state regulatory fees are non refundable.
3. _____ Complete and submit Jurisprudence Examination per Rule 1200-30-01-.08. The rules and regulations as well as the Tennessee Code can be found at: <http://tn.gov/health/article/AD-statutes>
4. _____ A certified or notarized copy of birth certificate (Short Form)
5. _____ All applicants must complete the attached Declaration of Citizenship form and **have it notarized.**
6. _____ Attach to the application in the space provided a clear, recognizable, passport photograph taken within the last twelve (12) months. The photo is to be signed by the applicant on the back.
7. _____ Submit two (2) recent (dated within the preceding twelve (12) months) original letters of recommendation from mental health professionals, one of which must be a licensed alcohol and drug abuse counselor in good standing, attesting to the applicant's personal character and professional ethics and typed on the signatory's letterhead.
8. _____ Submit a signed and notarized affidavit by the applicant stating the applicant is in compliance with alcohol and drug abuse counselor ethical standards and rules (sample attached).
9. _____ **For Level 1:** Submit verification of having completed a minimum of three (3) years clinically supervised, substance abuse counseling experience (6,000 contact hours) during which all eight (8) domains have been performed.

For Level 2: Bachelor's degree: Submit verification of having completed a minimum of two (2) years clinically supervised, substance abuse counseling experience (4,000 contact hours) during which all eight (8) domains have been performed.

For Level 2: Master's degree: Submit verification of having completed a minimum of one (1) year clinically supervised, substance abuse counseling experience (2,000 contact hours) during which all eight (8) domains have been performed.
10. _____ Provide a notarized photocopy of high school diploma or GED. If applicant indicates college degree, request transcript from degree granting institution showing highest degree(s) earned and carrying official seal to be sent directly from the educational institution to this office.
11. _____ Complete and mail Form #8 to each state, country, or province in which you hold or have ever held a license to practice any profession.

12. _____ Complete and submit the application worksheet for at least two hundred seventy (270) contact hours of classroom training (and, or) the clinically supervised practice experience, along with proof of attendance.
13. _____ Case Study (original only)
14. _____ Philosophy of Treatment (original only)
14. _____ Completed Mandatory Practitioner Profile <http://tn.gov/assets/entities/health/attachments/PH-3585.pdf>
15. _____ **Effective June 1, 2006, a criminal background check is required.** For instructions on how to obtain a criminal background check go to <http://tn.gov/health/topic/CBC-check>

AFFIDAVIT OF ETHICAL CONDUCT

STATE OF _____)
)
COUNTY OF _____)

I, _____, under oath hereby swear or affirm to abide by the principles of the National Association of Alcoholism and Drug Abuse Counselors Code of Ethics (AKA Ethical Standards), and do affirm that I have practiced these principles as a counselor since _____, _____.

By my signature I declare this statement to be true.

AFFIANT

DATE

Sworn to and subscribed before me this the _____ day of _____, _____.

Notary Public

My Commission Expires: _____

Form #1

Attach
Photo
Here

8078-001-\$250
8078-002-\$ 10
8078-001-\$ 75
8078-001-\$ 50



**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARD
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243
TENNESSEE BOARD OF ALCOHOL AND DRUG ABUSE COUNSELORS
(615) 741-5735 or (800) 778-4123 (Toll Free)**

APPLICATION FOR LICENSURE AS AN ALCOHOL AND DRUG ABUSE COUNSELOR

TYPE OF LICENSE: LEVEL 1 _____ LEVEL 2 _____

NAME _____
LAST FIRST MIDDLE MAIDEN

SOCIAL SECURITY NUMBER _____ SEX: Male _____ Female _____

PLACE OF BIRTH _____ DATE OF BIRTH _____
City or County and State MO. DAY YEAR

U.S. CITIZEN: Yes _____ No _____

FULL MAILING ADDRESS:

STREET _____

CITY _____ STATE _____ ZIP CODE _____

HOME TELEPHONE _____

CURRENT EMPLOYER _____

ADDRESS _____

POSITION _____ DATE EMPLOYED _____

WORK TELEPHONE _____ E-MAIL ADDRESS _____

Do you wish to receive notifications, including renewal notification, from the Department of Health via email?
Yes No

SIGNATURE _____ DATE _____

EDUCATION

	DATE OF GRADUATION	MAJOR	DEGREE
HIGH SCHOOL			
ADDRESS			
GED			
ADDRESS			
COLLEGE			
ADDRESS			
GRADUATE			
ADDRESS			
POST GRADUATE			
ADDRESS			
OTHER			
ADDRESS			

If additional space is needed, please attach a separate sheet. Include copy of high school diploma or GED. If you have attended college, have the institution send a copy of the transcript directly from the school to the administrative office. The institution submitting the degree must be accredited at the time the degree was granted. The transcript must show that the degree has been conferred and carries the official seal of the institution. If the name on the transcript differs from the name on the application, please explain.

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. *In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.*

- | | YES | NO |
|---|-------|-------|
| (1) If you have ever held or applied for a license or certificate to practice alcohol and drug counseling in any state, country or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? | _____ | _____ |
| (2) If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action? | _____ | _____ |
| (3) Have you ever been convicted of a crime involving moral turpitude, a felony, or a misdemeanor, other than a minor traffic violation? | _____ | _____ |
| (4) Have you ever been rejected or censured by a professional society? | _____ | _____ |
| (5) In relation to the performance of your professional services in any profession: | | |
| a. Have you ever had a final judgment rendered <u>against</u> you; | _____ | _____ |
| b. Have you ever had settlement of any legal action rendered <u>against</u> you; or | _____ | _____ |
| c. Are there any legal actions pending <u>against</u> you or to which you are a party? | _____ | _____ |
| (6) If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? | _____ | _____ |

AFFIDAVIT AND RELEASE

STATE OF _____)

)

COUNTY OF _____)

I, _____, of _____,
(Applicant's Name) (City) (State)

being duly sworn and identified as the person referred to in this application, attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations which are enclosed in the application packet and agree to abide by them in the practice of my profession in the State of Tennessee.

1. I signify my willingness to appear to answer such questions as the Licensure Board may find necessary, which may include an interview.
2. I agree to Release to the Licensure Board, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice my profession.
3. I authorize the Licensure Board, its staff and their representatives, to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and any other qualifications.
4. I release from liability the Licensure Board, its staff and all their representatives, and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for licensure.
5. I acknowledge that I, as an applicant for licensure, have the burden of producing sufficient information for a proper evaluation of my professional, ethical, and other qualifications and for resolving any doubts about such qualifications.

SIGNATURE

Sworn to before me this _____ day of _____, _____.

NOTARY PUBLIC

My commission expires: _____

ACCOMODATIONS REQUEST

If you have a disability and may require accommodation in taking the examination, be sure to fill out and submit this form along with your application. If accommodation is not requested in advance, we cannot guarantee the availability of accommodation on-site.

If you do not require special accommodation, please indicate by checking box to the right.

Please include this form in your application package.

Name: _____

Address: _____

Phone No.: _____

Examination applying for: _____

Accommodation requested: _____

PLEASE INCLUDE DOCUMENTATION FROM A DOCTOR, PSYCHOLOGIST, PSYCHIATRIST, OR OTHER APPROPRIATE PROFESSIONAL CERTIFYING YOUR DISABILITY.

Signed _____

Date _____

PRACTICE AND LICENSURE INFORMATION

List below and submit a copy of Form #8 to **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED AS AN ALCOHOL AND DRUG ABUSE COUNSELOR.** Additional pages may be added if necessary.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List below **ALL** state, countries, or provinces in which you hold or have ever held a license as a health professional other than an Alcohol and Drug Abuse Counselor. Submit a copy of Form #8 to all such state, country, or province regarding such licensure. Additional pages may be added if necessary.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

WORK EXPERIENCE

Starting with present employment, select only those work experiences which fit the description of qualifying work experience related to the area of alcohol and drug abuse. The final determination of acceptability of work experience will be made by the Licensure Board.

You are responsible for providing any supervisor you have indicated with the Supervisor Evaluation Form and insuring that they return the form.

EXPERIENCE

Begin with your most recent, relevant employment and work backward.

Employer _____ Type of Institution
or establishment _____

Address _____
(Street) (City) (State) (Zip)

Phone # _____ Fax # _____

Position Title _____ Employment Dates _____

Name of Evaluating Supervisor _____ Supervisor's
position/title _____

Does this supervisor meet the qualified supervisor criteria? Yes No

How many clinically supervised hours (see definition in rules governing Licensure of Alcohol and Drug Abuse Counselors 1200-30-1.10) did you perform in each of the eight (8) domains under this person's supervision? (List total number of hours for each)

Your duties and specialty in the position named above: _____

Form #2

Applicant's Name: _____

Employer _____

Type of Institution
or establishment _____

Address _____

(Street)

(City)

(State)

(Zip)

Phone # _____ Fax # _____

Position Title _____ Employment Dates _____

Name of Evaluating Supervisor _____ Supervisor's position/title _____

Does this supervisor meet the qualified supervisor criteria? Yes No

How many clinically supervised hours (see definition in rules governing Licensure of Alcohol and Drug Abuse Counselors 1200-30-1.10) did you perform in each of the eight (8) domains under this person's supervision? (List total number of hours for each)

Your duties and specialty in the position named above: _____

Form #2

Applicant's Name: _____

Employer _____

Type of Institution
or establishment _____

Address _____

(Street)

(City)

(State)

(Zip)

Phone # _____ Fax # _____

Position Title _____ Employment Dates _____

Name of Evaluating Supervisor _____ Supervisor's position/title _____

Does this supervisor meet the qualified supervisor criteria? Yes No

How many clinically supervised hours (see definition in rules governing Licensure of Alcohol and Drug Abuse Counselors 1200-30-1.10) did you perform in each of the eight (8) domains under this person's supervision? (List total number of hours for each)

Your duties and specialty in the position named above: _____

SUPERVISORS/PROFESSIONALS SUBMITTING EVALUATIONS

Supervisors Requested to Submit Evaluations (Give Complete Mailing Address)

Name: _____ Title: _____

Employer: _____

Mailing Address: _____

Dates he/she supervised you: From _____ To _____

Total number of hours worked under supervision: _____

Name: _____ Title: _____

Employer: _____

Mailing Address: _____

Dates he/she supervised you: From _____ To _____

Total number of hours worked under supervision: _____

Name: _____ Title: _____

Employer: _____

Mailing Address: _____

Dates he/she supervised you: From _____ To _____

Total number of hours worked under supervision: _____

Professional Reference Requested to Submit Evaluations
(Give Complete Mailing Address)

Name: _____ Relationship to Applicant: _____

Mailing Address: _____

Work Telephone: _____

Does this person hold a license (or certification prior to 1997)? Yes No

Name: _____ Relationship to Applicant: _____

Mailing Address: _____

Work Telephone: _____

Does this person hold a license (or certification prior to 1997)? Yes No

SUPERVISOR EVALUATION

Applicant's Name _____

Supervisor _____ Title _____

Mailing Address _____

(Street or Post Office Box)

(City)

(State)

(Zip)

Supervisor's Degrees/Certifications/Licensees: _____

Work Telephone (_____) Fax Number (_____)

Program/Agency where you supervised applicant: _____

What was the job title of applicant during the time of your supervision: _____

Acceptable activities that can be credited toward the required alcohol and drug counseling hours are only those activities which are directly related to the eight (8) domains.

Dates of supervision: From _____ To _____

How many HOURS of alcohol and drug counseling did the applicant deliver under your clinical supervision: _____

How many cases (average per week) does this present: _____

What non-alcohol and drug related counseling services did the applicant deliver under your supervision: _____

How many cases (average per week) does this present: _____

How many hours of **direct** clinical supervision did/do you provide to the applicant each week (average) _____

What activities did/does your clinical supervision include:

- sign off on charts
- discuss individual cases briefly
- discuss individual cases in depth
- member of treatment team
- other (describe) _____

- A. The following items are representative of the skills needed by an alcohol and drug abuse counselor. Please evaluate the applicant only as you have direct knowledge of their demonstrated ability in each area. Mark the rating most nearly descriptive of the counselor's demonstrated skills.

NOT ACCEPTABLE	AVERAGE	ABOVE AVERAGE	
			1. SCREENING Demonstrated ability to determine treatment appropriateness and client eligibility for a particular program. Ability to use appropriate diagnostic criteria in determining eligibility and ability to suggest alternative services if necessary.
			2. INTAKE Demonstrated ability to perform the administrative and initial assessment procedures for admission to a program. Understands clearly the purpose of the process.
			3. ORIENTATION Demonstrated ability to describe to client and significant others program philosophy, program, goals, procedures and rules governing client rights, and treatment costs.
			4. ASSESSMENT Demonstrated ability to identify and evaluate an individual's strengths, weakness, problems and needs for the development of the treatment plan.
			5. TREATMENT PLANNING Demonstrated ability to work with client to identify and rank problems needing resolution, establish agreed upon goals, and to determine appropriate process and resources to be utilized.
			6. COUNSELING Demonstrated ability to utilize special skills to assist individuals, families or groups in achieving objectives through; exploration of a problem and its ramifications; examination of attitudes and feelings; consideration of alternative solutions; and decision making.
			7. CASE MANAGEMENT Demonstrated ability to utilize activities which bring services, agencies, resources or people together within a planned framework of action toward the achievement of established client goals. Ability to coordinate multiple service plans.
			8. CRISIS INTERVENTION Demonstrated ability to identify a crisis when it surfaces, attempt to mitigate or resolve the immediate problem while using the negative events to enhance the treatment efforts.

NOT ACCEPTABLE	AVERAGE	ABOVE AVERAGE	
			9. CLIENT INTERVENTION Demonstrated ability to provide information to individuals and groups concerning available alcohol and drug abuse services and resources.
			10. REFERRAL Demonstrated ability to identify the needs of the client that cannot be met by the counselor and/or agency and assisting client in utilizing available support systems and community resources. Ability to utilize other resources while maintaining appropriate client confidentiality.
			11. REPORT AND RECORDKEEPING Demonstrated ability to perform the function of documentation to assist the client's progress toward achievement of established goals; facilitate communication between co-workers and other service providers; assist supervisor in evaluating therapeutic skills and effectiveness.
			12. CONSULTATION WITH OTHER PROFESSIONALS Demonstrated ability to relate with other professionals (both alcohol and drug counselors and non-alcohol and drug professionals) to assure quality care for the client.
			13. COMMUNICATION WITH UNDER-SERVED POPULATIONS Demonstrated ability to recognize and to respond effectively to behavior, attitudes, and values unique to different ethnic, racial, religious groups, homosexual adolescents, women, elderly, and other identified underserved client groups.
			14. SKILLS ENGAGING FAMILY MEMBERS/SIGNIFICANT OTHERS Demonstrated ability to involve family members and other significant persons present in client's life into the treatment process. Ability to communicate effectively information about family systems and recovery.

B. Please evaluate the applicant as you observe him/her in the following areas of interpersonal relationship with clients:

NOT ACCEPTABLE	AVERAGE	ABOVE AVERAGE	SUPERIOR	
				1. Respect for client
				2. Care and concern for client
				3. Genuineness with client
				4. Empathy with client
				5. Flexibility with client
				6. Judgment with client
				7. Spontaneity with client
				8. Capacity for appropriate confrontation with client
				9. Capacity for appropriate self-disclosure
				10. Sense of immediacy
				11. Concreteness

C. Listed below are ten (10) basic grounds on which licensure may be refused or revoked. Please read carefully. To your knowledge, has the applicant been involved in any of the following:

- (1) Making false statements or representation, being guilty of fraud or deceit in obtaining licensure or licensure renewal, or being guilty of fraud or deceit in the practice of alcohol or drug abuse counseling. Yes No

Comment: _____

- (2) The inability to perform or the consistent unsatisfactory performance of the expected functions of a licensed alcohol and drug abuse counselor. Yes No

Comment: _____

- (3) Knowingly assisting another in the procurement of licensure or licensure renewal through false statements or misrepresentation. Yes No

Comment: _____

- (4) Misrepresentation of professional qualifications, certifications, accreditation, affiliation or employment experiences. Yes No

Comment: _____

- (5) Violations of the provisions of applicable rules or any lawful order of the Board.
Yes No

Comment: _____

- (6) Engaging in malpractice, negligence, incompetence or conduct not authorized in the course and scope of practice.
Yes No

Comment: _____

- (7) Violations of standards of patient-confidentiality, as prescribed by the laws of the State of Tennessee, the United States, or the Tennessee Department of Health.
Yes No

Comment: _____

- (8) Conviction of a felony or conviction of any crime involving moral turpitude.
Yes No

Comment: _____

- (9) Any other breach of professional ethics.
Yes No

Comment: _____

Form #5

Applicant's Name: _____

- I do
recommend the applicant for licensure as an alcohol and drug abuse counselor.
- I do not

I hereby certify that all of the information given herein is true and complete to the best of my knowledge and belief.

Signature

Date

This form must be returned to:

Board of Alcohol and Drug Abuse Counselors
665 Mainstream Drive
Nashville, TN 37243

This affidavit must be completed by all supervisors who provided the applicant supervision **AFTER** August 1, 1994.

AFFIDAVIT OF SUPERVISOR

STATE OF _____)
)
COUNTY OF _____)

1. I, _____, have provided supervision of the activities of _____ pertaining to alcohol and drug abuse counseling.
2. I understand and that, according to paragraph 1200-30-1-.10 of the rules governing Licensed Alcohol and Drug Abuse Counselors, the required qualifications for the applicant's **supervisor** are:
 - (a) Has been a licensed/certified alcohol and drug abuse counselor for at least five (5) years; **and**
 - (b) Has at least two (2) years experience supervising alcohol and drug abuse counselors; or
 - (c) Has received at least thirty-six (36) contact (clock) hours of supervision (by an approved supervisor) of his supervisory work by at least one (1) person doing alcohol and drug abuse counseling.
3. I understand that supervision provided the applicant's parents, spouse (or former spouse), aunts, uncles, grandparents, grandchildren, stepchildren, employees, former counselor, or anyone sharing the same household, shall not be acceptable toward fulfillment of licensure requirements. For the purposes of this rule, a supervisor shall not be considered an employee of the applicant, if the only compensation received by the supervisor consists of payment of actual supervisor hours.
4. I understand that qualifying supervision of my work received prior to the implementation date of the rules will be acceptable as qualified supervision.
5. I hereby attest that I meet **all** the requirements as listed above and am licensed in good standing.
6. My license number is _____ and the date my initial licensure was _____

Further the affiant saith not.

Signature of Supervisor

Sworn to and subscribed before me this the _____ day of _____, _____

Notary Public

My Commission Expires

**ALCOHOL AND DRUG ABUSE COUNSELOR
PROFESSIONAL REFERENCE**

Applicant _____

Reference's Name _____ Title _____

Address _____

City, State, Zip _____

Work phone (_____) _____

Relationship to Applicant _____ Length of time of acquaintance _____

Are you a Tennessee licensed Alcohol and Drug Abuse Counselor? Yes No

The above applicant is applying for licensure as an alcohol and drug abuse counselor. It is our request that you provide information to the Licensure Board regarding the applicant and their relationship with you and others. In addressing interpersonal relationships, it is the belief that these traits impact client care. Your evaluation is of utmost importance in this licensure process.

Please evaluate the applicant as you observe him/her in the following areas of interpersonal relationships with yourself and/or others.

NOT ACCEPTABLE	AVERAGE	ABOVE AVERAGE	SUPERIOR	
				1. Respect for client
				2. Care and concern for client
				3. Genuineness with client
				4. Empathy with client
				5. Flexibility with client
				6. Judgment with client
				7. Spontaneity with client
				8. Capacity for appropriate confrontation with client
				9. Capacity for appropriate self-disclosure
				10. Sense of immediacy
				11. Concreteness

Please complete the following statements:

The applicant may be an asset to the field of alcohol and drug abuse counseling because he/she is:

The applicant may be a liability to the field of alcohol and drug abuse counseling because he/she is:

General Comments: _____

I do recommend the applicant for licensure as an alcohol and drug abuse counselor.

I do not

I hereby certify that all of the information given herein is true and complete to the best of my knowledge and belief.

Signature

Date

This form, along with a letter of formal recommendation on your letterhead, must be sent directly to:

BOARD OF ALCOHOL AND DRUG ABUSE COUNSELORS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243



**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243**

**TENNESSEE BOARD OF ALCOHOL AND DRUG ABUSE COUNSELORS
(615) 741-5735 or (800) 778-4123 (Toll Free)**

CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top portion and then mail one form to the licensure board in EACH state where you hold OR HAVE EVER HELD a license to practice any profession. (You may copy this form.)

NOTE: Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

_____ was granted a license to practice _____
(Name of Applicant) (Profession)
with license number _____ on _____ in the State of _____.
(Date)

The Board of Alcohol and Drug Abuse Counselors of Tennessee requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:

**State of Tennessee
Board of Alcohol and Drug Abuse Counselors
665 Mainstream Drive
Nashville, TN 37243**

Date: _____
Applicant's Signature

Applicant's typed or printed name

ADMINISTRATIVE OFFICE OF STATE LICENSURE BOARD, PLEASE COMPLETE:

Name In Full As It Appears On License: _____

License Number _____ Profession _____ Date Issued _____

Basis of issuance: _____ Endorsement/Reciprocity with _____
(Check One) (State)
_____ Written Examination _____
(Name of Exam)

The License is currently active and registered? Yes _____ No _____
Is there any derogatory information on file? Yes _____ No _____ If yes, an explanation must be attached.

Authorized Signature Title Date

**BOARD OF ALCOHOL AND DRUG ABUSE COUNSELORS
JURISPRUDENCE EXAMINATION**

NAME: _____ DATE: _____

1. True False A licensee need not report suspicions of unethical conduct because only reporting of actual unethical conduct witnessed is required to be reported.
2. True False A licensee's personal experiences constitute valid research material for the purposes of stating facts as part of communications made to the public and to clients.
3. True False A licensee shall not accept as clients anyone with whom he/she has engaged in sexual behavior.
4. True False A licensee shall provide the client his/her rights regarding confidentiality, verbally or in writing, as part of informing the client in any areas likely to affect the client's confidentiality.
5. True False A licensee shall use clinical and other material in teaching and/or writing only when there is no identifying information used about the parties involved.
6. True False A licensee shall terminate a counseling or consulting relationship when it is reasonably clear to the licensee that the client is not benefiting from the relationship.
7. True False A licensee may engage in romantic relationships with former clients after two (2) years following termination of the professional relationship.
8. True False A licensee shall be deemed as competent and authorized to treat all recognized addictions.
9. True False A licensee may accept a private fee for professional work with a person who is entitled to such services through an institution regardless of whether the client is informed of such available services.
10. True False A licensee shall offer to do things for the client, even if the client is able to perform them, in order to protect the client's welfare and model appropriate behavior for the client.
11. True False A licensee who has had a change of name or address shall notify the Department of Health no later than thirty (30) days after such change has occurred.
12. True False A licensee must report to the Board all malpractice awards, judgments, and settlements over \$10,000.00.
13. True False A licensee need not report any misdemeanors pursuant to the Health Care Consumer Right-To-Know Act of 1998.

NAME: _____ DATE: _____

14. True False A licensee may be referred to a professional peer assistance program if the Board determines this is necessary.
15. True False A licensee must complete continuing education on an annual basis, regardless of their renewal period.
16. True False A licensee may use the amount of compensation from a client as a guide for determining the amount and type of services the licensee should offer.
17. True False A licensee shall seek appropriate treatment for him or herself or for a colleague should it be necessary to avoid impairment and/or harm to the counselor-client relationship.
18. True False A licensee will receive no continuing education for attending business meetings of professional addiction associations.
19. True False A licensee upon receiving his/her license is deemed qualified to provide clinical supervision to non-licensed professionals.
20. True False A licensee must submit an affidavit of retirement to the Board six (6) months in advance of the cessation of practice.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DR
NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

Name: _____
Last First Middle Maiden

Mailing Address: _____

Phone Number: Home: (____)____-____ Office: (____)____-____ Fax: (____)____-____

I am a United States Citizen: ____Yes ____No

Applicants Claiming United States Citizenship **MUST** provide one of the following:

1. Tennessee Driver's License, or photo ID issued by Department of Homeland Security.
2. A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Homeland Security criteria.
3. An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
4. A federally issued birth certificate.
5. A valid, unexpired U.S. passport.
6. A report of birth abroad of a U.S. citizen.
7. A certificate of citizenship.
8. A certificate of naturalization.
9. A U.S. citizen ID card.
10. Any successor document to #'s 4-9 above.
11. SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.

If you checked "No" please indicate from the list below which category applies to you:

_____ Permanent Residents

_____ A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).

_____ Foreign nationals not present in the United States seeking the issuance or renewal of a professional license.

- _____ Asylees who meet the qualifications set out in 8 U.S.C. 1158
- _____ Refugees who meet the qualifications set out in 8 U.S.C. 1157
- _____ Persons who have been “paroled into the United States,” under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- _____ Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
- _____ Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7)
- _____ An alien who has been “battered” or subjected to “extreme cruelty” by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims’ children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status**, please submit one or more of the following forms of “documentation of identity and immigration status” as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status:

- I-327 (Reentry Permit)
- I-551 (Permanent Resident Card or “Green Card”)
- I-571 (Refugee Travel Document)
- I-766 (Employment Authorization Card)
- Machine Readable Immigrant Visa (with Temporary I-551 language)
- Temporary I-551 stamp (on passport or I-94)
- I-94 (Arrival/Departure record)
- Unexpired foreign passport
- WT/WB Admission Stamp in unexpired foreign passport
- I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status– “student visa”)
- DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this _____ day of _____, 20__.

Signature

Sworn to before me this _____ day of _____, 20__.

NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: _____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee’s False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee’s False Claims Act. Upon discovery of an applicant’s false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.