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

APPLICATION FOR LICENSURE AS AN ALCOHOL AND DRUG ABUSE COUNSELOR

UNDERSTANDING THE APPLICATION PROCESS

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://share.tn.gov/sos/rules/1200/1200-30/1200-30.htm

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 overnight delivery 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 is 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 within 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 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. Applicants will be notified of their exam eligibility.

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.

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); and the license fee of Fifty Dollars ($50.00) for a total of Three Hundred Eighty-Five Dollars ($310.00). 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.

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. _____ **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.

9. _____ Provide a notarized photocopy of high school diploma or GED. 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. If the name on the transcript differs from the name on the application, please include the name under which the degree was granted.

10. _____ Complete and mail Clearance From Other States Form to each state, country, or province in which you hold or have ever held a license to practice any profession.

11. _____ Complete and submit the application worksheet for at least two hundred seventy (270) contact hours of classroom training.

12. _____ Philosophy of Treatment (original only)

13. _____ Completed Mandatory Practitioner Profile
http://tn.gov/assets/entities/health/attachments/PH-3585.pdf

15. _____ **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

8078-001-$300
8078-002-$ 10

Attach
Photo
Here

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 _____ RECIPROCITY _____

Name: _____
Last First Middle Maiden (if not used as your middle name)

Social Security Number: _____ U.S. Citizen: Yes ____ No____
All applicants must complete the Declaration of Citizenship form

Date of Birth: _____ Entitled to Live and Work in the U.S. Yes ____ No___

Mailing Address: _____

_____ Zip _____

Practice Address*: _____

_____

_____ Zip _____

E-mail address: _____

Do you wish to receive notifications, including renewal notification, from Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. __Yes __ No

Race: _____ Phone: Home: _____

Gender: Female _____ Male _____ Office: _____

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.) Yes ____ No _____

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.) Yes ____ No _____

Have you ever been known by any other names besides what is listed above? Yes ____ No _____

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known: _____

_____

***If you have no practice address, notify the Board of your practice address within 30 days of obtaining a practice address. If you have multiple practice address, please attach an additional page listing all practice addresses.**

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 include the name under which the degree was granted.

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. **IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION**. Additional information may be requested and/or required before a licensure decision may be made. For the purposes of these questions, the following phrases or words have the following meanings:

1. "**Ability to practice alcohol and drug abuse**" is to be construed to include all of the following:

a. The evaluation and treatment of problems, misperceptions and misconceptions of persons who abuse mood-altering chemicals;

b. The physical capability to perform alcohol and drug abuse counseling tasks such as clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities.

2. "**Medical Condition**" includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction, and alcoholism.

3."**Minor Traffic Offense**" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under intoxication or reckless driving.

4. "**Chemical substances**" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. "**Currently**" does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. "**Illegal use of illicit or controlled substances**" means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

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 against you; _____ _____

b. Have you ever had settlement of any legal action rendered against you; or _____ _____

c. Are there any legal actions pending against 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? _____ _____

(7) Are you now in good physical and mental health? _____ _____

(8) Do you have a medical condition which in any way impairs or limits your ability to practice alcohol and drug abuse counseling with reasonable skill and safety? If yes, please explain on separate sheet. _____ _____

(9) If you use chemical substance(s) do they in any way impair or limit your ability to practice alcohol and drug abuse counseling with reasonable skill and safety? If yes, please explain on separate sheet. _____ _____

(10) If you have any limitations or impairments caused by an existing medical condition are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain on separate sheet. _____ _____

PRACTICE AND LICENSURE INFORMATION

List below and submit a copy of Clearance From Other State Licensure Boards form 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 Clearance From Other State Licensure Boards form 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.

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: _____

_____

_____

_____

_____

WORK EXPERIENCE (CONT)

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: _____

_____

_____

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: _____

_____

_____

Please carefully document two hundred seventy (270) total hours of alcohol and drug education and training on this form, including six (6) hours of education in alcohol and drug ethics.

EIGHT DOMAIN HOURS

Training Event (Course/Workshop/In-Service)and Date	CLINICAL EVALUATION	TREAMENT PLANNING	REFFERAL	SERVICE COORDINATION	COUNSELING	CLIENT, FAMILY, and COMMUNITY EDUCATION	DOCUMENTATION	PROFESSIONAL And ETHICAL RESPONSIBILITIES		ELECTIVE EDUCATION	Total Hours A&D Specific	Total Work-shop Hours
SUB-TOTAL PER FUNCTION												
CUMULATIVE TOTAL PER FUNCTION												

Attach training event verification of attendance in the order in which they are listed on this form.

SUPERVISORS SUBMITTING EVALUATIONS

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: _____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____,
(Applicant's Name) *(City)* *(State)*
being duly sworn and identified as the person referred to in this application attests 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 regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a dentist in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the 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 as a dentist.

AUTHORIZE the 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 other qualifications.

RELEASE from liability the 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 the malice concerning my competence, ethics, character, other qualifications, for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

I hereby agree 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 _____ , ____.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

My commission expires: _____

SUPERVISOR EVALUATION

Applicant's Name _____

Supervisor _____ Title _____

Mailing Address _____
(Street or Post Office Box)

_____
(City) (State) (Zip)

Email Address:_____

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: _____

_____

❑ 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

AFFIDAVIT OF SUPERVISOR QUALIFICATIONS

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 1200-30-01-.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)

Is the License 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

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__.

_____ AFFIX SEAL HERE
NOTARY PUBLIC

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.