STATE OF MAINE

STATE BOARD OF
ALCOHOL AND DRUG COUNSELORS

APPLICATION FOR EXAMINATION

Department of Professional and Financial Regulation

Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8689 or (207) 624-8620
TTY/HEARING IMPAIRED (207) 624-8563
FAX: (207) 624-8637

Office located at: 122 Northern Avenue, Gardiner, Maine
Email: susan.a.greenlaw@state.me.us

Printed under appropriation 014-021-4350 Revised April 2000

APPLICATION INSTRUCTIONS
EXAMINATION FOR ALCOHOL AND DRUG COUNSELOR

1. Complete, sign, and have the application notarized.
2. Submit a copy of birth certificate, driver's license, or passport.
3. Submit two Peer Evaluations.
4. Submit one Clinical Supervisor's Evaluation Statement.
5. Submit one Supervised Practical Training Summary.
6. Submit original transcripts and/or documentation of CEU's (must include 6 hours of approved ethics training).
7. Submit a copy of driving record from the Maine Department of Motor Vehicles (or appropriate agency if you are from another state).
8. Submit a written job description signed by your supervisor.
9. Submit verification of supervised work experience:
   4000 hours with Undergraduate Degree; or
   1000 hours with Master's Degree
10. Submit $25.00 non-refundable application fee and $77.50 written examination fee - Make checks payable to Treasurer, State of Maine. If paying by credit card, please submit the enclosed authorization form with your application.
11. Submit payment of a separate $8.00 fee for a criminal records (SBI) check. Make check payable to: Treasurer, State of Maine.

The following is the written examination schedule for 2000 and 2001:

Exam Date 6/9/2000
Deadline: 3/9/2000

Exam Date: 12/8/2000
Deadline: 9/8/2000

Exam Date: 6/8/2001
Deadline: 3/8/2001

Exam Date: 12/14/2001
Deadline: 9/14/2001

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
MAINE BOARD OF ALCOHOL AND DRUG COUNSELORS
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
Direct Tel: (207) 624-8689 Receptionist: (207) 624-8603
FAX: (207) 624-8637 - TTY/ Hearing Impaired: (207) 624-8563

ANGUS S. KING, JR.
GOVERNOR

ANNE L. HEAD
DIRECTOR

APPLICATION FOR EXAMINATION

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section 405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

(1446) Application Fee: $25
Please Make Check Payable to *Treasurer, State of Maine*

Name:		
Mailing Address:		
City:	***State:***	***Zip Code:***
County:	***Telephone #: (______)________-_____________***	
Social Security #: (__ __ __)-(__ __)-(__ __ __ __)	***Date of Birth: _________________***	
Business Name:		
Business Address: (if different from mailing address)		
City:	***State:***	***Zip Code:***
County:	***Telephone #: (______)________-_____________***	

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QUALIFYING WORK EXPERIENCE

1. Name of employer:		
***2. Complete Mailing Address*:**		
City:	***State:***	***Zip Code:***
3. Your Job Title:	***Telephone #: (______)________-_____________***	
4. Term of Employment: ***From.: ________________ To: : _______________*** ***From.: ________________ To: : _______________***	***5. My employer considered this:*** ***(Check One)*** ☐ Full Time ☐ Half Time ☐ Other: ________________	
6. Was at least fifty percent of your time devoted to client-centered activities? ☐ ***YES*** ☐ ***NO***		
7. Duties:(be specific)		
8. Name and qualifications of Clinical Supervisor:		
9. From item four (4) calculate the number of months worked, multiply that number by the percent (%) of full-time indicated in item five(5). The results is months of qualifying work experience. ☐		

1. Name of employer:		
***2. Complete Mailing Address*:**		
City:	***State:***	***Zip Code:***
3. Your Job Title:	***Telephone #: (______)________-_____________***	
4. Term of Employment: ***From.: ________________ To: : _______________*** ***From.: ________________ To: : _______________***	***5. My employer considered this:*** ***(Check One)*** ☐ Full Time ☐ Half Time ☐ Other: ________________	
6. Was at least fifty percent of your time devoted to client-centered activities? ☐ ***YES*** ☐ ***NO***		
7. Duties:(be specific)		
8. Name and qualifications of Clinical Supervisor:		
9. From item four (4) calculate the number of months worked, multiply that number by the percent (%) of full-time indicated in item five (5). The results is months of qualifying work experience.		

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QUALIFYING WORK EXPERIENCE (cont'd)

1. Name of employer:

2. Complete Mailing Address:

City:	***State:***	***Zip Code:***

3. Your Job Title: ***Telephone #: (______)________-____________***

4. Term of Employment:

From.: ________________ To: : _______________

From.: ________________ To: : _______________

5. My employer considered this: ***(Check One)***

☐ Full Time ☐ Half Time

☐ Other: ________________

6. Was at least fifty percent of your time devoted to client-centered activities?

☐ ***YES*** ☐ ***NO***

7. Duties:(be specific)

8. Name and qualifications of Clinical Supervisor:

9. From item four (4) calculate the number of months worked, multiply that number by the percent (%) of full-time indicated in item five(5). The results is months of qualifying work experience. ☐

---

1. Name of employer:

2. Complete Mailing Address:

City:	***State:***	***Zip Code:***

3. Your Job Title: ***Telephone #: (______)________-____________***

4. Term of Employment:

From.: ________________ To: : _______________

From.: ________________ To: : _______________

5. My employer considered this: ***(Check One)***

☐ Full Time ☐ Half Time

☐ Other: ________________

6. Was at least fifty percent of your time devoted to client-centered activities?

☐ ***YES*** ☐ ***NO***

7. Duties:(be specific)

8. Name and qualifications of Clinical Supervisor:

9. From item four (4) calculate the number of months worked, multiply that number by the percent (%) of full-time indicated in item five (5). The results is months of qualifying work experience.

VOLUNTEER WORK EXPERIENCE

1. Name of employer:		
***2. Complete Mailing Address*:**		
City:	***State:***	***Zip Code:***
3. Your Job Title:	***Telephone #: (______)________-____________***	
4. Term of Employment: ***From.:*** ________________ ***To: :*** _______________ ***From.:*** ________________ ***To: :*** _______________	***5. My employer considered this:*** ***(Check One)*** ☐ Full Time ☐ Half Time ☐ Other: ________________	
6. Was at least fifty percent of your time devoted to client-centered activities? ☐ ***YES*** ☐ ***NO***		
7. Duties:(be specific)		
8. Name and qualifications of Clinical Supervisor:		
9. From item four (4) calculate the number of months worked, multiply that number by the percent (%) of full-time indicated in item five(5). The results is months of qualifying work experience. ☐		

---

1. Name of employer:		
***2. Complete Mailing Address*:**		
City:	***State:***	***Zip Code:***
3. Your Job Title:	***Telephone #: (______)________-____________***	
4. Term of Employment: ***From.:*** ________________ ***To: :*** _______________ ***From.:*** ________________ ***To: :*** _______________	***5. My employer considered this:*** ***(Check One)*** ☐ Full Time ☐ Half Time ☐ Other: ________________	
6. Was at least fifty percent of your time devoted to client-centered activities? ☐ ***YES*** ☐ ***NO***		
7. Duties:(be specific)		
8. Name and qualifications of Clinical Supervisor:		
9. From item four (4) calculate the number of months worked, multiply that number by the percent (%) of full-time indicated in item five (5). The results is months of qualifying work experience.		

WORK-BASED EDUCATIONAL EXPERIENCE

1. Name of employer:				
2. Complete Mailing Address:				
City:	*State:*		*Zip Code:*	
3. Your Job Title:	*Telephone #: (______)________-____________*			
4. Term of Employment: *From.: ________________ To: : _______________* *From.: ________________ To: : _______________*		*5. My employer considered this:* *(Check One)* ☐ Full Time ☐ Half Time ☐ Other: ________________		
6. Was at least fifty percent of your time devoted to client-centered activities? ☐ *YES* ☐ *NO*				
7. Duties:(be specific)				
8. Name and qualifications of Clinical Supervisor:				
9. From item four (4) calculate the number of months worked, multiply that number by the percent (%) of full-time indicated in item five(5). The results is months of qualifying work experience. ☐				

TOTAL OF QUALIFYING WORK EXPERIENCE

1. Paid work experience	
2. Volunteer work experience. *(Can equal no more than 10% of total qualifying experience.)*	
3. Worked-based educational experience. *(Can equal no more than 50% of total qualifying experience.)*	
4. Total qualifying work experience. *(Add one through three above.)*	

PLEASE NOTE: If total qualifying work experience above is less than 24 months, or 6 months for master level counselors, you are presently ineligible for licensure.

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	School Name and Address	Credit Hours	Dates Graduated	Major	Minor	Degree	Number of Relevant Hours	Credit Hours
High School								
GED								
College								
Graduate								
Post Graduate								
Other								

If additional space is needed, please attach a separate sheet. OFFICIAL TRANSCRIPTS VERIFYING RELEVANT SOCIAL SCIENCE CREDITS MUST BE SENT DIRECTLY TO THE BOARD. The applicant is responsible for all costs incurred in the submission of transcripts.

TOTAL OF QUALIFYING EDUCATION EXPERIENCE

1. Total CEUs accumulated through training. (per Chapter I: Section 4.A.2 of the Rules)	
2.Total relevant credit hours(from EDUCATION Section above)	
3. Total qualifying education experience. (Add one and two above.)	

Note on a separate sheet any special knowledge or training that you consider to be relevant to your performance as a alcohol and drug counselor. Also list any special licenses, certificates, membership in professional organizations or awards that you feel support this application. Final determination of relevance shall be at the discretion of the Board.

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REFERENCES

Full and accurate assessment of counseling competence requires a knowledge of the actual performance of the counselor in the field. To satisfy this requirement, the Board will request you present clinical supervisor to provide an evaluation of your knowledge and competency as a alcohol and drug counselor. In addition, at least two (2) other persons of your choosing who have direct knowledge of your work experience should be contacted. Please furnish the names, mailing addresses and telephone numbers of these persons to whom you are sending evaluation forms so that we may ascertain receipt of the requested information. The appropriate evaluation forms are attached.

Name:		
Mailing Address:		
City:	*State:*	*Zip Code:*
County:	*Telephone #: (______)________-_____________*	

Name:		
Mailing Address:		
City:	*State:*	*Zip Code:*
County:	*Telephone #: (______)________-_____________*	

Name:		
Mailing Address:		
City:	*State:*	*Zip Code:*
County:	*Telephone #: (______)________-_____________*	

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AFFIDAVIT/DISCIPLINARY RECORD

1. Have you ever been convicted by any court for any offense other than a minor traffic violation?

   ☐ YES ☐ NO

- If yes, please list date(s), and conviction(s) on a separate sheet of paper and submit a copy of the court judgement with this application.

2. Have any of your occupational licenses, registrations or certifications ever been revoked or suspended in this or any other state?

   ☐ YES ☐ NO

- If yes, please list date(s) of suspension or revocation, type of license, registration or certification and state where occurred on a separate sheet of paper.

3. Do you have any pending complaints from a licensing board or professional counseling organization?

   ☐ YES ☐ NO

- If yes, please attach an explanation.

4. Have you been, or are you currently, a defendant in a civil proceeding related to the counseling profession?

   ☐ YES ☐ NO

- If yes, please attach an explanation.

Please provide a copy of your driving record from the Maine Division of Motor Vehicles (or appropriate agency if you are from another state).

I hereby certify that all of the information given herein is true and complete to the best of my knowledge and belief. I also authorize any necessary investigations and the release of personal information to the State Board of Alcohol and Drug Counselors and its agents.

I understand that falsification of any portion of this application will result in my being denied licensure, or revocation of same, upon discovery.

I understand that the fee of $25.00 submitted herewith represents the priliminary application fee, which is non-refundable. The Board will require an additional fee for examination and licensure.

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I agree to hold the State Board of Alcohol and Drug Counselors and its Board members, officers, agents, staff, peer evaluators, and examiners free from any civil liability for damages or complaints by reason of any action that is within the scope and arising out of the performance of their duties which they, or any of them, may take in connection with this application, the attendant examination, the grades with respect to any examination, an/or the failure of the Board to issue me a certificate of licensure.

The Ethics Committee of the International Certification Reciprocity Consortium has established a Disciplinary Information System (DIS) data bank which will list the ICRC certified counselors who has been sanctioned by their boards for violation of ethical standards and document the sanctions taken (i.e., revocation, suspension, etc.) The purpose of the DIS is to protect the consumer of alcohol and drug abuse counseling services from those individuals who have been proven to have violated the ethical boundaries required of professionals in this field.

The name of a Licensed Alcohol and Drug Counselor (LADC) in the State of Maine may be reported to the ICRC's DIS if he/she is sanctioned by the Board for violations of ethical standards.

AFFIDAVIT/DISCIPLINARY RECORD

By signing this statement, I acknowledge that I have read, understand, and agree to uphold the counselor Code of Ethics as it appears in the Rules of the Board and that I have been notified that my name may be reported to the International Certification Reciprocity Consortium Disciplinary Information System (DIS) data bank if I am sanctioned by the Maine State Board of Alcohol and Drug Counselors for violating the professional ethical standards of that Board.

____________________ ____

Date **Signature of Applicant**

Subscribed and sworn before me on this _____________ day of _______________

, 2000 My Commission expires: ______________________

Notary Public Signature: ____

PEER EVALUATION
(2 PEER EVALUATIONS REQUIRED)

Applicant's Name: ____

I hereby certify that I have observed and have first hand knowledge of the applicant's work at____
Name of work setting
during the time period from ___________________________ until ___________________

Please comment on:

- Applicant's knowledge of the substance abuse treatment process.

- Applicant's ability to work independently.

- Applicant's suitability for private practice.

Would you recommend that this applicant be licensed as a substance abuse counselor?
_ Yes _ No If no, please explain:

Additional comments: (if additional space is needed, please attach a second sheet).

Please type or print:

Evaluator's name:
Evaluator's position:
Name of organization:
Business phone:

____ ____________________
Evaluator Signature ***Date***

RETURN TO: STATE BOARD OF ALCOHOL AND DRUG COUNSELORS, 35 STATE HOUSE STATION, AUGUSTA, ME 04333

Printed under appropriation 014-021-4350 Revised April 2000

PEER EVALUATION
(2 PEER EVALUATIONS REQUIRED)

Applicant's Name:____

I hereby certify that I have observed and have first hand knowledge of the applicant's work at____

Name of work setting

during the time period from _____________ until _____________

Please comment on:

- Applicant's knowledge of the substance abuse treatment process.

- Applicant's ability to work independently.

- Applicant's suitability for private practice.

Would you recommend that this applicant be licensed as a substance abuse counselor?
_ Yes _ No If no, please explain:

Additional comments: (if additional space is needed, please attach a second sheet).

Please type or print:

Evaluator's name:
Evaluator's position:
Name of organization:
Business phone:

_______________________________________ _______________

Evaluator Signature ***Date***

RETURN TO: STATE BOARD OF ALCOHOL AND DRUG COUNSELORS, 35 STATE HOUSE STATION, AUGUSTA, ME 04333

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CLINICAL SUPERVISOR'S EVALUATION STATEMENT

Applicant's Name:____

I hereby certify that I have observed and have first hand knowledge of the applicant's work at____

Name of work setting

during the time period from _______________ until _______________

Please comment on:

- Applicant's knowledge of the substance abuse treatment process.

- Applicant's ability to work independently.

- Applicant's suitability for private practice.

Would you recommend that this applicant be licensed as a substance abuse counselor?
_ Yes _ No If no, please explain:

Additional comments: (if additional space is needed, please attach a second sheet).

Please type or print:

Evaluator's name:
Evaluator's position:
Name of organization:
Business phone:

_______________________________________ __________________

Evaluator Signature ***Date***

RETURN TO: STATE BOARD OF ALCOHOL AND DRUG COUNSELORS, 35 STATE HOUSE STATION, AUGUSTA, ME 04333

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SUPERVISED PRACTICAL TRAINING SUMMARY

Name:	Social Security Number:

Supervised Practical Training includes activities desinged to provide training in specific counselor functions. These activities are monitored by supervisory personnel who provide timely positive and negative feedback to assist the Counselor in this learning process. If you received no formal training, your past work experience may be acceptable. In this case, please thoroughly document such experience, explaining how you learned to be a Counselor.

TYPES OF TRAINING:	**ON-THE-JOB TRAINING (OJT)**	**IN-SERVICE TRAINING PROGRAM (TP)**	**PAST WORK EXPERIENCE (PWE)**	
FUNCTIONS	**# OF HRS**	**AGENCY**	**TYPE OF TRAINING**	**PERSON DOING THE TRAINING**
Screening				
Intake				
Orientation				
Assessment				
Treatment Planning				
Counseling				
Case Management				
Crisis Intervention				
Client Education				
Referral				
Reports & Recordkeeping				
Consultation with Other Professionals				

Total Hours_______________ (Should be 300 hours for licensure) Note: See Chapter 1, Section VI of the Rules.

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
MAINE BOARD OF ALCOHOL AND DRUG COUNSELORS
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

ANGUS S. KING, JR.
GOVERNOR

ANNE L. HEAD
DIRECTOR

TO: PROSPECTIVE APPLICANT

FROM: OFFICE OF LICENSING & REGISTRATION

RE: CRIMINAL RECORDS CHECK

Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration **requires** a criminal history records check as part of the application process for all applicants.

CRIMINAL HISTORY RECORDS CHECK PROCEDURE

Attached is a form addressed to the Maine Department of Public Safety, Bureau of Identification. Please complete the applicant information section of the enclosed form and send it to the appropriate licensing board with your completed application and supporting documentation as may be necessary. **Do not send the request directly to the Department of Public Safety.**

Public Law Chapter 401, sec. W-1, amends Title 25 §1541, sub-§6 to allow the State Bureau of Identifications to charge a fee to government organizations for services provided. Therefore, as of October 1, 1999 all criminal background checks of individuals are subject to a fee as determined by the Commissioner of Public Safety.

You must provide a separate check in the amount of $8.00, made payable to Maine State Treasurer, as payment for your criminal history record check in addition to the licensing fees presently required. Please note that the criminal history record will be returned to the licensing board, not the applicant.

Please contact the board clerk at the number below if you have questions or need assistance.

(Clerk Name and Phone Number) **Sue Greenlaw**
(207) 624-8689

PHONE: (207)624-8689
(Office Phone)

PRINTED ON RECYCLED PAPER

FAX: (207)624-8637

(207)624-8563 (HEARING IMPAIRED)
OFFICES LOCATED AT: 122 NORTHERN AVENUE,
GARDINER, MAINE

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STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
MAINE BOARD OF ALCOHOL AND DRUG COUNSELORS
35 STATE HOUSE STATION
AUGUSTA, MAINE
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ANGUS S. KING, JR.
GOVERNOR

ANNE L. HEAD
DIRECTOR

CRIMINAL HISTORY RECORD CHECK FEE: $8.00

Make checks payable to: Treasurer, State of Maine
Submit this Application with License Application

APPLICANT INFORMATION

Name:____
Last **First** **Middle**

Address: ____

Social Security/Federal I.D. #:______________ **Date of Birth:** ______________

Any other names used:____

Please return the criminal history record information or a notice of no record to the following:

REQUESTING AGENCY INFORMATION

(Office Use Only)

Date:______________ **Contact Person:** **SUE GREENLAW**

Agency Name & Address: **Office of Licensing and Registration**
MAINE BOARD OF ALCOHOL AND DRUG COUNSELORS
35 State House Station
Augusta, Maine 04333-0035

PRINTED ON RECYCLED PAPER

FAX: (207)624-8637

PHONE: (207)624-8689
(Office Phone)

(207)624-8653 (TTY/HEARING IMPAIRED)
OFFICES LOCATED AT: 122 NORTHERN AVENUE, GARDINER, MAINE

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35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

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ANNE L. HEAD
DIRECTOR

AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: **(applicant fees being paid for)**		
***Mailing Address*:** **(applicant fees being paid for)**		
City:	***State:***	***Zip Code:***
County:	***Telephone #: (_____)________-____________***	
Name of cardholder: **(if other than applicant)**		
***Mailing Address*:** **(if other than applicant)**		
City:	***State:***	***Zip Code:***

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ **Visa** ☐ **MasterCard** ____
Card number

Expiration date: _________/______/______ in the amount of: $______________________

Signature: ____Date: ______/______/________

PHONE: (207)624-8689
(Office Phone)

PRINTED ON RECYCLED PAPER
(207)624-8563 (TTY/HEARING IMPAIRED)

FAX: (207)624-8637

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04333-0035

ANGUS S. KING, JR.
GOVERNOR

ANNE L. HEAD
DIRECTOR

ACCOMMODATION REQUEST FORM

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission

Name: ____

Address: ____

Telephone #: _______________________ Social Security Number: _______________________

Accommodations Requested for the ______________________ Examination.

Disability _____________________________

Please check all that apply

- ❑ **Accessible Testing Site**
- ❑ **Separate Testing Site**
- ❑ **Braille**
- ❑ **Large Print**
- ❑ **Tape**
- ❑ **Reader as Accommodation for Visual Impairment**
- ❑ **Scribe/Amanuensis as Accommodation for Visual or Motor Impairment**
- ❑ **Reader as Accommodation for Learning Disability**
- ❑ **Scribe/Amanuensis as Accommodation for Learning**
- ❑ **Sign Language Interpreter**
- ❑ **Extended Time**
  - ❑ **Time-and-a-half**
  - ❑ **Double time**
  - ❑ **More than double time (specify)** _____________
- ❑ **Use of Computer or Other Adaptive Equipment (specify)** ____________________
- ❑ **Other:**

____

Signed and dated:

DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known ______________________________________ **since** _________________________ **in my capacity as a**

(Test applicant) **(date)**

____

(Professional title)

The applicant has discussed with me the nature of the test to be administrated. It is my opinion that because of this applicant's disability, providing the following should accommodate him/her: **(check all types)**

- ❑ **Taped test**
- ❑ **Large print test**
- ❑ **Reader**
- ❑ **Scribe/amanuensis**
- ❑ **Extended time**
  - ❑ **Time-and-a-half**
  - ❑ **Double time**
  - ❑ **More that double time** **(please justify)** ____
- ❑ **Separate Testing Area**
- ❑ **Use of Computer or Other Adaptive Equipment** **(please specify)** ___________________
- ❑ **Other** **(please specify)** ____

Signed: ____ **Title:** _______________________

Date: ____________________ **License #** **(if applicable):** _________________________________