



# State of Maine

## STATE BOARD OF ALCOHOL AND DRUG COUNSELORS

Application information to assist in completing your application. This information is not designed to include all information on laws and rules and it is strongly recommended that you review applicable laws and rules.

### **Application for Licensure by Endorsement** ***Certified Alcohol and Drug Counselor (CADC)*** ***Licensed Alcohol and Drug Counselor (LADC)*** ***Certified Clinical Supervisor (CCS)***

Do not return the informational pages of this packet;  
these are for you to retain  
Submit only the application and required documents

Department of Professional and Financial Regulation  
Office of Professional and Occupational Regulation  
(Mailing address) 35 State House Station, Augusta, ME 04333  
(Office location) Gardiner Annex, 76 Northern Avenue, Gardiner, Maine 04345

**Note: The office location address may only be used for overnight deliveries. The office address does not accept postal deliveries. You must use the mailing address for all other regular mail deliveries.**

Office Direct Line (207) 624-8689 or Main Receptionist (207) 624-8603  
TTY users call Maine relay 711  
FAX (207) 624-8637  
Web address: [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing)  
Email: [alcoholdrug.lic@maine.gov](mailto:alcoholdrug.lic@maine.gov)

## APPLICATION INSTRUCTIONS

### LICENSURE BY ENDORSEMENT

**Helping Tool:** This is a checklist to help you identify the documents for submission with your application. (This is an abbreviated checklist and does not replace the requirements outlined in the Alcohol and Drug Counseling Laws and Rules. Please review them carefully for more detailed and clarifying information.) You must submit a complete application and all required documents and information.

**Fax submissions of applications and supporting documentation will not be accepted.**

- **Completed Application**

Complete and sign the application (being sure the Board-Certified Clinical Supervisor portion has been completed and signed by your Board-Certified Clinical Supervisor) and submit with the appropriate fees and documentation.

- **Proof of age**

A copy of your official birth certificate or other official legal document is acceptable.

- **Proof of Clinically Supervised Work Experience**

Submit completed verification of clinically supervised work experience form.

CADC - see 32 MRS §6214-C

LADC - see 32 MRS §6214-D

CCS - see Board Rules, Chapter 6

- **Proof of Education**

Submit documentation of the highest education you have obtained.

- **Examination Results**

Submit proof of passing the required applicable IC&RC written examinations:

CADC - ADC (AODA) Examination (Board Rules, Chapter 4, Section 5)

LADC - ADC (AODA) & AADC (Advanced AODA) Examinations **or** ADC (AODA),

CPM and Oral Examinations

(Board Rules, Chapter 5, Section 4)

CCS - CS (CCS) Examination (Board Rules, Chapter 6, Section 4)

\*\*If you have not taken exams in another state or jurisdiction you may be required to take exams in order to qualify for licensure.

- **Motor Vehicle Report**

Submit a 10-year non certified motor vehicle report of your driving record from the Bureau of Motor Vehicles (or appropriate agency if you are from another state). This report must contain your name and must be current. You can obtain a report from the Bureau of Motor Vehicles at <http://www.informe.org/bmv/drc/index.html> or please call 624-9000.

- **Any other supporting documentation such as: verification of licensure or criminal conviction information.**

- ◆ Submit verification from every state or jurisdiction in which you currently hold or have ever held any type of professional license (except Maine).
- ◆ Court judgment and decision of any criminal conviction and a signed, detailed, written statement regarding the crime.

**INITIAL EACH PAGE OF YOUR APPLICATION WHERE NOTED.** Be sure to initial the bottom of each page where noted on your application. All pages requiring initials must be returned to our office as part of your complete application.

The State Board of Alcohol and Drug Counselors requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted.** Applications that are incomplete, altered, defaced, or compromised will not be accepted and will be returned. This includes, but not limited to, unanswered questions, lack of appropriate signature, information is illegible, missing supporting documents, and/or missing or wrong fee.

**NOTE:**

If you are applying for various levels of licensure such as Alcohol and Drug Counseling Aide, (CADC), (LADC), or (CCS), you must submit all required documentation for each license category you are applying for at the time you submit your application. **Submitting a complete application will optimize our ability to process your application quickly.**

Processing Time

- ✓ Your application has greater chance of being processed expeditiously if it is complete and all supporting documents are attached. Action on this application is posted to the web in real time. Please visit our website if you wish to monitor progress. If the status appears as Pending, this means that your application was received by this office and it is pending or under review. Once reviewed and if everything about your application is complete and complies with requirements, the license will be issued and the status will show as ACTIVE. If incomplete and a letter is being sent to you, the letter will be available for you to see online.
- ✓ Please refrain from calling our office to “check” on your application as these calls only serve to slow our ability to review and process applications. Information regarding the status of applications may be found at the Office of Professional and Occupational Regulation’s website [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing). We appreciate your thoughtful attention to this request.
- ✓ Once your license is issued it is immediately visible online with an “active” status. Licenses are printed off site and require at least 14 business days for delivery.

## VERIFICATION OF LICENSURE

If you hold or have held a professional license in another state or jurisdiction, you must submit evidence from the State of licensure in the form of a License Verification.

Please contact the state of licensure to request an official License Verification. At a minimum, the license verification must contain:

- Name of State providing the License Verification
- Your name
- License number and expiration date
- Status of your license i.e. active, inactive, lapsed, probation, restricted, suspended, revoked...
- Type of license issued to you
- Date your license was issued
- If appropriate, hours of internship completed with beginning and ending dates
- Method your license was issued i.e. Original State, Reciprocity/Endorsement, Score Transfer
- Examinations taken i.e. ICRC Examinations, Jurisprudence, other
- Disciplinary action(s) against your license, if any
- Signature and title of person from the licensing jurisdiction providing License Verification
- State Seal

Please direct the licensing jurisdiction to send the License Verification report to you directly and in turn you must submit this verification with your completed Maine application.

A sample license verification is available on the Board's website in the applications and forms section.

**IMPORTANT:** Applications submitted without all of the Verifications of Licensure from the licensing jurisdiction(s) will not be accepted and your application returned as incomplete.

You may also obtain an electronically produced License Verification directly from the State Board website. For electronic License Verifications please be sure that it contains the State web-address, date the License Verification was printed, and any indication of disciplinary history, e.g. no discipline or discipline. If discipline is indicated, please submit a copy of the discipline imposed such as the Board Order or Agreement.

STATE OF MAINE DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION  
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION

**Mailing Address:** 35 State House Station, Augusta, Maine 04333 - **Courier/Delivery address:** 76 Northern Avenue, Gardiner, Maine 04345  
Phone: (207) 624-8603 Fax: (207) 624-8637 TTY users call Maine relay 711 web: [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing)

### Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035
- **Where are you located?** Gardiner Annex, 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** 8:00 AM to 5:00 PM weekdays
- **Can I come to Gardiner to drop off my application?** Yes. You will not leave with a license, though.
- **Can I come to Gardiner to pick up my license?** No. Your license will be mailed to you.
- **How long does it take to process an application?** You can check our website: [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing). Your license will show up as PENDING at first; as soon as your status is ACTIVE you are authorized to practice.
- **How far back do I go answering the criminal question?** Any conviction, ever.

### NOTICES

**BACKGROUND CHECK:** Pursuant to 5 MRS §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Professional and Occupational Regulation requires a criminal history records check as part of the application process for all applicants.

**PUBLIC RECORD:** This application is a public record for purposes of the Maine Freedom of Access Law (1 MRS §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

**SOCIAL SECURITY NUMBER:** The following statement is made pursuant to the Privacy Act of 1974. Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 36 MRS §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(c)(2)(C)(i)). 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 MRS §191.

#### Before you seal the envelope, did you:

- Complete every item on the application (incomplete applications may be returned)
- Answer the criminal background disclosure questions
- Sign and date your application
- Include correct amount (payable to Maine State Treasurer) or credit card information (plus signature)
- Include any required transcripts or exam results
- Make a copy of your application to keep for your records
- DO NOT SEND CASH.



**STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION  
INDIVIDUAL LICENSE APPLICATION**

APPLICANT INFORMATION (please print)

FULL LEGAL NAME      *FIRST*                      *MIDDLE INITIAL*                      *LAST*

ANY OTHER NAMES EVER USED:

DATE OF BIRTH      *mm / dd / yyyy*                      SOCIAL SECURITY NUMBER      -      -

MAILING ADDRESS

CITY                      STATE                      ZIP                      COUNTY

PHONE # (    )                      FAX # (    )                      E-MAIL

**CRIMINAL BACKGROUND DISCLOSURE**

*NOTE: Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.*

**1. Have you ever been convicted by any court of any crime?**  
(circle one)                      **NO**                      **YES**

If yes, enclose a signed detailed description of what happened (including dates) and a copy of the court judgment.

**2. Has any state or jurisdiction taken disciplinary action against any professional license you hold or have held, or denied your application for licensure? (circle one)**                      **NO**                      **YES**

If yes, enclose a signed detailed explanation and copies of all documents.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Professional and Occupational Regulation will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.

**SIGNATURE**                      **DATE**

**State Board of Alcohol and Drug Counselors  
Licensure By Endorsement for  
CADC, LADC or CCS**

**LICENSE TYPE: (CHECK BOX)**

**CADC**—CERTIFIED ALCOHOL AND DRUG COUNSELOR (CAC) - TOTAL REQUIRED FEES: **\$61.00**  
(INCLUDES LICENSE AND CRIMINAL RECORDS CHECK)

**LADC**—LICENSED ALCOHOL AND DRUG COUNSELOR (LC) - TOTAL REQUIRED FEES: **\$61.00**  
(INCLUDES LICENSE AND CRIMINAL RECORDS CHECK)

**CCS**—CERTIFIED CLINICAL SUPERVISOR (CCS) - TOTAL REQUIRED FEES: **\$ 61.00**  
(INCLUDES LICENSE AND CRIMINAL RECORDS CHECK)

**(FEES ARE NON-REFUNDABLE)**

*Office Use Only:*

ALL	2619 - \$21.00
CAC	1421 - \$40.00
LC	1421 - \$40.00
CCS	1421 - \$40.00

Check # \_\_\_\_\_  
Amount: \_\_\_\_\_  
Cash # \_\_\_\_\_  
Lic. # \_\_\_\_\_

**PAYMENT OPTIONS:**

Make checks payable to "Maine State Treasurer" - If you wish to pay by Mastercard or Visa, fill out the following:

NAME OF CARDHOLDER (please print)      *FIRST*                      *MIDDLE INITIAL*                      *LAST*

I authorize the Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation to charge my       VISA                       MASTERCARD      the following amount: \$ \_\_\_\_\_  
 I understand that fees are non-refundable

Card number:      *XXXX-XXXX-XXXX-XXXX*                      Expiration Date      *mm / yyyy*

**SIGNATURE**                      **DATE**

**SECTION 1: EDUCATION**

Please check one:		
<input type="checkbox"/> High School Diploma or GED	<input type="checkbox"/> MHRT/C	
<input type="checkbox"/> Associate's Degree	<input type="checkbox"/> Substance Abuse Rehabilitation Certificate	
<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Master's Degree	<input type="checkbox"/> Other describe: _____
Name of Educational Provider		Date of Graduation
Contact Address: _____ Street or P.O. Box _____		
City	State	Zip Code
Official transcript demonstrating your education must be submitted with your application		

**SECTION 2: LIST BELOW EVERY STATE OR JURISDICTION IN WHICH YOU HOLD OR HAVE EVER HELD A PROFESSIONAL LICENSE.**

1. State, Territory, Country	License Number/Type	Date Issued	Expiration Date
2. State, Territory, Country	License Number/Type	Date Issued	Expiration Date
3. State, Territory, Country	License Number/Type	Date Issued	Expiration Date
4. State, Territory, Country	License Number/Type	Date Issued	Expiration Date

**INITIALS OF APPLICANT**

**SECTION 3: EXAMINATION**

<p>Have you ever taken an ICRC examination?</p> <p>If yes, list the jurisdiction(s) where you took the examination, type of examination, date of examination and score:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr style="background-color: #e0e0e0;"> <th style="width: 25%;">Location Site City, State</th> <th style="width: 25%;">Examination Type</th> <th style="width: 25%;">Date</th> <th style="width: 25%;">Score</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Location Site City, State	Examination Type	Date	Score													<input type="checkbox"/> Yes <input type="checkbox"/> No
Location Site City, State	Examination Type	Date	Score														

**SECTION 4: FOR CERTIFIED CLINICAL SUPERVISOR'S ONLY: QUALIFYING LICENSE INFORMATION**

List your qualifying license i.e. LCPC, LADC, LCSW etc. See 32 MRS §6212(12) and Board Rules Chapter 6.

License Type	License Number	Expiration Date

**CONTINUING EDUCATION**

Submit certificate of attendance of 30 hours of didactic training in clinical supervision.

**SECTION 5: CHECK APPROPRIATE RESPONSE TO THE QUESTIONS BELOW. ANY YES RESPONSE MUST BE FULLY EXPLAINED BY WRITTEN STATEMENT ON A SEPARATE SHEET OF PAPER, SIGNED AND DATED, AND SUBMITTED WITH YOUR APPLICATION.**

<p>Have you had hospital or similar health care institution privileges denied or suspended, restricted or withdrawn involuntarily; or have you ever voluntarily surrendered privileges or resigned from staff membership while under peer review?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Have you ever received a sanction from Medicare or from a state Medicaid program?</p> <p>1. <input type="checkbox"/> Medicare <u>OR</u> <input type="checkbox"/> Medicaid Program (State) _____</p> <p>2. Submit a copy of the official action by the entity.</p> <p>3. Provide a detailed explanation in your own words on a separate sheet of paper.</p> <p>Clarification on programs:</p> <ul style="list-style-type: none"> <li>• Medicare – Health program administered by the United States government for people that are (1) ages 65 or older, (2) under the age of 65 with certain disabilities, and/or (3) all ages with end-stage renal disease.</li> <li>• Medicaid – Health program administered by the United States government for people with limited incomes.</li> <li>• MaineCare – Health program administered by the State of Maine with similar eligibility requirements as Medicaid.</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**INITIALS OF APPLICANT**

## **SECTION 6: NOTICES**

### **Please Note:**

Pursuant to 10 MRS §8003-G - any change in name, address, email address, criminal convictions, disciplinary actions, or any material change set forth in your original application for licensure must be reported to the Office within 10 days.

You can access this Law for your review at:

<http://www.mainelegislature.org/legis/statutes/10/title10ch901sec0.html>

## **SECTION 7: APPLICANT'S CERTIFICATION AND SIGNATURE**

Read the statement below and sign where indicated as your certification of the information provided on this application. Applications that are incomplete, altered (including use of any white out), defaced, or compromised will not be accepted and will be returned. This includes, but not limited to, unanswered questions, lack of appropriate signature, information is illegible, missing required supporting documents, and/or missing or wrong fee.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application I understand that the Maine Board of Alcohol & Drug Counselors will rely upon this information for issuance of my license and that this information is truthful and factual. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

Applications that are incomplete, altered (including the use of any white out substance), defaced, or compromised will not be accepted and will be returned. This includes, but is not limited to, unanswered questions, lack of appropriate signature, information is illegible, missing supporting documents, and/or missing or wrong fee.

Printed Name of Applicant	Title
Signature of Applicant	Date
	



STATE OF MAINE  
 DEPARTMENT OF PROFESSIONAL  
 AND FINANCIAL REGULATION  
**STATE BOARD OF ALCOHOL AND DRUG COUNSELORS**  
 35 STATE HOUSE STATION  
 AUGUSTA, MAINE 04333-0035  
 TEL:(207)624-8603 – FAX:(207)624-8637

**VERIFICATION OF CLINICALLY SUPERVISED EXPERIENCE**

Name of Applicant:		
Address:		
City:	State:	Zip:
Applicant's Job Title:		Telephone #:

**The following section is to be completed by employer or supervisor only**

Name of Agency: \_\_\_\_\_

Address: \_\_\_\_\_

**Clinically supervised work experience must be obtained while licensed. Please include the applicant's valid license type and number.**

Date of employment/ Dates worked to obtain hours (mm/yyyy)	Applicant's License Type	Applicant's License Number	Work area of practice that was Supervised in the practice of Alcohol and Drug Counseling (Check all that apply)	Number of Hours of Clinically Supervised Work Experience in the practice of Alcohol and Drug Counseling
From: _____ To: _____			<input type="checkbox"/> Screening <input type="checkbox"/> Intake <input type="checkbox"/> Orientation <input type="checkbox"/> Assessment <input type="checkbox"/> Client education <input type="checkbox"/> Referral <input type="checkbox"/> Case management <input type="checkbox"/> Crisis intervention <input type="checkbox"/> Reports and record keeping <input type="checkbox"/> Treatment planning <input type="checkbox"/> Individual, group & family counseling <input type="checkbox"/> Consultation with other Professionals	
From: _____ To: _____			<input type="checkbox"/> Screening <input type="checkbox"/> Intake <input type="checkbox"/> Orientation <input type="checkbox"/> Assessment <input type="checkbox"/> Client education <input type="checkbox"/> Referral <input type="checkbox"/> Case management <input type="checkbox"/> Crisis intervention <input type="checkbox"/> Reports and record keeping <input type="checkbox"/> Treatment planning <input type="checkbox"/> Individual, group & family counseling <input type="checkbox"/> Consultation with other Professionals	

**VERIFICATION OF CLINICALLY SUPERVISED EXPERIENCE  
(Continued)**

Date of employment/ Dates worked to obtain hours (mm/yyyy)	Applicant's License Type	Applicant's License Number	Type of Work Experience that was Supervised in the practice of Alcohol and Drug Counseling (Check all that apply)	Number of Hours of Clinically Supervised Work Experience in the practice of Alcohol and Drug Counseling
From: _____ To: _____			<input type="checkbox"/> Screening <input type="checkbox"/> Intake <input type="checkbox"/> Orientation <input type="checkbox"/> Assessment <input type="checkbox"/> Client education <input type="checkbox"/> Referral <input type="checkbox"/> Case management <input type="checkbox"/> Crisis intervention <input type="checkbox"/> Reports and record keeping <input type="checkbox"/> Treatment planning <input type="checkbox"/> Individual, group & family counseling <input type="checkbox"/> Consultation with other Professionals	
From: _____ To: _____			<input type="checkbox"/> Screening <input type="checkbox"/> Intake <input type="checkbox"/> Orientation <input type="checkbox"/> Assessment <input type="checkbox"/> Client education <input type="checkbox"/> Referral <input type="checkbox"/> Case management <input type="checkbox"/> Crisis intervention <input type="checkbox"/> Reports and record keeping <input type="checkbox"/> Treatment planning <input type="checkbox"/> Individual, group & family counseling <input type="checkbox"/> Consultation with other Professionals	
<b>TOTAL NUMBER OF HOURS OF CLINICALLY SUPERVISED ALCOHOL AND DRUG COUNSELING WORK EXPERIENCE:</b>				

Did you personally supervise the above named applicant during the timeframe indicated on this form?  Yes       No

If no, describe your relationship with the applicant and include name and license number of Certified Clinical Supervisor: \_\_\_\_\_  
\_\_\_\_\_

I, the \_\_\_\_\_ of the above named applicant, certify that the information (i.e. supervisor, human resources, etc) provided on this form is verifiable, factual and accurate.

Print Name: \_\_\_\_\_ License #: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TO SUPERVISOR COMPLETING THIS FORM: Return this completed form directly to the applicant; not the Board.**