

**Arizona Board of Behavioral Health Examiners  
Substance Abuse Counselor Application Supplement**

**Part 1. EDUCATION**

NOTE: Substance Abuse Counselor licensure is available at the following levels (check one):

**Licensed Substance Abuse Technician**

Requires either:

\_\_\_ **Associate of Applied Science degree**

An Associate of Applied Science degree in chemical dependency with an emphasis on counseling from a regionally accredited college or university with a minimum of 30 semester credit hours of counseling related coursework, including 18 hours of coursework specifically related to chemical dependency.

**OR**

\_\_\_ **Bachelors degree**

A bachelors degree in a behavioral health science from a regionally accredited college or university with a minimum of 30 semester credit hours of counseling related coursework

**Licensed Associate Substance Abuse Counselor**

Requires either:

\_\_\_ **Bachelors degree**

A bachelors degree in a behavioral health science from a regionally accredited college or university with a minimum of 30 semester credit hours of counseling related coursework, a minimum of 3200 hours of supervised work experience in substance abuse counseling in no less than 24 months, including 1600 hours of direct client contact, and 100 hours of clinical supervision

**OR**

\_\_\_ **Masters degree**

A masters or higher degree in a behavioral health science from a regionally accredited college or university with a minimum of 24 semester credit hours of counseling related coursework

\_\_\_ **Licensed Independent Substance Abuse Counselor**

Requires a masters or higher degree in a behavioral health science from a regionally accredited college or university with a minimum of 24 semester credit hours of counseling related coursework and a minimum of 3200 hours of supervised work experience in substance abuse counseling in no less than 24 months (post masters degree), including 1600 hours of direct client contact, and 100 hours of clinical supervision

**Part 2. OFFICIAL TRANSCRIPTS**

You must include an official transcript for each qualifying educational program you attended. Request that the educational institution send you an official transcript. **DO NOT OPEN THE ENVELOPE CONTAINING YOUR TRANSCRIPT.** Submit all transcripts in unopened envelopes **WITH** your application. Transcripts submitted in open envelopes will not be accepted.



Name: \_\_\_\_\_ Social Security Number \_\_\_\_\_

**Part 4. VERIFICATION OF SUPERVISED WORK EXPERIENCE**

[Not required for Licensed Substance Abuse Technician or Licensed Associate Substance Abuse Counselor (qualifying with master degree) applicants]

NOTE: After notarization, the supervisor must send the verification form back to the applicant in a sealed envelope with the supervisor's name written across the seal. Applicants must submit these unopened supervision envelopes with their applications. **The Board will not accept unsigned, unnotarized or unsealed envelopes.** If your work experience was acquired as an independent contractor, please contact the Board for additional instructions.

**SECTION A: TO BE COMPLETED BY APPLICANT**

\_\_\_\_\_  
Supervisor's Name

\_\_\_\_\_  
Name of the agency where you obtained your supervised work experience

I have applied to the Arizona Board of Behavioral Health Examiners (AzBBHE) for licensure as a Substance Abuse Counselor. Please complete the following information verifying my supervised work experience, have the form notarized, and return the form to me in a sealed envelope. Please sign your name across the seal. I hereby authorize the above-named individual and agency to release the requested information to AzBBHE. **DO NOT INCLUDE DATES OR HOURS OF EMPLOYMENT PRIOR TO THE DATE MY GRADUATE DEGREE WAS AWARDED ON**

\_\_\_\_\_.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**SECTION B: TO BE COMPLETED BY APPLICANT'S EMPLOYER OR SUPERVISOR**

NOTE: After notarization, the supervisor must send the verification form back to the applicant in a sealed envelope with the supervisor's name written across the seal. Applicants must submit these unopened supervision envelopes with their applications. **The Board will not accept unsigned, unnotarized or unsealed envelopes.**

I certify that \_\_\_\_\_ (applicant name) was engaged in supervised work experience in the practice of substance abuse counseling as follows:

**NOTE: You must list a specific end date. "Current" or "Present" will not be accepted.**

Dates of supervised work experience: From \_\_\_\_\_ through \_\_\_\_\_  
mm/dd/yy mm/dd/yy

**(NOTE: In both places below, identify total hours worked, not hours per week.)**

Total hours of **direct client contact** involving the use of psychotherapy for the purpose of assessment, diagnosis and treatment of individuals, couples, families and groups during the time period identified above: \_\_\_\_\_

Total hours of supervised work experience: Direct client contact hours plus the hours the supervisee spent in activities directly related to the provision of the psychotherapy, such as time spent doing documentation and receiving clinical supervision, during the time period identified above: \_\_\_\_\_

You must attach a copy of the published job description for the position(s) the applicant held during the work experience identified above.

YES  NO I have attached a copy of the applicant's published job description.

Name: \_\_\_\_\_ Social Security Number \_\_\_\_\_

Identify your position with the entity / agency where the applicant obtained the work experience which you are verifying:

\_\_\_\_\_

During the period of supervised work experience, the applicant was an:

employee  independent contractor  other

I was the applicant's:  Employer  Supervisor

Name: \_\_\_\_\_ Degree: \_\_\_\_\_

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

Agency: \_\_\_\_\_

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

Agency OBHL License # if applicable: \_\_\_\_\_

I hold the following professional license(s) or certification(s):

Type of Credential	Issuing State	Date Issued	Expiration Date	License # and Current Status

**NOTE: You must sign and date this affidavit IN THE PRESENCE of the notary and the date you write must be the same as the date written by the notary. Affidavits with different dates will not be accepted.**

I certify under penalty of perjury that all information contained in this verification, including all supporting documents, is true and correct to the best of my knowledge and belief with full knowledge that any false statements or misrepresentations made in this verification may be grounds for disciplinary action against any license I hold.

\_\_\_\_\_  
Employer/Supervisor Signature

\_\_\_\_\_  
Date

**TO BE COMPETED BY NOTARY**

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, in the State of \_\_\_\_\_ and County of \_\_\_\_\_.

Notary Public \_\_\_\_\_ My Commission Expires \_\_\_\_\_

Notary Seal

## INSTRUCTIONS FOR COMPLETING THE VERIFICATION OF SUPERVISED WORK EXPERIENCE FORM

1. Your employer or supervisor must list the dates of the supervised work experience in a mm/dd/yy format. Using the words “current” or “present” is not acceptable.
2. Your employer or supervisor must verify your hours of direct client contact providing **psychotherapy only**. **Hours counted must be limited to only those hours spent providing assessment, diagnosis and treatment services.**
3. **TOTAL hours of supervised work experience verified should include all direct client contact hours AND all indirect hours RELATED to direct services, such as training, supervision hours you received and documentation. DO NOT include non-clinical hours, such as case management, administrative time or supervision hours you provided to others.**
4. **Total hours of direct client contact must be limited to only those hours spent providing assessment, diagnosis and treatment services.**

**NOTE: You must list a specific end date. “Current” or “Present” will not be accepted.**

Dates of supervised work experience: From \_\_\_\_\_ through \_\_\_\_\_  
mm/dd/yy mm/dd/yy

**(NOTE: In both places below, identify total hours worked, not hours per week.)**

Total hours of **direct client contact** involving the use of psychotherapy for the purpose of assessment, diagnosis and treatment of individuals, couples, families and groups during the time period identified above: \_\_\_\_\_

Total hours of supervised work experience: Direct client contact hours plus the hours the supervisee spent in activities directly related to the provision of the psychotherapy, such as time spent doing documentation and receiving clinical supervision, during the time period identified above: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security Number \_\_\_\_\_

**Part 5. VERIFICATION OF CLINICAL SUPERVISION AND ASSESSMENT**

[Not required for Licensed Substance Abuse Technician or Licensed Associate Substance Abuse Counselor (qualifying with master degree) applicants]

NOTE: After notarization, the supervisor must send the verification form back to the applicant in a sealed envelope with the supervisor’s name written across the seal. Applicants must submit these unopened supervision envelopes with their applications. **The Board will not accept unsigned, unnotarized or unsealed envelopes.**

**SECTION A: TO BE COMPLETED BY THE APPLICANT BEFORE SUBMITTING TO EACH SUPERVISOR**

To: \_\_\_\_\_ (Supervisor’s name)

I have applied to the Arizona Board of Behavioral Health Examiners (AzBBHE) for licensure as a Substance Abuse Counselor. Please complete the following information verifying the clinical supervision that I received from you, have the form notarized, and return the form to me in a sealed envelope. Please sign your name across the seal. I hereby authorize the above-named individual to release the requested information to AzBBHE. **DO NOT INCLUDE SUPERVISION HOURS PRIOR TO THE DATE MY GRADUATE DEGREE WAS AWARDED ON**

\_\_\_\_\_.

\_\_\_\_\_  
Applicant’s Signature

\_\_\_\_\_  
Date

**SECTION B: TO BE COMPLETED BY THE APPLICANT’S SUPERVISOR**

NOTE: After notarization, the supervisor must send the verification form back to the applicant in a sealed envelope with the supervisor’s name written across the seal. Applicants must submit these unopened supervision envelopes with their applications. **The Board will not accept unsigned, unnotarized or unsealed envelopes**

I certify that \_\_\_\_\_ (applicant name) received face-to-face clinical supervision from me as follows:

**NOTE: You must list a specific end date. “Current” or “Present” will not be accepted.**

Dates of clinical supervision: From \_\_\_\_\_ through \_\_\_\_\_  
mm/dd/yy mm/dd/yy

Applicant’s position or title: \_\_\_\_\_

Describe below the applicant’s specific work activities:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Skills / Attributes	Outstanding	Above Avg	Average	Below Avg	Poor	Can’t evaluate
Assessment						
Diagnosis						
Individual psychotherapy skills						
Ability to make appropriate referrals						
Group psychotherapy skills						
Personal integrity						
Appropriate use of supervision						
Insight into client’s problems						
Ability to maintain appropriate boundaries						
Ability to be objective on the job						
Ethical conduct						
Concern for welfare of clients						
Sense of responsibility						
Recognition of own limits						
Ability to maintain confidentiality						

Name: \_\_\_\_\_ Social Security Number \_\_\_\_\_

**(NOTE: Identify total supervision hours, not supervision hours per week.)**

Total hours of clinical supervision during the above dates: \_\_\_\_\_

Total hours of direct observation or review of audio or video tapes of applicant providing treatment: \_\_\_\_\_

Of the total hours of clinical supervision identified above, indicate the following:

Group supervision hours \_\_\_\_\_ Individual supervision hours \_\_\_\_\_

Name: \_\_\_\_\_ Degree: \_\_\_\_\_

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

Agency: \_\_\_\_\_

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

I hold the following professional license(s) or certification(s):

**NOTE to Supervisor: If you were not licensed or certified as a behavioral health professional in Arizona or any other state when you provided this supervision, you must enclose a copy of your graduate transcript and curriculum vitae with this form.**

Type of Credential	Issuing State	Date Issued	Expiration Date	License # and Current Status

**NOTE: You must sign and date this affidavit IN THE PRESENCE of the notary and the date you write must be the same as the date written by the notary. Affidavits with different dates will not be accepted.**

I certify under penalty of perjury that all information contained in this verification, including all supporting documents, is true and correct to the best of my knowledge and belief with full knowledge that any false statements or misrepresentations made in this verification may be grounds for disciplinary action against any license I hold.

I certify that I have complied with the requirement for continuing education that addresses clinical supervision or that I hold a clinical supervisor certification as provided in A.A.C. R4-6-212 (J) and that I have included copies of all certificates of completion and the comprehensive published description of the content of the course which includes the course objectives and the presenter's qualifications or I have included a letter issued to me by the Board.  YES  NO

I certify that I have read and understand the clinical supervision requirements in A.A.C. R4-6-212 and that the clinical supervision identified above complied with those requirements.  YES  NO

I certify that I have maintained clinical supervision documentation in compliance with A.A.C R4-6-212(F)(4) and that I agree to provide such documentation upon request.  YES  NO

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Supervisor

**TO BE COMPETED BY NOTARY**

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, in the State  
of \_\_\_\_\_ and County of \_\_\_\_\_.

Notary Public \_\_\_\_\_ My Commission Expires \_\_\_\_\_

Notary Seal

**INSTRUCTIONS FOR COMPLETING THE  
VERIFICATION OF CLINICAL SUPERVISION AND ASSESSMENT FORM**

1. Your clinical supervisor must verify hours he/she spent **meeting directly with you** to review and discuss clinical practice issues only. Time spent discussing non-clinical matters, such as staff meetings covering administrative issues cannot be verified.
2. ALL clinical supervision hours verified on the Clinical Supervision and Assessment form **MUST** occur during the supervised work period identified on your completed Verification of Supervised Work Experience form.
3. Your clinical supervisor can only verify clinical supervision hours he/she provided directly to you. A supervisor cannot verify clinical supervision hours provided by another supervisor.
4. The clinical supervisor must verify that he/she has maintained written documentation to validate all clinical supervision hours he/she verifies. The supervisor's clinical supervision documentation must comply with Board standards set out in A.A.C. R4-6-212(F)(4). A copy of the Board standards for clinical supervision documentation is attached for your convenience. PLEASE NOTE that the Board may request copies of clinical supervision documentation during the application process.
5. Group supervision hours may be verified for clinical supervision provided to two but no more than six supervisees. Typically, staff meetings do not qualify as clinical supervision hours because the supervisor meets with more than six supervisees, discussions are not limited to clinical practice issues ONLY, or the supervisor does not maintain clinical supervision documentation for staff meetings in accordance with the standards set out in A.A.C. R4-6-212(F)(4).
6. Individual supervision hours may be verified for clinical supervision meetings between the clinical supervisor and the applicant.
7. Any clinical supervision submitted for work experience acquired after July 1, 2006, must include at least 10 hours of clinical supervision acquired through direct observation or review of video/audio tapes by the clinical supervisor (A.A.C. R4-6-212(G)) of the applicant providing treatment and evaluation services to a client.
8. The clinical supervisor must complete continuing education required in A.A.C. R4-6-212(J) and must include verification of the training with the completed supervision form.

Name: \_\_\_\_\_ Social Security Number \_\_\_\_\_

**PART 6. SUPERVISOR VERIFICATION OF CREDENTIAL FORM**

**NOTE:** Use this form only if you are applying as a Licensed Independent Substance Abuse Counselor or a Licensed Associate Substance Abuse Counselor with a bachelors degree AND your clinical supervisor(s) was licensed or certified in another state and is not licensed as a Licensed Independent Substance Abuse Counselor in Arizona.

Complete Section I and mail to your supervisors to obtain a verification of their license or certification. Your supervisor must complete Section 2 and mail to their licensing or certifying agency.

**SECTION 1: TO BE COMPLETED BY THE APPLICANT BEFORE SUBMITTING THE FORM TO EACH SUPERVISOR**

To: \_\_\_\_\_ (Supervisor)

I have applied to the Arizona Board of Behavioral Health Examiners for licensure as a behavioral health professional. Please submit the following form to your licensing or certifying agency to verify your credentials. Please return this form with the clinical supervision forms that you completed in an envelope sealed and signed across the seal.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**SECTION 2: TO BE COMPLETED BY THE APPLICANT'S SUPERVISOR**

Mail this form and any necessary fee to your licensing, registering or certifying agency. Upon receipt of the completed verification form from your licensing, registering or certifying agency, please submit the verification form with the supervision and work experience forms that you completed.

Name: \_\_\_\_\_ License or Certification No: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 3: TO BE COMPLETED BY THE STATE IN WHICH THE INDIVIDUAL IDENTIFIED IN SECTION 2 ABOVE IS LICENSED OR CERTIFIED:**

I am the person named in Section 2 who provided supervision to an applicant of the Arizona Board of Behavioral Health Examiners. I hereby authorize you to release the information requested below. **Please return the completed form to me at the address listed in Section 2 above.**

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

Professional's Name (supervisor) \_\_\_\_\_

Credential Held \_\_\_\_\_

Credential Number \_\_\_\_\_

Issuance Date \_\_\_\_\_

Expiration Date \_\_\_\_\_

Current Status \_\_\_\_\_

Pending Disciplinary Actions  YES  NO

Number of Past or Pending Disciplinary Actions \_\_\_\_\_

Attach explanation of all disciplinary actions.

\_\_\_\_\_  
Form Completed By

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Include State Seal

\_\_\_\_\_  
Credentialing Agency Name and Phone Number

**Part 7. CHECKLIST OF REQUIRED DOCUMENTS**

***APPLICATIONS SUBMITTED WITHOUT ALL REQUIRED DOCUMENTATION  
WILL NOT BE PROCESSED***

YOU MUST SUBMIT THE FOLLOWING DOCUMENTS WITH YOUR APPLICATION. Indicate below that your application includes all required documentation.

**ALL substance abuse licensure applicants must submit the following required documentation:**

- \_\_\_\_\_ Cashier's check, certified check or money order for \$250.00 payable to the Arizona Board of Behavioral Health Examiners. ***Personal checks will not be accepted and the fee is NON-REFUNDABLE.***
- \_\_\_\_\_ A copy of your fingerprint card or a completed fingerprint card obtained directly from the Board.
- \_\_\_\_\_ Parts I – III, V-VII and IX of the General Application.
- \_\_\_\_\_ Submit a completed Part IV form of the General Application for every active and non-active credential listed in Part III of the General Application.
- \_\_\_\_\_ HIPDB / NPDB reports, submitted in an unopened envelope from the federal databank as required in Part VIII of the General Application. Reports must be dated within 90 days of the date you submit your application. The 90 days begins when you hit submit on line.
- \_\_\_\_\_ Part 1 of the Substance Abuse Licensure Application Supplement.
- \_\_\_\_\_ Part 2 of the Substance Abuse Licensure Application Supplement. Submit an official transcript for each educational institution attended. Although courses from one school may appear on the transcript of another, the Board requires separate transcripts from each institution attended. All transcripts are to be sent to you in a sealed envelope. **You must submit these unopened transcripts with your application.**

**SUPPLEMENTARY DOCUMENTATION**

- \_\_\_\_\_ Submit your exam score in an unopened envelope **IF** you have already taken and passed one of the required exams.

**Licensed Independent Substance Abuse Counselor applicants or Licensed Associate Substance Abuse Counselor applicants at the Bachelor's level must submit the following required documentation:**

- \_\_\_\_\_ Parts 4 and 5 of the Substance Abuse Licensure Application Supplement.
- \_\_\_\_\_ Submit Part 6 of the Substance Abuse Licensure Application Supplement **ONLY** if your supervisor is licensed or certified as a substance abuse counselor in another state and is not licensed as a LISAC in Arizona.