



LICENSED INDEPENDENT CHEMICAL DEPENDENCY COUNSELOR - CLINICAL SUPERVISOR FORMAL APPLICATION

This application must be returned to the Chemical Dependency Professionals Board. It will not be considered complete until all related documents, transcripts, reference forms and fees have been received by the Board. Applicant and supervisor answers should be full and complete. Vague and/or incomplete applications will be returned, causing a delay in the application process. **Intentionally false and/or misleading statements may result in denial or revocation of licensure.**

Please type or print legibly.

Applicant Name (first, middle and last) _____

Maiden Name (if applicable) _____

Date of Birth _____ **SS #** _____ - _____ - _____

Current Home Address

Current Work Address

(Please provide street number, street name, city, state and zip.)

County _____

Preferred Mailing Address **Home** **Work**

Home Phone _____ / _____ - _____

Work phone _____ / _____ - _____

Mobile Phone _____ / _____ - _____

FAX # _____ / _____ - _____

E-Mail Address _____

Would you like to receive correspondences regarding your renewal application via email? _____ **Yes** _____ **No**

I. PERSONAL HISTORY INFORMATION

Have you ever had a professional license/certificate reprimanded, suspended, revoked, surrendered or in any other way sanctioned? If yes, please attach a written explanation.

_____ **Yes** _____ **No**

Have you ever been convicted of a felony? If yes, please complete the felony questionnaire

_____ **Yes** _____ **No**

Do you currently live or work at least 51% of the time in Ohio?

_____ **Yes** _____ **No**

II. CHEMICAL DEPENDENCY COUNSELING WORK EXPERIENCE

Supervisor references are required as part of this application. The supervisor reference form must provide at least three years (6,000 hours) of knowledge of the applicant's chemical dependency counseling work experience of which one year (2,000 hours) must be experience as a clinical supervisor of chemical dependency counseling services. One year of full time work experience equals 2,000 hours. Your supervisor-signed job description(s) covering this time must be included with this application.

A practical experience verification form must be completed documenting a minimum of 220 practical experience hours in the 12 core functions. If there was more than one supervisor during these times, forms should be duplicated so that each may have an appropriate form to complete. Completed reference forms and verification of tasks forms must be returned with this application.

Please record your chemical dependency counseling work experience below. To meet the Chemical Dependency Professionals Board work experience requirements, a minimum 20 percent of employment must have been spent in the counseling portion of the 12 core functions as it relates to the alcohol and/or other drug-addicted client. Final determination of the acceptability of work experience shall be at the discretion of the Board. Duplicate this page as needed to account for the required minimum amount of work experience. Please list most recent experience first.

Employer: _____ Name and Title of Supervisor: _____ Length of Employment (month and year): From _____ To _____ Job Title: _____ Number of hrs worked per week: _____
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III. FORMAL ACADEMIC EDUCATION

Applicants must hold at least a master's degree in a behavioral science or nursing. Enter all requested information for each institution you list. An official sealed transcript from each must be included with this application. Please list in order, starting with the most recently attended institution.

Institution: _____ Dates Attended: From _____ To _____ Total Hours Earned: _____ Major or Core of Study: _____ Degree Awarded: _____ Date Degree Awarded: _____
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IV. APPLICANT STATEMENT FOR NOTARIZATION

I hereby affirm that I am of good moral character and that all information given herein is true and complete to the best of my knowledge and belief. I authorize any necessary investigations and/or release of personal information to the Chemical Dependency Professionals Board and its agents. I understand that falsification of any portion of this application may result in my being denied certification/licensure or in revocation of the same.

I hereby affirm that I have read the Chemical Dependency Code of Ethics, and I agree to abide by this code. (The Chemical Dependency Code of Ethics may be accessed at www.ocdp.ohio.gov or may be sent to an applicant upon request.)

I further agree to hold the Chemical Dependency Professionals Board free from any civil liability for damages or complaints related to any action within the scope and/or arising out of the performance of its duties, which it or any of its employees may take in connection with this application and/or failure to issue me said license.

I understand that the \$50 fee submitted herewith represents the non-refundable LICDC-CS Formal Application fee. (A non-refundable \$20 fee will be charged for any check not accepted for deposit by the bank.)

Applicant Signature Date

Subscribed and sworn before me this _____ day of _____, 20_____

Notary Signature Date Commission Expires

If paying via check or money order: make payable to “**Treasurer, State of Ohio.**”

If paying via credit card: complete the CREDIT CARD AUTHORIZATION form.

Please return completed application, including required documentation and fee, to:

Ohio Chemical Dependency Professionals Board
77 South High Street, 16th Floor Columbus, Ohio 43215
614/387-1110 (phone) 614/387-1109 (fax) www.ocdp.ohio.gov
Email: credentialing@ocdp.state.oh.us

FOR OFFICE USE ONLY		
Date Received:	Fee Paid:	Check/M.O./C.C. #:



Credit Card Payment Authorization Form

Please check one: Master Card Visa

Cardholder Name: _____

Address: _____

City, State, Zip: _____

Telephone #: _____

Email Address (for receipt) _____

Credit Card Number: _____

Expiration Date: _____

CVV2/CID Code # (Three digit number on back of card): _____

Payment Amount: _____

Payment for (exam, application, etc): _____

Signature

Date

Credit Card Payments may be mailed, faxed, emailed, or phoned in to the Board office.

Ohio Chemical Dependency Professionals Board
77 South High Street, 16th Floor Columbus, Ohio 43215
614/387-1110 (phone) 614/387-1109 (fax) www.ocdp.ohio.gov
Email: credentialing@ocdp.state.oh.us

This document will be shredded after your payment is processed.



LICENSED INDEPENDENT CHEMICAL DEPENDENCY COUNSELOR – CLINICAL SUPERVISOR FORMAL APPLICATION CHECKLIST

To facilitate the review of your LICDC - CS formal application and to avoid unnecessary delays in processing, please use the following checklist when completing the application. All items on this checklist must be included for your formal application to be complete and acceptable to the Board. Incomplete or inappropriately completed applications will be returned and will result in a delay of processing.

Check each item when completed:

- _____ Application is complete, signed and notarized
- _____ \$50.00 application fee enclosed. All fees must be made payable to Treasurer, State of Ohio.
- _____ Felony question has been answered. If you have been previously convicted of a felony, you will need to complete a felony questionnaire and submit it with your formal application along with documentation of completion of probation, parole, or incarceration.
- _____ Counselors Reference Form enclosed.
- _____ Clinical Supervisors Reference Form enclosed.
- _____ A job description, signed by your supervisor, has been enclosed with this application.
- _____ Verification of Tasks Form completed documenting 220 practical experience hours in the 12 core functions.
- _____ Completion of Education Grid and verification of education hours in the form of transcripts, certificates and/or letters of completion have been submitted with this application.
- _____ Submission of official sealed transcripts verifying completion of a Master's degree in a behavioral science and completion of the Master's Degree Grid.

All forms are available at www.ocdp.ohio.gov or by calling (614) 387-1110.



Military Request Application Addendum

Individuals or spouses of individuals who are veterans or members of the armed forces may have their application expedited by completing this form and returning it with documentation of military service.

Name

SSN

1. Have you served in the U.S. military? Yes No

2. Has your spouse served in the U.S. military? Yes No

If your spouse has served, please provide their first and last name:

4. In which branch of the military did you/your spouse serve? _____

5. Please provide the military service dates:

Military Service From: _____ Military Service To: _____

6. Are you still active in the military or reserves? Yes No

7. Were you discharged under honorable conditions? Yes No

Attach this Addendum to the front of your application and include a copy of your/your spouse's DD214 form or proof of current service.

Please contact your County Veterans Services Office (1-877-OHIO-VET) or the Ohio Department of Veterans Services (www.ohiovet.gov) if you need assistance in obtaining a copy of the DD214 form.