MINNESOTA
BOARD OF BEHAVIORAL
HEALTH AND THERAPY

ADC LICENSING PROGRAM
2829 University Avenue SE, Suite 210
Minneapolis, MN 55414
Phone: (651) 201-2758; Fax: (612) 617-2187
MN Relay Service: 1(800) 627-3529
E-MAIL: bbht.board@state.mn.us

APPLICATION FOR LICENSURE AS AN ALCOHOL AND DRUG COUNSELOR

INSTRUCTIONS

1. This application must be completed by all applicants for licensure as a Licensed Alcohol and Drug Counselor. The application must be filled out completely. Page 14 must be signed and notarized. Incomplete applications will be returned to you to provide the missing information. If there is not enough space for you to answer a question sufficiently, please attach a separate sheet of paper with your answer.

2. This application must be accompanied by the appropriate fees. The fee must be paid by check or money order made payable to "BBHT." All fees are non-refundable. The application fee is $295 and the background check fee is $33.25. The total fee that must accompany your application is **$328.25**.

3. All applicants for licensure are required to complete a fingerprint-based criminal background check. A fingerprint information packet with instructions will be emailed to you AFTER you submit this license application and the applicable fees. Fingerprints submitted for other purposes (DHS background study, other professional licenses, etc.) cannot be used for this check.

4. Licensed Alcohol and Drug Counselors are governed by Minnesota Statutes Chapter 148F and Minnesota Rules Chapter 4747. All applicants and licensees of the Board are responsible for familiarizing themselves with these laws. You may visit the Board's website at www.bbht.state.mn.us to access the Board's most current statutes and rules.

5. The method under which you apply determines the sections of the application you must complete. There is a box on the top of each section that identifies which sections need to be completed according to the application method you select. If your method has an "x" next to it, you are required to complete the form (unless otherwise noted).

6. Except where noted, all applicants must complete and submit the following:

   - License Application, completed, signed, notarized (All sections must be submitted. All sections and questions that do not apply to you must be marked "NA").
   - Fee of $328.25 made payable to BBHT. Pursuant to Minnesota Statutes, section 604.113, there will be a $30 service charge for all checks not honored by your bank.
   - For Methods D and I, a copy of your exam results

7. The following items must be sent directly to the Board office from the issuing authority/institution:
   - All relevant transcripts. Transcripts should be submitted from each school where you completed alcohol and drug counseling course work and practicum hours. Transcript(s) must show that you have completed a bachelor's degree.
   - A Letter of Standing ("Verification of Credential") must be sent directly to the Board office from each licensing board/credentialing agency granting each license/certification listed on question 16.

8. Make a copy of this completed application for your records. You may need the information contained in it after you become licensed.

RIGHTS OF SUJECTS OF DATA

Pursuant to Minn. Stat. sec. 13.41, subd. 2, information you provide in this application, except for your name and address, is classified as private while you remain an applicant. Private data is accessible only to you, the staff and members of the Board, the Board's legal counsel, and persons you designate. When you become licensed, the information in your file related to your licensure is classified as public under Minn. Stat. sec. 13.41, subds. 2 and 5.

The purpose and intended use of this information is to enable the Board to determine whether you meet statutory requirements for licensure. You are not legally obligated to provide this information, but you cannot be licensed without doing so.

PUBLIC ADDRESS

Pursuant to Minnesota Statutes section 13.41, subd. 2(b), a person who is subject to the jurisdiction of a health-related board must designate to the board a residence or business address and telephone number at which the licensee can by contacted in connection with the license. These data are to be maintained in the board's records as public data. Therefore, the address and telephone number which you designate public are the address and telephone number the board will release in response to public inquiries. The address that you designate as mailing is the address the board will use for all contact with you regarding your license, including renewal information. If you change your address and/or telephone number you are required to notify the board within 30 days of any change. Your notification must be made in writing and submitted to the BBHT office.

TAX INFORMATION

Pursuant to Minnesota Statutes, Section 270C.72, subdivisions 1 and 4, the Board is required to ask all applicants to provide their social security number and Minnesota business identification number on all license applications. Failure to supply this information may jeopardize or delay the processing of your application. Upon request of the Commissioner of Revenue, the Board must provide to the Commissioner a list of all regulated individuals and applicants, including their names and addresses, social security numbers, and business identification numbers. Under the Minnesota Government Data Practices Act, you are advised of the following regarding the use of this information:

a. This information may be used to deny the issuance or renewal of your license in the event you owe the Minnesota Department of Revenue delinquent taxes in the amount of $500.00 or more.
b. Upon receiving this information, the Board will supply it only to the Minnesota Department of Revenue. However, under the Federal Exchange of Information Agreement, the Department of Revenue may supply this information to the Internal Revenue Service.

In compliance with the Americans with Disabilities Act, this document may be made available in alternative formats upon request.

Minnesota Board of Behavioral Health and Therapy
2829 University Avenue SE, Suite 210
Minneapolis, MN 55414

Applicant's Name: _____
(Please print)

MINNESOTA BOARD OF BEHAVIORAL HEALTH AND THERAPY APPLICATION FOR ALCOHOL AND DRUG COUNSELOR LICENSURE

Applicants are responsible for reading the statutory provisions for licensure before making a selection
ALL FEES ARE NON-REFUNDABLE

METHOD APPLYING FOR – MARK WITH "x"	METHOD	REQUIREMENTS
	Method D-Standard Method Minnesota Statutes section 148F.025, subd. 1, 2, 3(1) and (2)(i)	• Bachelor's degree • 270 clock hours of specific alcohol and drug counseling course work • 880 hour alcohol and drug counseling practicum • Passing score on written comprehensive exam OR • Passing score on a written and oral exam
	Method I-Supervision Alternative Minnesota Statutes section 148F.025, subd. 1, 2, 3(2)(ii)	• Bachelor's degree • 270 clock hours of specific alcohol and drug counseling course work • 880 hour alcohol and drug counseling practicum • Passing score on written exam (not comprehensive) • 2,000 hours of supervised postdegree professional practice acceptable to the Board
	Method F-Reciprocity Minnesota Statutes section 148F.03 The board shall issue a license if the board finds that the requirements which the applicant met to obtain the credential from the other jurisdiction were substantially similar to the current requirements for licensure in this chapter and that the applicant is not otherwise disqualified under section 148F.090.	• Active license or certification as an alcohol and drug counselor from another jurisdiction Applicants must submit: • Copy of the jurisdiction's credentialing laws and rules that were in effect at the time the applicant obtained the credential. • Verification that license or certification is active and in good standing. The verification must be sent directly to the Board office from the licensing board/credentialing agency.

Board Office use only

Payment Info:
Check # _____ Amount $: _____ Staff Initials: _____

Deposit #_____ Date: _____

Who Completes:
×Method D
×Method I
×Method F

Minnesota Board of Behavioral Health and Therapy
2829 University Avenue SE, Suite 210
Minneapolis, MN 55414

Applicant's Name: _____
(Please print)

Minnesota Application for Alcohol and Drug Counselor Licensure

Please print legibly in ink. Illegible applications will be returned. Photocopied and faxed applications without original signatures will be returned.

1. Full, Legal Name: _____
(Last) (First) (Middle)

2. Gender (check one): ☐ Male ☐ Female

3. Social Security Number: _____

4. Date of Birth: _____

5. Current Home Address: _____
(Street or Rural Route) (Apt.#)

_____
(City) (State) (Zip) (County)

6. Telephone Number: _____

7. Email Address (optional): _____

8. Current Employer: _____

9. Employer Address: _____
(Street or Rural Route)

_____
(City) (State) (Zip) (County)

10. Employer Telephone Number: _____ Title of Position: _____

11. Designated address the Board should use for release to the public (check **one**): ❑ Home ❑ Business
12. Designated phone number the Board should use for release to the public (check **one**): ❑ Home ❑ Business
13. Designated address for official Board mailings (check **one**): ❑ Home ❑ Business

14. Driver's License State & Number: _____ _____
(State) (DL Number)

15. Have you ever used another name? ☐ Yes ☐ No If yes, please print last, first, and middle name(s) used (including maiden name).

_____
(Last) (First) (Middle) (Date last used mo/yr)

_____
(Last) (First) (Middle) (Date last used mo/yr)

_____
(Last) (First) (Middle) (Date last used mo/yr)

16. Do you now hold or have you ever held a credential (e.g. a permit, registration, certification, or license) to practice alcohol and drug counseling or another related profession in this or another state? ☐ Yes ☐ No

If yes, fill in the information about the credential(s) below. You will need to have verification of each credential you list below sent to the Board office. Verification must be sent directly from the credentialing agency(ies) to the Board office.

AGENCY	STATE	OCCUPATION	DATE OF ISSUANCE	STATUS	ID #

Who Completes:
×Method D
×Method I
×Method F

Minnesota Board of Behavioral Health and Therapy
2829 University Avenue SE, Suite 210
Minneapolis, MN 55414

Applicant's Name: _____
(Please print)

17. List the dates that you passed a written comprehensive exam, written exam, or oral exam:

Written Comprehensive Exam: _____
(date)

Written exam: _____ Oral Exam _____
(date) (date)

18. Please list the name of each educational institution you have attended. You will need to request that all of your educational institutions send an official transcript directly to the Board office at the address listed above:

NAME OF SCHOOL LOCATION DATES ATTENDED MAJOR

_____

_____

_____

19. Please answer the following questions by circling yes or no. All "yes" answers must be explained in detail and signed on a separate sheet of paper. Applicants should be aware that answering "yes" to some questions might necessitate special screening procedures by the Board. Failure to disclose the following information may result in the denial of your application or other appropriate action.

	Question	**Answer**
1.	Have you ever had any application for any professional license denied by any licensing authority?	YES NO
2.	Has your professional license or registration ever been revoked, or have you ever been the subject of disciplinary action, or non-disciplinary corrective action; or have you been sanctioned by any licensing authority including, but not limited to, the authority's refusal to grant you a license, or the authority's action to revoke, suspend, condition, limit, restrict, or qualify the professional license or registration in any way?	YES NO
3.	Have you ever practiced alcohol and drug counseling or mental health counseling in a setting where licensure was not required?	YES NO
4.	If you answered yes to question #3 above, have you ever been the subject of a complaint, disciplinary action, or non-disciplinary action related to your unlicensed practice?	YES NO NA
5.	To your knowledge, have any complaints ever been filed against you with any professional licensing or regulatory board?	YES NO
6.	Have you ever been charged with a crime? You must report charges that were expunged or otherwise removed from your record by executive pardon. Please list **all** criminal charges.	YES NO
7.	Have you ever been charged with Driving While Intoxicated (DWI) or Driving Under the Influence (DUI)? Have you ever been charged with any other impaired driving offenses involving the use of alcohol or other chemical substances?	YES NO
8.	Have you ever been named a defendant in a criminal suit related to your profession?	YES NO
9.	Have you ever been named a defendant in a civil suit related to your profession?	YES NO
10.	Do you have any physical or mental health condition which in any way may impair or limit your ability to practice alcohol and drug counseling with reasonable skill and safety?	YES NO
11.	Have you ever been adjudicated as mentally incompetent, or as a person who has a psychopathic personality, or who is dangerous to self, or has been adjudicated as chemically dependent, mentally ill, mentally disabled, or mentally ill and dangerous to the public?	YES NO
12.	Do you participate in any professional program designed to monitor or assist you in any management of chemical dependency, physical, physiological, or emotional impairment?	YES NO
13.	Are you now or have you in the last five years been addicted to any chemical substance including alcohol?	YES NO
14.	Are you now being treated or have you in the last five years been treated for a drug or alcohol addiction or participated in a rehabilitation program?	YES NO
15.	Do you currently have any other condition or impairment, not reported in any question in this application, which in any way affects, or if left untreated might affect, your ability to practice alcohol and drug counseling with reasonable skill and safety to clients?	YES NO

Who Completes:
×Method D
×Method I
Method F

Minnesota Board of Behavioral Health and Therapy
2829 University Avenue SE, Suite 210
Minneapolis, MN 55414

Applicant's Name: _____
(Please print)

PRACTICUM INFORMATION

INSTRUCTIONS: Please list each location at which you completed practicum hours. Feel free to attach additional page(s) if necessary.

"Alcohol and Drug Counselor Practicum" means formal experience gained by a student and supervised by either a licensed alcohol and drug counselor or a supervisor in another profession that is exempt under Minnesota Statutes, section 148F.11, as part of an accredited school or educational program of alcohol and drug counseling.

Please begin with your most recent practicum activity.

---

1. Name & Address of practicum site: _____
Name

_____
Street Address City State Zip

Name and address of accredited school or educational program: _____

Dates: From: _____To:_____
(Month & Year) (Month & Year)

Total number of hours earned: _____

Supervisor's Name and Phone Number: _____

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2. Name & Address of practicum site: _____
Name

_____
Street Address City State Zip

Name and address of accredited school or educational program: _____

Dates: From: _____To:_____
(Month & Year) (Month & Year)

Total number of hours earned: _____

Supervisor's Name and Phone Number: _____

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3. Name & Address of practicum site: _____
Name

_____
Street Address City State Zip

Name and address of accredited school or educational program: _____

Dates: From: _____To:_____
(Month & Year) (Month & Year)

Total number of hours earned: _____

Supervisor's Name and Phone Number: _____

Who Completes:
×Method D
×Method I
Method F

Minnesota Board of Behavioral Health and Therapy
2829 University Avenue SE, Suite 210
Minneapolis, MN 55414

Applicant's Name: _____
(Please print)

Academic Course Work Summary

If a course title is not clearly indicative of the content areas as set forth in Minnesota Statutes, section 148F.025, subd. 2, attach the college catalog description or course syllabus indicating that specific material was included. In addition, please highlight the areas of the literature that best demonstrate coverage of the content area. (1 semester credit = 15 clock hours, 1 quarter credit = 10 clock hours.)

Only one course is required for each course work area listed below (although multiple courses may be listed). Each course work area does not require a certain amount of credits, the content listed just needs to be covered in the course. A single course may be utilized for more than one content area.

Course Work Area	Name of College or University	Course Number and Title	Credits Earned	Number of Clock hours
Area (1): an overview of the transdisciplinary foundations of alcohol and drug counseling, including theories of chemical dependency, the continuum of care, and the process of change				
Area (2): pharmacology of substance abuse disorders and the dynamics of addiction, including medication-assisted therapy				
Area (3): professional and ethical responsibilities				
Area (4): multicultural aspects of chemical dependency				
Area (5): co-occurring disorders				
Area (6): the core functions defined in section 148F.010, subdivision 1:				
(1) "screening" means the process by which a client is determined appropriate and eligible for admission to a particular program				
(2) "intake" means the administrative and initial assessment procedures for admission to a program				
(3) "orientation" means describing to the client the general nature and goals of the program; rules governing client conduct and infractions that can lead to disciplinary action or discharge from the program; in a nonresidential program, the hours during which services are available; treatment costs to be borne by the client, if any; and client's rights				

(4) "assessment" means those procedures by which a counselor identifies and evaluates an individual's strengths, weaknesses, problems, and needs to develop a treatment plan or make recommendations for level of care placement;				
(5) "treatment planning" means the process by which the counselor and the client identify and rank problems needing resolution; establish agreed upon immediate and long-term goals; and decide on a treatment process and the sources to be utilized				
(6) "counseling" means the utilization of 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" means activities that bring services, agencies, resources, or people together within a planned framework of action toward the achievement of established goals;				
(8) "crisis intervention" means those services which respond to an alcohol or other drug user's needs during acute emotional or physical distress				
(9) "client education" means the provision of information to clients who are receiving or seeking counseling concerning alcohol and other drug abuse and the available services and resources;				
(10) "referral" means identifying the needs of the client which cannot be met by the counselor or agency and assisting the client to utilize the support systems and available community resources;				
(11) "reports and record keeping" means charting the results of the assessment and treatment plan and writing reports, progress notes, discharge summaries, and other client-related data				
(12) "consultation with other professionals regarding client treatment and services" means communicating with other professionals in regard to client treatment and services to assure comprehensive, quality care for the client				
Other courses with alcohol and drug counseling content				
			Total Clock Hours	

Who Completes:
Method D
×Method I
Method F

Minnesota Board of Behavioral Health and Therapy
2829 University Avenue SE, Suite 210
Minneapolis, MN 55414

Applicant's Name: _____
(Please print)

Minnesota Board of Behavioral Health and Therapy
ADC Verification of Completion of Supervision Plan

1. Please have your supervisor complete this form if any or all of your supervised practice hours were completed on or after July 1, 2005.
2. This form is to be completed by the supervisor and must be submitted directly to the Board office.
3. This form is to be completed when the approved supervision plan of a temporary permit holder or applicant of the Board has been completed according to Minnesota Statutes sections 148F.025, subd. 3(2)(ii) and 148F.04, subds. 1, 2, and 4.
4. If the supervisee received supervised experience at more than one setting or with more than one supervisor, the supervisee must provide the information below on a separate form for each supervisor and/or setting.

Date supervision began: _____ Date supervision ended: _____

Name of Supervisee: _____

Name of Supervisor: _____

Name of supervision location (Business): _____

Address of supervision location: _____

Number of on-the-job hours scheduled to work: □ per week □ per month _____

Actual hours spent in in-person supervision sessions: □ per week □ per month _____

Total number of supervised professional practice hours (Example: 1 year of full time employment, 40 hours/week, is 2080 hours): _____

*Supervisor: Please **initial** the following certifying statements (if you do not agree to initial these statements, please explain in a separate written statement the reasons you are in disagreement with them):*

I certify that the supervised professional practice of the supervisee listed above complied with Minnesota Statutes section 148F.04, subd. 4, including (please initial each):

_____ The content of supervision included alcohol and drug counseling knowledge, skills, values, and ethics with specific application to the practice issues faced by the supervisee.

_____ The content of supervision included the standards of practice and ethical conduct, with particular emphasis given to the counselor's role and appropriate responsibilities, professional boundaries, and power dynamics.

_____ The content of supervision included the supervisee's permissible scope of practice, as defined by Minnesota Statutes section 148F.01, subd. 18.

_____ Supervision was obtained at the rate of 1 hour of supervision per 40 hours of professional practice, for a total of 50 hours of supervision.

_____ Supervision was evenly distributed over the course of the supervised professional practice.

_____ At least 75 percent of the supervision was received in person.

Verification of Completion of ADC Supervision Plan continued…

_____ Supervision received via telephone or audio or audiovisual electronic device totaled 25 percent or less of the supervision.

_____ At least 50 percent of the supervision was done on an individual basis (one-on-one).

_____ Supervision done in a group setting totaled 50 percent or less of supervision.

_____ Supervision was completed in no fewer than 12 consecutive months and no more than 36 consecutive months.

_____ The supervision was completed satisfactorily.

I, the undersigned, have read and agree that the supervision was conducted as described above and that the information contained therein is true and correct to the best of my knowledge.

Supervisor's Signature: _____ Date: _____

Please complete this form and mail directly to:
The Minnesota Board of Behavioral Health and Therapy
2829 University Avenue S.E., Suite 210
Minneapolis, MN 55414

For office use only

Date approved _____

Date disapproved _____

Staff initials _____

Who Completes:
Method D
×Method I
Method F

Minnesota Board of Behavioral Health and Therapy
2829 University Avenue SE, Suite 210
Minneapolis, MN 55414

Applicant's Name: _____
(Please print)

Minnesota Board of Behavioral Health and Therapy

ADC Verification of Past Supervised Professional Practice

1. Please complete this form if any or all of your supervised professional practice took place on or before June 30, 2005.

2. If, upon completion of the alcohol and drug counseling educational requirements, you worked under a temporary permit, were licensed, certified or credentialed in another jurisdiction, or worked pursuant to the authority of another professional license, **and** you received professional supervision while performing this work, you may seek to have these hours applied to the 2,000 hours of supervised professional practice described in Minnesota Statutes sections 148F.025, subd. 3(2)(ii) and 148F.04, subds. 1, 2, and 4.

3. If you received supervised experience at more than one setting or with more than one supervisor, you must provide the information below on a separate form for each supervisor and/or setting.

4. In addition to providing the information below, your supervisor must complete and submit the Supervisor Credential Verification form (available on our website or by contacting the BBHT office).

Date supervision began: _____ Date supervision ended: _____

Name of Supervisee: _____

Name of Supervisor: _____

Supervisor's Licensure/credentials: _____

Name of supervision location (Business): _____

Address of supervision location: _____

Number of on-the-job hours scheduled to work: □ per week □ per month _____

Actual hours spent in in-person supervision sessions: □ per week □ per month _____

Total number of supervised professional practice hours (Example: 1 year of full time employment, 40 hours/wk, is 2080 hours): _____

Describe the types of clients seen at this setting: _____
_____
_____
_____

Describe how the supervision was conducted, including scheduling of supervision and documentation of supervision sessions:
_____
_____
_____

ADC Verification of Supervised Professional Practice continued…

Record the approximate percentage of time supervisee spent in the professional activities listed below. Total for all categories should not exceed 100%.

Screening:	%	Case Management:	%
Intake:	%	Crisis Intervention:	%
Orientation:	%	Client Education:	%
Assessment:	%	Referral:	%
Treatment Planning:	%	Reports & Recordkeeping:	%
Counseling:	%	Consultation with Other Professionals	%
		TOTAL	**100%**

*For the **supervisee** to complete*:

I, the undersigned, have read and agree that the supervision was conducted as described above and that the information contained therein is true and correct to the best of my knowledge.

Supervisee signature: _____ Date: _____

*For the **supervisor** to complete*:

I, the undersigned, have read and agree that the supervision was conducted as described above, and that the information contained therein is true and correct to the best of my knowledge.

Supervisor signature: _____ Date: _____

Supervisor: Please **initial** the following certifying statements (if you do not agree to initial these statements, please explain in a separate written statement the reasons you are in disagreement with them):

_____ I certify that the 2,000* hours of supervised professional practice of the above listed supervisee was within the scope of practice of alcohol and drug counseling as defined by Minnesota Statutes section 148F.01, subd. 18.

_____ I certify that the supervision was completed satisfactorily.

*Cross out and enter the correct number of supervised practice hours if the hours total more or less than 2000

Who Completes:
×Method D
×Method I
×Method F

Minnesota Board of Behavioral Health and Therapy
2829 University Avenue SE, Suite 210
Minneapolis, MN 55414

Applicant's Name: _____
(Please print)

Records Waiver Authorization and Release

I HEREBY AUTHORIZE the Minnesota Board of Behavioral Health and Therapy or the Board's designee to obtain, and authorize the person to whom this authorization is presented to release, any and all information contained in the records of **all colleges and post-secondary educational institutions, police departments, the Minnesota Certification Board (MCB), the International Certification and Reciprocity Consortium (ICRC), Department of Human Services (DHS), the Office of Health Facility Complaints, the Office of Mental Health Practice, Division of Driver and Vehicle Services in the Department of Public Safety, the Bureau of Criminal Apprehension (BCA), and any other entity maintaining records on me. This includes results of the Department of Human Services (DHS) Background Investigations** including license, registration, permit and/or other credentialing records, and any other investigative and/or disciplinary records, in this or any other state. The DHS Background Investigation includes records pertinent to maltreatment of vulnerable adults and minors and criminal history information obtained by DHS.

This authorization also allows the Board or the Board's designee to prepare summaries or photocopies of all or any portion of any records in this or any other state. A copy of this authorization may be considered to be as valid as the original.

MINNESOTA GOVERNMENT DATA PRACTICES ACT NOTICE. This notice is given pursuant to Minnesota Statutes section 13.04, subdivision 2, and section 13.41, subdivision 2. The Board will use the information received through this background check and within this application to determine if you meet the requirements for licensure in Minnesota Statutes chapter 148F. You are required to sign this authorization form pursuant to Minnesota Statutes section 148F.025, subd. 4. If the matter of your licensure becomes contested and thereby results either in a contested case hearing or litigation, the data submitted by you or on your behalf may also become accessible to the Minnesota Office of Administrative Hearings, appropriate courts, and those associated with such proceedings, and thereby become public data.

Dated this_____day of_____, 20___

_____
Signature

_____
Name typed or printed

Who Completes:
×Method D
×Method I
×Method F

Minnesota Board of Behavioral Health and Therapy
2829 University Avenue SE, Suite 210
Minneapolis, MN 55414

Applicant's Name: _____
(Please print)

Affidavit

By completing this application I hereby request that the Minnesota Board of Behavioral Health and Therapy (Board) approve my application for licensure as an alcohol and drug counselor and consider the information provided herein as evidence of qualification for Minnesota licensure.

I agree that while my application is pending, should any situation arise that might contradict or alter any of the answers to the questions, listed requirements or affirmations contained in this application, I will, **within ten working** days of such knowledge, **notify** the Board of that change.

I agree that I will cooperate with any necessary investigation or inquiry initiated by the Board, prior to licensure, according to Minnesota statutes section 148F.10.

I understand that should this application for licensure be denied, I am entitled to request a contested case hearing within 30 days of receipt of the notice of denial. Should I choose not to appeal the denial I understand that I may not reapply earlier than one year from the date of the denial.

Further, I, the undersigned, being duly sworn, state upon oath that the answers given in this application are true and correct, and agree, if issued a license, to abide by the laws of the State of Minnesota concerning the practice of licensed alcohol and drug counseling.

I affirm that I:

(1) am not the subject of any current complaints or investigations in Minnesota or in any other state or jurisdiction in which I hold/have held a license to practice or that if I have been the subject of complaints or investigations in another state or jurisdiction. I have provided all details regarding such complaint(s) or investigations to the Minnesota Board of Behavioral Health and Therapy. I understand that existence of such complaints or disciplinary matters may increase the time it takes to approve this application.

(2) have attached a copy of any order for discipline that precedes this application.

Additionally, by completing and signing this form, I further acknowledge that I have read and understand all information, notices, and requirements contained in it; including the warning regarding RIGHTS OF SUBJECTS OF DATA; the information contained in the WAIVER, and the information contained in the AFFIDAVIT.

_____ _____
Signature of Applicant Date

Subscribed and sworn to before me:

This _____ day of _____, 20____

_____
Signature of Notary