

MARYLAND BOARD OF PROFESSIONAL COUNSELORS AND THERAPISTS  
4201 PATTERSON AVENUE – 316  
BALTIMORE, MARYLAND 21215 410-764-4732  
[www.dhmf.maryland.gov/bopc/](http://www.dhmf.maryland.gov/bopc/)

INSTRUCTIONS  
ALCOHOL AND OTHER DRUG COUNSELING  
OUT OF STATE APPLICANTS  
CSC-AD (Certified Supervised Counselor-Alcohol and Drug)

COUNSELORS AT THIS CERTIFICATION LEVEL **CAN NOT PROVIDE**  
SUPERVISION

- (1) **Application**: Submit a completed Out-of-State Board application, identifying the level of certification or licensure that you are requesting (enclosed);
- (2) **Fee**: Submit **(\$250.00) NON REFUNDABLE** application fee with the Out of State Board Application.
- (3) **Out of State Verification Form** Complete items 1-10 and send this form to the state(s) where you are currently licensed or certified. The credentialing state(s) must complete items 11-17, attach their state certification/licensure requirements with scope of practice, and then forward this form directly to the Maryland Board.
- (4) **Out of State Licensure/Certification**: Submit verification and copies of all professional licenses ever held in another state, territory or jurisdiction where you were authorized to practice alcohol and other drug counseling.
- (5) **Education**: Fill out the Education section and submit an official, sealed transcript to the Board documenting completion of at least an Associate's degree in a health or human services counseling field from an accredited college.
- (6) Submit a completed Coursework Outline Form (enclosed);
- (7) **Examination**: Submit documentation of having taken and passed the examination developed by the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse (ICRC/AODA). If you have not taken the ICRC/AODA exam, you may take it upon receiving Board approval.
- (8) Take and pass the Maryland Law Test after receiving Board approval. The Maryland Law Test is administered at the Board's office twice monthly.
- (9) Submit verification of the required clinical experience on the **“Professional Experience Verification Form.”** The Form is enclosed. The Board will accept verification from employers, supervisors, or colleagues. **In the case of a colleague, the colleague must have a mental health credential. Provide documentation.**



**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**Maryland Board of Professional Counselors and Therapists**  
**4201 Patterson Avenue**  
**Baltimore, MD 21215**  
**410-764-4732**  
**410-358-1610 (fax)**  
[www.dhmh.maryland.gov/bopc/](http://www.dhmh.maryland.gov/bopc/)

**OUT OF STATE BOARD APPLICATION FOR**  
**CSC-AD: Certified Supervised Counselor-Alcohol and Drug**  
**COUNSELORS AT THIS CERTIFICATION LEVEL CAN NOT PROVIDE**  
**SUPERVISION**

Application Date: \_\_\_\_\_  
(Date)

**MUST BE TYPED or PRINTED**

Name \_\_\_\_\_  
(Last) (First) (Middle)

Home Address \_\_\_\_\_  
(Number and Street)

\_\_\_\_\_  
(City) (State) (Zip Code)

E-mail Address \_\_\_\_\_

Telephone Number \_\_\_\_\_  
(Home) (Work)

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Race: Caucasian African American. Native American Asian Hispanic Other

Gender: Female Male

**EDUCATION: CSC –AD = Associates Degree in a Health or Human Services Counseling field.** Directions: Please list your relevant educational history below, beginning with your most recent college education. Official Transcripts are required.

College or University	Date(s) of Attendance	Degree Awarded/Major

**EXAMINATION REQUIRED**

Have you successfully passed the following national exam?  
 ICRC/AODA(International Certification Reciprocity Consortium)       Yes     No

If the answer is yes, please include documentation of passing score with application.  
 If no, you may take the examination upon receiving Board approval.

a. Have you ever been denied an initial application, reinstatement or renewal of a license and /or certificate by any state licensing or disciplinary board?     Yes     No  
 If “yes” explain reason(s).\_\_\_\_\_

b. Has any state licensing or disciplinary board ever taken any action against your license and/or certification, including but not limited to limitations of practice, required education, admonishment, reprimand, revocation, suspension?     Yes     No  
 If yes, explain circumstance(s).\_\_\_\_\_

c. Has an investigation or charges ever been brought against you by any licensing or disciplinary board?     Yes     No  
 If yes, explain circumstance(s).\_\_\_\_\_

d. Have you pled guilty, nolo contendere, or been convicted of or received probation before judgment or any criminal act (excluding traffic violations)?     Yes     No  
 If “yes” provide the following information: Date of Conviction: \_\_\_\_\_

Where convicted \_\_\_\_\_ Charge \_\_\_\_\_

If conviction was set aside, give date and explain using additional pages if necessary. Include required information on all felony convictions attaching additional sheets behind this page if necessary. \_\_\_\_\_

I hereby certify that the information provided in this application is true, accurate and complete to the best of my knowledge and belief.

Signature of Applicant:\_\_\_\_\_ Date:\_\_\_\_\_

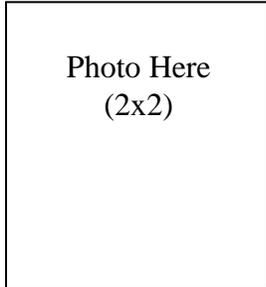
**AFFIDAVIT: The following statement must be executed by a Notary Public.**

State of \_\_\_\_\_, County of \_\_\_\_\_

Name \_\_\_\_\_, being duly sworn, says that he/she is the person who is referred to in the foregoing application for licensure or certification as an Alcohol and Other Drug counselor in Maryland, that the statements herein contained are true in every respect, that he/she has complied with all requirements of the law; and that he/she has read and understands this affidavit.

Subscribed to and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_. 20\_\_\_\_\_.

My commission expires on \_\_\_\_\_. Signature of Notary: \_\_\_\_\_



SEAL

**MARYLAND BOARD OF PROFESSIONAL COUNSELORS AND THERAPISTS**  
**4201 Patterson Avenue – Suite 316**  
**Baltimore, Maryland 21215**  
[www.dhmf.maryland.gov/bopc](http://www.dhmf.maryland.gov/bopc)  
**410-764-4732 – Main Number**

**CSC-AD (Certified Supervised Counselor-Alcohol & Drug)**  
**Alcohol and Other Drug Counselors**  
**Out of State Licensure or Certification Verification Form**

Applicant must complete items 1 thru 10 below and then forward this form to the state(s) where licensed.

1. Name:		2. Date Of Birth:	
3. Address (street, city, state, zip code):			
Telephone No.			
4. Social Security Number:		7. Academic Institution:	
5. License/Certificate Name and No.:		8. Degree:	
6. Years of Experience practicing as an AOD Counselor:		9. Date Rec'd.:	10. Total credits:

I authorize the information requested below to be provided to the Maryland Board of Professional Counselors and Therapists.

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

**Items 11 thru 17 must be completed by the state(s) where the license or certificate is currently held. Return this form directly to the Maryland Board of Professional Counselors and Therapists.**

**Do not return to applicant. PLEASE ATTACH STATE CERTIFICATION REQUIREMENTS AND SCOPE OF PRACTICE.**

11. License/Certificate Title:	
12. Issuing State:	13. Date of Original Issue:
14. Issued by: <input type="checkbox"/> Examination <input type="checkbox"/> Endorsement/ Reciprocity <input type="checkbox"/> Grandfathering	15. License/certificate is : <input type="checkbox"/> Active (Expiration Date: _____) <input type="checkbox"/> Inactive (Expired on: _____)
16. If applicant was credentialed by examination, indicate title of the licensing/certification exam taken:  Other:	
17. Has this license/certificate ever been revoked, suspended, restricted or placed on probation?  Yes <input type="checkbox"/> No <input type="checkbox"/> IF YES, PLEASE EXPLAIN ON REVERSE SIDE. Attach Final Order.	

\_\_\_\_\_  
Name (print) Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

**SEAL**

**COURSE FORM FOR OUT OF STATE APPLICANTS**  
**CSC-AD: Certified Supervised Counselor-Alcohol and Drug**

**Applicants must document completion of coursework appropriate to the level of certification or licensure for which they are applying. Please attach official transcripts from an accredited college or university or copies of continuing education certificates.**

**Please note: “Health or human services counseling field” includes programs such as Human Services, Psychology, Social Work, Substance Abuse Counseling, Addictions, Counseling, Psychiatric Nursing, Human Development, Counselor Education, Education Psychology, or Rehabilitation Counseling. Other degree programs are considered on a case-by-case basis, but MUST include preparation for counseling/therapy as a major component of the program.**

**An applicant for CSC-AD must: (1) Hold an Associate’s degree in a health or human services counseling field from an accredited educational institution approved by the Board. (2) Complete a minimum of (1 semester credit hours OR, 2 quarter credit hours, OR 12 educational workshop hours) covering:**

**Alcohol and Other Drug-Specific Ethics**, including the following content: (a) Self-disclosure of recovery status (b) Ethics of being a two- hatter. (c) Self-help fellowship participation (d) Avoiding dual relationships (e) Relapsing counselors (f) Confidentiality laws

<i>Office Use Only</i>	REQUIRED ALCOHOL AND OTHER DRUG COUNSELING COURSEWORK	WRITE IN CREDITS EARNED	WRITE IN NUMBER(S) & TITLES OF REQUIRED COURSES	WRITE IN YEAR AND SCHOOL WHERE COURSES TAKEN (mark unofficial transcripts to correspond to this list)	WRITE IN EXPLANATION- If needed
	Alcohol and drug-specific ethics <i>(1 semester credit/2 quarter credits/ 12 continuing education units required)</i>				

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**Professional Experience Verification Form**

The person named below has applied to the Maryland Board of Professional Counselors and Therapists to become a **Certified Supervised Counselor – Alcohol and Drug (CSC-AD)**. Your documentation of the applicant's alcohol and other drug counseling experience will enable the Board to evaluate whether this applicant meets the requirements for certification. **Please attest to the following statement and return the form to the applicant in the sealed envelope with the sealed flap signed.**

(Print name of applicant) \_\_\_\_\_ has

an Associates Degree, and has 2 years experience with a minimum of 2,000 hours of supervised experience in providing alcohol and other drug counseling.

**I HEREBY AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE FOREGOING INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE INFORMATION AND BELIEF.**

Check one: \_\_\_ Applicant's supervisor \_\_\_ Applicant's employer \_\_\_ Applicant's colleague (*in case of colleague, provide documentation of colleague's mental health credential*)

Your Name: \_\_\_\_\_

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

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

Your Business Address: \_\_\_\_\_

\_\_\_\_\_  
(Zip code)

Daytime Contact: \_\_\_\_\_

Email \_\_\_\_\_