



CANNON BUILDING  
861 SILVER LAKE BLVD., SUITE 203  
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE  
DEPARTMENT OF STATE

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: WWW.DPR.DELAWARE.GOV

DIVISION OF PROFESSIONAL REGULATION

### **INSTRUCTIONS FOR COMPLETION OF LICENSED CHEMICAL DEPENDENCY PROFESSIONAL APPLICATION**

1. **LCDP Application** – Submit a completed application, which must be signed and notarized, along with the appropriate pro-rated fee. Make your check or money order payable to the “State of Delaware”.
2. **Direct Supervision Reference Form** – Your supervisor(s) must complete this form and send it directly to the Board. The forms must clearly indicate the number of substance abuse counseling hours. The supervisor(s) must be a licensed chemical dependency professional, licensed clinical social worker, licensed psychologist, licensed professional counselor of mental health or licensed physician specializing in chemical dependency treatment.
3. **Employment Verification Form** – Your administrative or clinical supervisor(s) must complete this form and send it directly to the Board. The forms must clearly indicate the number of supervised and unsupervised substance abuse counseling experience hours.
4. **DCB Inc. Certification Form** – If you are certified by DCB Inc., complete Part 1 of the form and mail to the Delaware Certification Board, Inc. They will complete the form and forward it to the Board.
5. **NAADAC Certification Form** - If you are certified by NAADAC, complete Part 1 of the form and mail to NAADAC. They will complete the form and forward it to the Board. Note that if you are certified by both DCB Inc. and NAADAC, you will need to complete both verifications.
6. **Verification of Licensure Form** - If you hold any license in another state, submit verification of licensure in good standing from each state where you are licensed.
7. **Official Transcript** – Submit an official transcript of your completed Masters degree which documents 30 graduate semester hours in counseling.

**Please note the Board will not accept any faxed or copied forms. All documents must be originals.**

**Board Rule 5.3 Time Limit for Completion of Application** - Any application not completed within one (1) year shall be considered null and void.

If you have any questions, please contact the board’s Administrative Specialist at (302) 744-4500.



8. **National Certifying Organization:**

Name of Certifying Organization	Certification Number	Date Certified	Expiration Date
DCB INC			
NAADAC			
Other Certifying Organization	(Requires completion of "Other Certifying Organization Form," available from the Board office.)		

9. **Graduate Education** - Please list graduate degrees below. (Use additional page if needed.)

Degree	Date Awarded	Educational Institution Granting Degree	Field of Study

10. **Summary of Professional Counseling Experience and Clinical Supervision by Setting/Location:**

Please complete the following table:

No.	Name of Setting/Location* in which Substance Abuse Counseling Experience and Clinical Supervision were acquired	Dates		Number of Hours of Substance Abuse Counseling Experience/Supervision		
		From	To	Unsupervised Substance Abuse Counseling Experience	Supervised Substance Abuse Counseling Experience*	Face to Face Clinical Supervision
1						
2						
3						
4						
5						
Total Number of Hours of Substance Abuse Counseling Experience/Clinical Supervision						

**\*Minimum 1,600 hours of clinical supervised experience, at least 100 hours of which shall consist of face to face clinical supervision.**

**Please note: You must complete the attached "Setting/Location Information Form" for each setting/location listed.**

11. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction? Yes  No   
**If yes, submit a certified copy of your criminal history record.**

To assure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- Completed, signed and notarized application form
- Fee payment
- All required supporting documentation.

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is complete, please allow 4-6 weeks to receive your license

*I certify that the information provided in this application is accurate and complete to the best of my knowledge and belief. I understand that the State of Delaware, Board of Mental Health and Chemical Dependency Professionals has the right to deny or revoke licensure if my application contains fraudulent information. I also understand that this application, if incomplete, will be considered null and void one year after receipt by the Board of Mental Health and Chemical Dependency Professionals.*

*I hereby authorize any administrative supervisor, clinical supervisor, designated objective agent and/or other person listed as a reference in this application to release any and all information relevant to my qualifications as a mental health counselor, including, but not limited to, my education and training, professional counseling experience, professional history, character and ethics to the Delaware Board of Mental Health and Chemical Dependency Professionals.*

---

Signature of Applicant

---

Date

**Delaware Board of Mental Health and Chemical Dependency Professionals**

SETTING/LOCATION INFORMATION FORM

Please complete one of these forms for each setting/location in which you acquired your professional counseling experience and clinical supervision, as listed in Question 10 on the "Application for Licensure." Please photocopy this form as needed.

1. **Your Name:** \_\_\_\_\_

2. **Setting/Location:**

A. Setting/Location Number (from Question 10 on Application): \_\_\_\_\_

B. Setting/Location Name: \_\_\_\_\_

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

C. Description of Setting/Location (for example, private/group practice, community mental Health agency, elementary school, etc.): \_\_\_\_\_

D. State Business License Number (if self-employed): \_\_\_\_\_

3. **Substance Abuse Counseling Experience in this Setting/Location:**

A. Dates of Substance Abuse Counseling Experience: From \_\_\_\_\_ To \_\_\_\_\_

Number of Hours of **Unsupervised** Substance Abuse Counseling Experience: \_\_\_\_\_

Number of Hours of **Supervised** Substance Abuse Counseling Experience: \_\_\_\_\_

Total Number of Hours of Substance Abuse Counseling Experience: \_\_\_\_\_

B. Job Position/Title: \_\_\_\_\_

C. Job Responsibilities and Activities (use additional page if needed): \_\_\_\_\_

D. Verification of Substance Abuse Counseling Experience in this Setting/Location: Who will verify your professional counseling experience? (Check one.)

Clinical Supervisor

Administrative Supervisor

Designated Objective Agent (for Self-Employed Applicants)

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

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

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

\_\_\_\_\_ Zip Code: \_\_\_\_\_

4. **Face to Face Clinical Supervision in this Setting/Location:**

A. Please complete the following table:

Name of Supervisor	Type of Supervision	Number of Hours of Face to Face Supervision
	(a) Individual Supervision:	
	(b) Group Supervision:	
	(c) Individual Supervision:	
	(d) Group Supervision:	
(e) Total Individual Clinical Supervision in this setting/ location: [(a) + (c)]:		
(f) Total Group Clinical Supervision in this setting/location: [(b) + (d)]:		
(g) Total of All Clinical Supervision in this setting/location: [(e) +(f)]:		

B. Name of Clinical Supervisor: \_\_\_\_\_

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

\_\_\_\_\_ Zip Code: \_\_\_\_\_

Degree: \_\_\_\_\_ Type of License: \_\_\_\_\_  
(e.g., LPCMH, LCSW, LCDP, Psychologist, Psychiatrist)

License #: \_\_\_\_\_ State: \_\_\_\_\_ Date of Licensure: \_\_\_\_\_

C. Name of Additional Direct Supervisor: \_\_\_\_\_

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

\_\_\_\_\_ Zip Code: \_\_\_\_\_

Degree: \_\_\_\_\_ Type of License: \_\_\_\_\_  
(e.g., LPCMH, LCSW, LCDP, Psychologist, Psychiatrist)

License #: \_\_\_\_\_ State: \_\_\_\_\_ Date of Licensure: \_\_\_\_\_

D. Name of Additional Direct Supervisor: \_\_\_\_\_

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

\_\_\_\_\_ Zip Code: \_\_\_\_\_

Degree: \_\_\_\_\_ Type of License: \_\_\_\_\_  
(e.g., LPCMH, LCSW, LCDP, Psychologist, Psychiatrist)

License #: \_\_\_\_\_ State: \_\_\_\_\_ Date of Licensure: \_\_\_\_\_

**Delaware Board of Mental Health and Chemical Dependency Professionals**

**AFFIDAVIT**

The undersigned applicant for Chemical Dependency Professional Licensure, being sworn, deposes and affirms that she/he meets the following Qualifications for Licensure as stated in Title 24 *Delaware Code*, Chapter 30:

The applicant is not the recipient of any administrative penalties regarding his/her actions as a licensed, registered or certified mental health provider, and has not entered into any "consent agreements" containing conditions placed upon his/her professional conduct, including voluntary surrender of license;

The applicant does not have any impairment related to drugs, alcohol, or a finding of mental incompetence by a physician that would limit the applicant's ability to safely act as a Licensed Chemical Dependency Professional.

The applicant has not been convicted of a felony and does not have any criminal conviction or pending criminal charge which is substantially related to the fitness or ability to perform one or more of the duties or responsibilities necessarily related to practice as a Licensed Chemical Dependency Professional.

The applicant has not been penalized for any willful violation of any code of ethics or professional mental health or chemical dependency counseling standard.

The applicant further states that she/he has not violated any rule or regulation set forth by the Delaware Board of Mental Health and Chemical Dependency Professionals.

\_\_\_\_\_  
Signature of Applicant

State of \_\_\_\_\_

City of \_\_\_\_\_ County of \_\_\_\_\_

Sworn to me before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

My commission expires on \_\_\_\_\_.

\_\_\_\_\_  
Signature of Notary Public



CANNON BUILDING  
861 SILVER LAKE BLVD., SUITE 203  
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE  
DEPARTMENT OF STATE

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: WWW.DPR.DELAWARE.GOV

DIVISION OF PROFESSIONAL REGULATION

**Board of Mental Health and Licensed Chemical Dependency Professionals**

**DIRECT SUPERVISION REFERENCE FORM  
FOR CHEMICAL DEPENDENCY PROFESSIONALS**

(To be completed by Direct Supervisor)

1. Name of Applicant: \_\_\_\_\_
2. Name of Direct Supervisor: \_\_\_\_\_  
 Title: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Setting/Location Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_ Zip Code: \_\_\_\_\_
2. Dates of Direct Supervision: From \_\_\_\_\_ To \_\_\_\_\_  
 Total Number of Hours of Direct Supervision: \_\_\_\_\_\*
- Number of Hours of Individual Face-to-Face Supervision: \_\_\_\_\_
- Number of Hours of Group Face-to-Face Supervision: \_\_\_\_\_
- Total Number of Hours of Face-to-Face Supervision: \_\_\_\_\_
3. Did you provide the actual face-to-face supervision of this applicant?  
 Yes  No  If not, who did? \_\_\_\_\_
4. Where did this supervision occur? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\*Minimum 1,600 hours of directly supervised substance abuse counseling experience, at least 100 hours of which shall consist of face-to-face supervision.

5. Please list the mental-health-related license(s) you held at the time of this supervision:

State	Type of License	License Number	Date Licensed

-----  
*I certify that the information provided herein is accurate and complete to the best of my knowledge and belief and that this applicant competently and satisfactorily performed his/her counseling duties.*

\_\_\_\_\_  
Signature of Clinical Supervisor

\_\_\_\_\_  
Date

**Board of Mental Health and Chemical Dependency Professionals**

**EMPLOYMENT VERIFICATION FORM FOR LCDP APPLICANTS**

(To be completed by Administrative or Clinical Supervisor)

1. Name of Applicant: \_\_\_\_\_

2. Name of Administrative Supervisor: \_\_\_\_\_

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

Setting/Location Name: \_\_\_\_\_

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

\_\_\_\_\_ Zip Code: \_\_\_\_\_

3. Dates of Employment: From \_\_\_\_\_ To \_\_\_\_\_

Number of Hours of **Unsupervised** Substance Abuse Counseling Experience: \_\_\_\_\_

Number of Hours of **Supervised** Substance Abuse Counseling Experience: \_\_\_\_\_  
(This includes group and/or face-to-face hours)

Total Number of Hours of Substance Abuse Counseling Experience: \_\_\_\_\_

4. Description of Agency/Work Setting (for example, Alcohol and drug treatment center; residential, outpatient or detox, methadone clinic, partial hospital program, hospital setting, school setting, etc.)

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

*I certify that the information provided herein is accurate and complete to the best of my knowledge and belief and that this applicant competently and satisfactorily performed his/her substance abuse counseling duties.*

\_\_\_\_\_  
Signature of Administrative or Clinical Supervisor

\_\_\_\_\_  
Date



CANNON BUILDING  
861 SILVER LAKE BLVD., SUITE 203  
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE  
DEPARTMENT OF STATE

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: WWW.DPR.DELAWARE.GOV

DIVISION OF PROFESSIONAL REGULATION

DCB INC CERTIFICATION FORM

To: Delaware Certification Board, Inc.  
100 W. 10<sup>th</sup> St., Suite 106  
Wilmington, DE 19801

The applicant named below has applied for licensure as a Chemical Dependency Professional in the State of Delaware. Please verify that s/he is a Certified Alcohol and Drug Counselor (CADC) in good standing and return this form to the Delaware Board of Mental Health and Chemical Dependency Professionals at the address above. Thank you in advance for your assistance.

**Part 1 - To be completed by Applicant:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

\_\_\_\_\_ Zip Code: \_\_\_\_\_

Certification No. \_\_\_\_\_ Date Certified: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

*I hereby authorize the Delaware Certification Board, Inc., to release information regarding my certification to the Delaware Board of Mental Health and Chemical Dependency Professionals.*

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**Part 2 - To be completed by an Official of the Delaware Certification Board, Inc.:**

Is the applicant currently certified as represented above? Yes  No

Is the applicant currently in good standing? Yes  No

**Part 2 -- Continued**

If the answer to either of the above is “no,” please give full particulars: \_\_\_\_\_

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

Name of DCB INC Official: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_  
Signature of DCB INC Official

\_\_\_\_\_  
Date



CANNON BUILDING  
861 SILVER LAKE BLVD., SUITE 203  
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE  
DEPARTMENT OF STATE

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: WWW.DPR.DELAWARE.GOV

DIVISION OF PROFESSIONAL REGULATION

NAADAC CERTIFICATION FORM

To: NAADAC, the Association of Addiction Professionals  
901 N. Washington St. Suite 600  
Alexandria, VA 22314

The applicant named below has applied for licensure as a Chemical Dependency Professional in the State of Delaware. Please verify that s/he is a NCAC I, NCAC II or MAC in good standing and return this form to the Delaware Board of Mental Health and Chemical Dependency Professionals at the address above. Thank you in advance for your assistance.

**Part 1 - To be completed by Applicant:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

\_\_\_\_\_ Zip Code: \_\_\_\_\_

Certification No. \_\_\_\_\_ Date Certified: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

*I hereby authorize NAADAC, the Association of Addiction Professionals, to release information regarding my certification to the Delaware Board of Mental Health and Chemical Dependency Professionals.*

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**Part 2 - To be completed by an Official of NAADAC, the Association of Addiction Professionals:**

Is the applicant currently certified as represented above? Yes  No

Is the applicant currently in good standing? Yes  No

**Part 2** Continued

If the answer to either of the above is “no,” please give full particulars: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of NAADAC Official: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_  
Signature of NAADAC Certification Official

\_\_\_\_\_  
Date



CANNON BUILDING  
861 SILVER LAKE BLVD., SUITE 203  
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE  
DEPARTMENT OF STATE

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: WWW.DPR.DELAWARE.GOV

DIVISION OF PROFESSIONAL REGULATION

**Delaware Board of Mental Health and Chemical Dependency Professionals**

VERIFICATION OF LICENSURE FORM

**Part 1 – Applicant completes this section and sends to states where currently (or previously) licensed. Duplicate form as needed.**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Licensed as: \_\_\_\_\_ License No.: \_\_\_\_\_

I authorize \_\_\_\_\_ to release information regarding my licensure or  
Name of State Licensing Board/Authority  
registration to the Delaware Board.

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

**Part 2 - State Licensure Board/Authority completes this section and returns to Board address above:**

Registration/License No: \_\_\_\_\_

Original Date of Registration/Licensure: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Has the licensee ever been subject to any disciplinary action, or had his/her license suspended or revoked?  
Yes  No  (If yes, please explain below, the nature of the disciplinary action and the current status of the  
license. Use additional pages, if needed.) \_\_\_\_\_

Are there any current or pending disciplinary proceedings or unresolved complaints against the applicant?  
Yes  No  (If yes, please explain below, the nature of the proceeding or complaint and current status. Use  
additional pages, if needed.) \_\_\_\_\_

**I certify the statements contained herein are true and correct.**

Name of Official: \_\_\_\_\_ Title: \_\_\_\_\_

Name and Address of Licensure Authority: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Official: \_\_\_\_\_ Date: \_\_\_\_\_

**AFFIX BOARD SEAL**