



UTAH DEPARTMENT OF COMMERCE

Division of Professional Licensing

Associate Master Addiction Counselor (AMAC)

Initial Application

Endorsement Application

APPLICANT INFORMATION

Full Legal Name: First Middle Last

All Previous Legal Names:

Other DOPL Licenses Held:

SSN:\* Date of Birth: Gender: Male Female

\*If you don't have a social security number, please follow the instructions on the last page.

Address: Street Address (including Apt/Unit/Ste #) and/or PO Box

City: State: Zip:

Phone: ( ) - Email:

Note: All Division notices and communication will be sent to this email.

Please select one:

- I am a United States citizen or a non-citizen of the United States who is lawfully present.
I am a foreign national not physically present in the United States.
None of the above, please explain:

Driver License or State ID Card: State of Issue License Number Expiration Date

NOTE: If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of lawful presence in the United States.

AFFIDAVIT AND RELEASE

I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, and discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.

I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Department of Commerce, State of Utah, any files, records, or information of any type reasonably required for the Department to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

I understand that I am responsible for updating the Department of any changes relating to my application/license/certification/registration.

I understand that if the application is not complete at the time of submission, it will delay approval and could result in a denial.

I declare under criminal penalty under the law of Utah that this application is true and correct.

Signature of Applicant: Date:



## PRIVACY NOTICE

The information you provide on this form will be used to determine your eligibility for a license, registration, or certification in Utah. Failure to provide complete information as requested will result in the denial of your request as incomplete.

Information provided in this form is retained in accordance with state record retention laws. For specific information about the records retention for this form, please visit <https://dopl.utah.gov/records>.

To comply with legal and regulatory requirements, we may share limited information about your license, registration, or certification with authorized parties. This may include government agencies, national databases, and contracted vendors. Shared information may include issue date, status, expiration date, disciplinary actions, and your name or other direct identifiers.

We may also share aggregated and de-identified data (e.g., education levels, exam pass rates, length of licensure, etc.) with relevant stakeholders for data analysis and reporting purposes.

## ACKNOWLEDGEMENT:

Your signature acknowledges receipt of this information.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## QUALIFYING QUESTIONNAIRE

**Do not leave any question blank.**

*DOPL may request additional documentation if the information submitted is insufficient.*

1.  Yes  No      Have you EVER had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, resigned, or surrendered while under investigation, or otherwise **disciplined in any way**?

2.  Yes  No      Do you CURRENTLY have **any criminal action active or pending**?

3.  Yes  No      WITHIN THE PAST 10 YEARS, have you pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a **misdemeanor** in any jurisdiction?

4.  Yes  No      Have you EVER pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a felony in any jurisdiction?

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "Yes" to questions 2, 3, or 4 you must submit the following for EACH and EVERY incident:

- **personal account of the incident**
- **court record(s)**
- **police report(s)**
- **probation/parole officer report(s)**

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

Please **DISCLOSE** the following:

- charges that were later held in abeyance (plea in abeyance), diverted, reduced, or dismissed.
- motor vehicle offenses such as driving while impaired or intoxicated.
- if you are restricted from possession, purchase, transfer, or ownership of a firearm or ammunition (even if your restriction is based on a non-reportable juvenile conviction).

You do **NOT** need to disclose:

- minor traffic offenses such as parking or speeding violations.
- juvenile offenses, unless you were tried as an adult.
- legally expunged or sealed criminal history incidents.

For more information, see DOPL's [criminal history FAQs](#).

## PROFESSIONAL LICENSES

List all other licenses, registrations, or certifications issued by any jurisdictions, which you now hold or have ever held, in any profession. *(Use additional sheets if necessary.)*

Profession: \_\_\_\_\_ License Number: \_\_\_\_\_

Issuing State: \_\_\_\_\_ License Status: \_\_\_\_\_ Issue Date: \_\_\_\_\_

Profession: \_\_\_\_\_ License Number: \_\_\_\_\_

Issuing State: \_\_\_\_\_ License Status: \_\_\_\_\_ Issue Date: \_\_\_\_\_

If you identified an Associate Master Addiction Counselor license above, please answer the following:

Yes  No      After obtaining the license(s) above, have you engaged in at least one year of experience in the state, district, or territory of the United States where the license was issued?

**Note:** *If you answer "Yes" to the question above, please see the checklist at the end of this application or [our website](#) for instructions on applying by endorsement.*



## MEDICAL QUALIFYING QUESTIONNAIRE

**Read thoroughly and answer each question. Do not leave any question blank.**

*A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.*

1. **Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:**
  - Yes  No a hospital or health care facility
  - Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program
  - Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency
  - Yes  No malpractice insurance coverage
  - Yes  No other entity: \_\_\_\_\_

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2. **Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:**
  - Yes  No a hospital or health care facility
  - Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program
  - Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency
  - Yes  No malpractice insurance coverage
  - Yes  No other entity: \_\_\_\_\_

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3. **Is any action pending against you now by:**
  - Yes  No a hospital or health care facility
  - Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program
  - Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency
  - Yes  No malpractice insurance coverage
  - Yes  No other entity: \_\_\_\_\_

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4.  Yes  No **Have you been named as a defendant in a malpractice suit?**

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5.  Yes  No **Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?**

If you answered "Yes" to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. NPDB website: <http://www.npdb.hrsa.gov>.

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

## NATIONAL PROVIDER IDENTIFIER (NPI)

Your NPI: \_\_\_\_\_

## SUICIDE PREVENTION TRAINING

I have completed the following:

- A 2-hour training in suicide prevention obtained **AFTER** completion of my education needed for licensure.

**NOTE: A completion certificate must be uploaded with the online application or submitted with this application.**



**EDUCATION REQUIREMENTS**

I meet one of the following educational requirements:

- I have completed a doctoral or master's degree from a regionally accredited institution of higher learning in substance use disorders or addiction counseling and treatment.
- I have completed a doctoral or master's degree, or higher, from a regionally accredited institution of higher learning in social work, mental health counseling, marriage and family counseling, psychology, medicine.

**AND**

I have completed an associates degree or higher, or 18 credit hours, in substance use disorder or addiction counseling and treatment from a regionally accredited institution of higher learning.

**AND**

I have completed 200 hours of direct client care in substance use disorder or addiction treatment during an internship or practicum under the oversight of a regionally accredited institution of higher learning.

**NOTE: Official examination scores, transcripts, or certifications must be submitted directly from the accredited educational institution, NAADAC, NCC AP, IC&RC, the National Certification Commission for Addiction Professionals, or the International Certification and Reciprocity Consortium to verify this information.**

**CLINICAL SUPERVISION ACKNOWLEDGEMENT**

Please read and acknowledge each statement below:

- I understand that, should I be issued an Associate Master Addiction Counselor license I will only be able to practice under clinical supervision.
- I have read and understand the clinical supervision requirements as outlined in [Utah Code § 58-60-506](#).
- I understand that, in order to be considered a clinical supervisor, a person must hold master's level licensure for at least two years and be currently in good standing before providing supervision.
- I understand that, before beginning to gather Clinical Supervision hours I must enter into and sign a supervision contract with my clinical supervisor as outlined in Utah Administrative Code.
- I understand that an Associate level license is only valid for three years and is for the sole purpose of allowing time to pass the required examination and gather the required clinical supervision hours and it is not a renewable or extendable license.

I acknowledge the I have read and agree with the statements above.

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

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



# Verification of Active Licensed Practice in Another State

*For endorsement applicants. See checklist for additional information.*

Each employer must complete a separate form.

## APPLICANT INFORMATION (TO BE COMPLETED BY THE APPLICANT)

Full Legal Name: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

License Number: \_\_\_\_\_ State of Issue: \_\_\_\_\_

## EMPLOYMENT INFORMATION: (TO BE COMPLETED BY THE EMPLOYER, HUMAN RESOURCES, SUPERVISOR OR A PROFESSIONAL COLLEAGUE)

Name of Establishment: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ – \_\_\_\_\_ Email: \_\_\_\_\_

Dates of Employment : \_\_\_\_\_ to \_\_\_\_\_  
MM/DD/YYYY MM/DD/YYYY

How many hours did the applicant work per week? \_\_\_\_\_

Number of hours practicing clinical counseling: \_\_\_\_\_

Describe the applicant's duties: *(attach additional sheet if needed)*

Is the applicant still employed?  Yes  No

If no, is the applicant re-hirable?  Yes  No

If not re-hirable, please explain *(attach additional sheet if needed)*:

## ATTESTATION:

I do hereby certify that the applicant for licensure was actively engaged in lawful practice at the above-named establishment for the time frame listed. I further certify that the applicant is qualified and competent to practice mental health therapy.

**I declare under criminal penalty under the law of Utah that this information is true and correct.**

Signature of certifying individual: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

**NOTE:** Verification of an active and in good standing license to practice must be submitted with this form.



## APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience; you do not need to include it with your application.

**NOTE: Incomplete applications will be denied.**

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information that is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other laws.

**If you do not have a valid Social Security number**, you must submit your Individual Taxpayer Identification Number (ITIN), Alien Registration Number (A-number), or a copy of an unexpired government issued passport from your country of residence and an intent-to-hire letter from a Utah based employer ([Utah Admin. Code R156-1-301](#)). Submission of the above documents may require additional documents to demonstrate lawful presence ([Utah Code § 63G-12-402 \(3\)\(k\)](#)).

### ALL APPLICANTS

The following items are required to complete your application:

- \$120.00 non-refundable application processing fee, made payable to "DOPL".
- Supporting documentation for any "yes" answers provided on either of the qualifying questionnaires.

### INITIAL LICENSURE

If applying for Initial Licensure, in addition to the items required for all applicants, you must submit:

- Documentation of meeting the education requirements for licensure (see page 6 of application).

### LICENSURE BY ENDORSEMENT

If applying licensure by endorsement, in addition to the items required for all applicants, you must submit:

- Official verification, showing active licensure in good standing for at least one year, from a jurisdiction designated by the Division as equivalent to Utah.
- If required, official transcripts and/or exam scores to demonstrate equivalency.
- Verification of Active Practice in another state, hours must total at least 500.

Please see [our website](#) for additional information regarding approved jurisdictions, and any additional documentation that may be necessary.

Submit completed application to the Division:

By US Postal Service:  
**Division of Professional Licensing**  
**PO BOX 146741**  
**Salt Lake City, UT 84114-6741**

By in-person or express delivery:  
**Division of Professional Licensing**  
**Heber M Wells Building, 1st Floor**  
**160 E 300 S**  
**Salt Lake City, UT 84111**

If you have questions, please contact the Division via our direct email address: [b8@utah.gov](mailto:b8@utah.gov), or via the phone or fax number listed below. Do not send applications or payments to this email.