UTAH DEPARTMENT OF COMMERCE
Division of Professional Licensing

Master Addiction Counselor (MAC)

☐ Initial Application ☐ Endorsement Application Clear Form

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**
- **police report(s)**
- **court record(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 a 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: _____

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: _____

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: _____

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

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 & EXAMINATION REQUIREMENTS

I have passed one of the following exams:

- ☐ National Association of Alcohol and Drug Abuse Counselors (NAADAC) National Certification Exam Level II
- ☐ Master Addiction Counselor (MAC) administered by the National Certification Commission for Addiction Professionals (NCC AP)
- ☐ Advanced Alcohol and Drug Counselor (AADC) administered by the International Certification & Reciprocity Consortium (IC&RC)

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.

I meet the above education AND exam requirements by holding one of the following certifications:

- ☐ I hold current certification in good standing as a Master Addiction Counselor (MAC) from the National Certification Commission for Addiction Professionals (NCC AP).
- ☐ I hold current certification in good standing as a Master Addiction Counselor (MAC) from the National Board for Certified Counselors (NBCC).
- ☐ I hold current certification in good standing which I believe is equivalent to the approved certifications listed above. I am requesting Board review of my certification.
  NOTE: *This will require a review by the Behavioral Health Board's Qualification and Professional Development Advisory Committee and may result in a processing delay of up to 65 days.*

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 REQUIREMENTS

Use this form to record your clinical supervision **AFTER** obtaining licensure as an Associate level license holder. Each Supervisor must be associated to you **BEFORE** you begin accruing clinical supervision hours. **NO EXCEPTIONS**. Clinical Supervision hours may **NOT** be obtained while completing the education requirements for licensure.

APPLICANT INFORMATION (TO BE COMPLETED BY THE APPLICANT)

Full Legal Name: _____ _____ _____
First *Middle* *Last*

Associate License Number: _____ Date Issued: _____

CLINICAL SUPERVISOR INFORMATION (TO BE COMPLETED BY THE SUPERVISOR)

Supervisor Name: _____ _____ _____
First *Middle* *Last*

Email: _____
Note: REQUIRED All Division notices and communication regarding supervision will be sent to this email.

License Type: _____ License Number: _____ State of Issue: _____

NOTE: *If the supervisor listed above is licensed outside of the state of Utah an official verification of the supervisor's license, showing it is active and in good standing, must be submitted with this form.*

RECORD OF CLINICAL SUPERVISION HOURS (TO BE COMPLETED BY THE SUPERVISOR)

Dates of Supervision from _____ to _____

TOTAL HOURS IN EACH CATERGORY COMPLETED UNDER THIS CLINICAL SUPERVISOR.

Total Hours Direct Client Care: _____

Total Hours Direct Clinical Supervision: _____

Total Hours Direct Observation: _____

Total Hours Clinical Supervision: ___*0*___

SUPERVISION LOGS MUST BE SUBMITTED TO SUPPORT ALL HOURS RECORDED ON THIS FORM

Signature of Clinical Supervisor: _____ **Date:** _____

CLINICAL SUPERVISION DEFINITIONS

CLINICAL SUPERVISION HOURS 3,000 HOURS OR MORE THAN TWO YEARS

Clinical Supervision Hours means work experience conducted under the supervision of a clinical supervisor, including:

The practice of mental health therapy, direct client care, direct clinical supervision, direct observation, and other duties and activities completed in the course of the day-to-day job functions and work, wherein the supervisor is available for consultation with the supervisee by personal face to face contact, or direct voice contact by telephone, radio, or some other means within a reasonable time consistent with the acts and practices in which the supervisee is engaged, and **MUST** Include the Following:

DIRECT CLIENT CARE HOURS

MUST INCLUDE the practice of mental health therapy, the utilization of patient-reported progress and outcomes to inform care, and direct observation. Hours in this category, from all supervisors, must total at least 1,200.

DIRECT CLINICAL SUPERVISION

MUST INCLUDE the supervisee and their direct clinical supervisor meeting in real time and in accordance with the supervision contract. "Direct clinical supervision" may include group supervision of up to 2 supervisees present. Hours in this category, from all supervisors, must total at least 100.

DIRECT OBSERVATION

MUST INCLUDE observation of a supervisees live or recorded direct client care by the supervisee's clinical supervisor OR a license holder observer who the supervisees direct clinical supervisor approves; and after which, the supervisee and the approved license holder observer meet, in-person or electronically, to discuss the direct client care for the purpose of developing the supervisees clinical knowledge and skill. Hours in this category, from all supervisors, must total at least 25.

GROUP SUPERVISION WITH 3 OR MORE SUPERVISEES

NO MORE THAN 25 hours, from all supervisors, allowed in this category.

Applicant Name: _____ _____ _____
First *Middle* *Last*

Clinical Supervisors Name: _____ License Number: _____

CLINICAL SUPERVISOR ATTESTATION

I certify that the applicant for licensure has successfully completed the clinical supervision, which includes direct client care, direct clinical supervision, direct observation, and may include group supervision as attested by my signature on the Record of Clinical Supervision Hours form.

I further certify that the clinical supervision provided meets the requirements outlined in Utah Code § 58-60-506. During the clinical supervision period for this applicant for licensure, I approved the following license holder(s) to participate in Direct Observation:

Approved Licensed Observers Name: _____ _____ _____
First *Middle* *Last*

License Number: _____ **License Type:** _____

Approved Licensed Observers Name: _____ _____ _____
First *Middle* *Last*

License Number: _____ **License Type:** _____

Approved Licensed Observers Name: _____ _____ _____
First *Middle* *Last*

License Number: _____ **License Type:** _____

Approved Licensed Observers Name: _____ _____ _____
First *Middle* *Last*

License Number: _____ **License Type:** _____

I further certify that the applicant is qualified and competent to practice as a Master Addiction Counselor.

Signature of Clinical Supervisor: _____ **Date:** _____

As a supervisor you are required to sign off for clinical supervision hours legally obtained by a supervised individual. However, if the supervised individual did NOT meet the expectations of clinical supervision with regard to the quality of work performed, submit a written statement regarding the performance to the Division at b8@utah.gov. All submitted statements will be reviewed by the Behavioral Health Board.

NOTE: *This Supervisor Attestation must be completed by every clinical supervisor who has signed the Record of Clinical Supervision Hours form verifying hours.*

UTAH DEPARTMENT OF COMMERCE
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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:

- ☐ Supervised Experience. NOTE: Each supervisor must complete the form for the hours they supervised and the hours from all supervisors must total 500.
- ☐ Official score report of passing the NAADAC - NCE Level II, MAC, or AADC – IC&RC, please see the exam section of our website for additional information.
- ☐ Documentation of meeting the education requirements, which included one of the following:
  - ◎ Official transcripts documenting completion of a bachelor's degree, or higher, from a regionally accredited institution of higher learning in substance use disorders, addiction, social work, mental health counseling, marriage and family counseling, or psychology.
  - ◎ Official transcripts documenting completion of two academic years of study in a master's of addiction counseling curriculum and practicum approved by the National Addictions Studies Accreditation Commission.
  - ◎ Current certification in good standing as a National Certified Addiction Counselor Level II (NCAC II) from the National Certification Commission for Addiction Professionals (NCC AP) OR current certification as an Advanced Alcohol & Drug Counselor (AADC), from the International Certification and Reciprocity Consortium.

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, or via the phone or fax number listed below. Do not send applications or payments to this email.