AR Department of Health

State Board of Examiners of Alcoholism & Drug Abuse Counselors

4815 West Markham, Box 42A
Little Rock, AR 72205
Phone: (501) 295-1100 Fax: (501)251-1151
E-mail: sbeadac@gmail.com

REGISTRATION APPLICATION

CREDENTIAL APPLYING FOR:
LADAC_____ LAADAC____

Name: _____
(last) (first) (middle initial)
Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

Telephone: Home ( )_____Work ( ) _____ Cell ( ) _____

Gender: Male ___ Female ___ Ethnicity: (optional) _____

DOB: _____ Social Security #:_____

EMPLOYMENT

Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( ) _____ Fax: ( ) _____

Position Title: _____

EDUCATION

Highest degree earned:
_____ Doctoral
_____ Masters
_____ Bachelor
_____ High school or equivalent

Institution awarding highest level of education: _____

Date highest level awarded: _____ Major: _____

EXPERIENCE

Number of years of professional experience: _____

Please list all relevant, current professional credentials; including the issuing authority, credential number, and date of expiration. (**Attach copy**.)

_____
_____
_____
_____

Professional affiliations:

_____
_____
_____
_____

Have you ever been refused a professional credential/license?_____ Have you ever had a professional credential/license revoked?_____ Are you currently under investigation?_____ If you answered yes to any of the above questions please explain: _____
_____
_____

*Per the Workforce Expansion Act 725 of 2021, the Board shall waive the initial licensing fee if the applicant: (1) Is receiving assistance through the AR Medicaid Program; the Supplemental Nutrition Assistance Program; the Special Supplemental Nutrition Program for Women, Infants, and Children; the Temporary Assistance for Needy Families Program; or the Lifeline Assistance Program; (2) Was approved for unemployment within the last 12 months; or (3) Has an income not to exceed 200% of the federal poverty income guidelines. It will be up to the applicant to provide documentation to prove these extenuating circumstances, and then up to the SBEADAC Board to approve waiving the initial fee.

STATEMENT OF AGREEMENT

I, _____, hereby submit my application for licensure/certification to the Arkansas State Board of Examiners of Alcoholism and Drug Abuse Counselors. I hereby certify that the information submitted in this application is true and complete to the best of my knowledge and understand that, if licensed, falsified statements shall be grounds for revocation or denial of licensure.

I authorize the investigation of all statements contained herein to include references, educational, and other pertinent background information required by law for licensure.

_____ _____
Signature Date

State of: _____

County of: _____

Subscribed and sworn before me, a Notary Public in and for the county and state aforesaid, this the _____ day of _____, 20_____.

Notary Public: _____

My commission expires: _____