



**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: \_\_\_\_\_

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

**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: \_\_\_\_\_

