# AR Department of Health

**State Board of Examiners of Alcoholism & Drug Abuse Counselors**

**4815 West Markham, Box 42A**
**Little Rock, AR 72205**
**Phone: (501) 683-0707 Fax: (501)682-0427**
**E-mail: ARBEADAC@Arkansas.Gov**


## 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: _____