OKLAHOMA
Board of Licensed
Alcohol and Drug Counselors

P O Box 54388
Oklahoma City, OK 73154
Telephone: (405) 521-0779

APPLICATION INVENTORY

(Please attach this form to the front of your completed application material)

Applicant's name: _____Date:_____

Please check the line beside the appropriate response:

I am applying to become licensed/certified as an: ___LADC/MH ___CADC

Forms may be printed from the website in the future.

Inside this packet I have enclosed the following:

___ This Inventory Sheet

__ Notarized Application Form

___ The application fee $175.00

___ Personal Philosophy

___ Signed Code of Ethics

___ Three (3) Professional References.

___ Supervision contract.

___ Photocopy of personal identification (e.g., current driver's license, passport, etc.)

___ Official Transcript(s).

___ Practicum

___ Employment Verification Form

___ Notarized Affidavit of Legal Status

Please list any additional enclosures in the space below:

OKLAHOMA
Board of Licensed
Alcohol and Drug Counselors

☐ Check if you have taken & passed the IC&RC (or equivalent) written exam only.

I am applying for ☐ LADC/MH ☐ CADC Application Date: _____

Name: _____ Date of Birth: _____ Gender: _____

Race: _____ Ethnicity: _____ Languages Spoken: _____

Educational Background: _____ Type of Degree: _____

Internship Information, If Applicable & Location of Internship: _____

Training Information: _____ Other M/H Certifications or Licenses: _____

Address: _____
(Street or PO Box) (City) (State) (Zip)

Day Time Phone: _____ Email: _____

Social Security Number: _____ Work Phone: _____

Employer: _____

Address: _____
(Street or PO Box) (City) (State) (Zip)

Have you ever been convicted, pled guilty or nolo contendere to a felony? ☐ Yes ☐ No
If yes, when? _____ **Include documentation with materials submitted.**
Are you on probation? ☐ Yes ☐ No **Include documentation with materials submitted.**

***Having a conviction does not exempt you from obtaining certification or licensure. The Board will make the final decision.**

Initial, sign and notarize

_____ I authorize the Oklahoma Board of Licensed Alcohol and Drug Counselors to conduct a criminal background check and contact any/all references imperative for verification and/or clarification.

_____ _____
(Signature) (Printed Name)

State of_____ Signed or attested before me on _____ by _____.
Date Name of Applicant

County of_____ Notary signature_____ My commission expires:_____

Notary Seal

OKLAHOMA
Board of Licensed
Alcohol and Drug Counselors

LICENSED/CERTIFIED COUNSELOR
CODE OF ETHICS

I HEREBY AFFIRM THAT…

A. My primary goal is recovery for the client and his families; that I have a total commitment to provide the highest quality care for those who seek my professional services.

B. I shall evidence a genuine interest in all clients and families and do hereby dedicate myself to the best interest of the clients and to helping them to help themselves.

C. I shall always maintain an objective, non-possessive, professional relationship with all clients.

D. I shall be willing to recognize when it is in the best interest of the client to release them or refer them to another program or individual.

E. I shall adhere to all the professional rules of confidentiality of all maintenance and distributions of records, material, and knowledge concerning the client and respect the integrity and protect the welfare of the person or group with whom I am working.

F. I shall not in any way discriminate between clients, families, or fellow professionals based on race, religion, age, sex, handicap, national ancestry, sexual orientation or economic conditions.

G. I shall respect the rights and views of other counselors and professionals.

H. I shall advocate changes in public policy and legislation to afford opportunities and choices for all diseased chemical abusers endangering themselves and others.

I. I shall maintain respect for institutional policies and management functions within agencies and institutions but will take the initiative toward improving such policies when it will better serve the interest of the client.

J. I have a commitment to assess my own personal strengths, limitations, biases, and effectiveness on a continuing basis; that I shall continuously strive for self-improvement; that I have a personal responsibility for professional growth through further education and training.

K. I have an individual responsibility to espouse objectivity and integrity; responsibility to uphold legal and moral turpitude and ethical professional codes, responsibility for my own conduct in all areas. Including, but not limited to, personal behavioral, the use of mood-altering drugs, and
community activities. I am further willing to provide, respond to, and support requests by the credentialing body for professional disclosure of legal and ethical behavior and records relating, impinging or affecting the Alcohol Drug Counselor profession and my professional status.

L. I shall cooperate with duly constituted professional Ethics Boards and promptly supply necessary information unless constrained by demands of specialized confidentiality rules.

M. I have a responsibility to myself, my clients, the community and associates to maintain my physical and mental health and well-being and shall adopt a personal and professional stance which promotes the well-being of all human beings.

I hereby certify that I have read and agree to abide by the OBLADC code of ethics. I also understand that failure to abide by the OBLADC code of ethics may result in the revocation of my intent status to practice as an alcohol/drug counselor.

_____
PRINT NAME

_____
SIGNATURE DATE

OKLAHOMA STATE BOARD OF LICENSED ALCOHOL AND DRUG COUNSELORS

LADC/MH CODE OF ETHICS

LADC/MH Candidate Name: _____

1 – **Non-discrimination**
LADC/MH counselors must not discriminate against clients or other counselors based on race, color, religious creed, age, marital status, national origin, ancestry, sex, sexual orientation or mental or physical disability.

2 - **Responsibilities**
LADC/MH counselors shall exercise professional judgment when dealing with clients and other professionals, and at all times, shall maintain the best interests of the client when providing counseling.

3 – **Competence**
LADC/MH counselors shall provide competent professional service to clients. Competent professional service requires thorough knowledge of alcohol and drug abuse, mental disorders, and the interactive relationship of these disorders and skill in presentation and counseling techniques, thoroughness and preparation reasonably necessary to assure the highest level of quality care to a client, and a willingness to maintain state-of-the-art knowledge through on-going professional education in co-occurring specific training and education.

4 – **Professional Standards**
LADC/MH counselors shall maintain the highest professional standards and shall not:

- Claim either directly or by implication, professional knowledge, qualifications or affiliations that they do not possess;
- Lend their names to, or participate in, any professional and/or business relationship which may misrepresent or mislead the public in any way;
- compromise professional status as co-occurring recovery counselors with clients through the association, development and/or promotion of books or other products offered for commercial sale;
- Fail to recognize the effect of professional impairment or professional performance and must be willing to seek appropriate treatment for themselves.

5 – **Professional Obligations to the Public**
LADC/MH counselors must not state or imply a higher degree of knowledge and/or insight into alcoholism and drug abuse that would be available through similarly situated and/or trained professionals.

6 – **Publications**
LADC/MH counselors that participate in the writing, editing, or publication of professional papers, pamphlets, or books, must act to preserve the integrity of the profession by acknowledging and documenting any materials and/or techniques used in creating their opinions, papers, books, etc.

7 – **Client Welfare**
LADC/MH counselors must place the best interest of clients before conflicting professional commitments or professional gain.

LADC/MH counselors shall always strive to provide an appropriate setting for clinical work to ensure professionalism, and providing a supportive environment for those clients having special needs

8 – **Confidentiality**
LADC/MH counselors shall not reveal information relating to a client unless the client consents to such release of information in writing, and after consultation with the LADC/MH counselor.

8 - **Confidentiality (continued)**

LADC/MH counselors shall strive to preserve the records and information, regardless of the media used to store such information.

LADC/MH counselors may reveal confidential information to public authorities or other professionals to the extent that the LADC/MH, in their professional capacity, reasonably believe it to be necessary:

- to prevent a client from serious harm whether self-inflicted or inflicted upon a third person,
- to prevent a client in imminent danger or in danger of injuring another person.

9 - **Client Relationships**

LADC/MH counselors shall not:

- make false or misleading communication about the LADC/MH counselor's abilities, training, and/or experience;
- fail to obtain a client's permission for recording a session, for involving any third party in a session, or for releasing information pertaining to the client;
- enter into a business relationship with any other person when to do so would be adverse to the interest of any of the counselor's clients;
- engage in any sexual activity with a client
- enter into a counseling arrangement with a client if the counseling of that client could be materially limited by the LADC/MH counselor's own responsibilities to, or relationship with, a third person or property.

10 - **Professional Integrity**

LADC/MH counselors must agree to cooperate and adhere to the principles of Professional Responsibility of the licensing and disciplinary authority of the State in which they practice.

The LADC/MH counselor shall:

- never knowingly make a false statement to any disciplinary authority;
- report violations of professional conduct of other counselors in the appropriate licensing/disciplinary authority, when the LADC/MH counselor has knowledge that another counselor has violated professional standards;
- not fail to disclose a material fact which could adversely affect a counselor-client relationship.

11 - **Financial Arrangements**

LADC/MH counselors shall establish reasonable financial arrangements based on the fees customarily charged in the counselor's locality for similar services.

LADC/MH counselors shall not accept fees or gratuities for professional work from a person who is entitled to, and, is reliant upon, such services through an institution and/or agency.

12 - **Professional Promotion**

LADC/MH counselors will strive to maintain and promote the integrity and advancement of the LADC/MH counselor profession.

Whenever possible, LADC/MH counselors shall render services at a reduced cost, or at no cost, to the disadvantaged or impoverished person requiring counseling, as a means of promoting the good will of the LADC/MH counseling profession.

Printed Name: _____

Signature: _____ **Date:** _____

This document is based upon the Connecticut Certification Board – Code of Ethical Conduct and Disciplinary Procedures COPYRIGHT (2012). The OBLADC has received written authorization for use of the material. For more information, please visit the www.ctcertboard.org

Co-Occurring Treatment Code of Ethics

This **Co-Occurring Treatment Code of Ethics**, used in conjunction with the **LICENSED/CERTIFIED COUNSELOR CODE OF ETHICS**, is designed to guide licensed addiction treatment professionals credentialed to provide care to individuals with co-occurring substance use and mental health disorders. This code emphasizes the importance of ethical conduct, respect, and professionalism in all aspects of clinical practice. It serves as a standard for professional behavior and decision-making, ensuring the welfare of clients and the integrity of the profession.

1. Respect for Client Dignity and Rights

- Recognize and respect the inherent dignity, worth, and individual rights of every client, regardless of their background, diagnosis, or stage of recovery.
- Promote client autonomy, self-determination, and informed consent in all aspects of treatment.
- Ensure confidentiality and privacy of client information, except where disclosure is required by law or for the protection of the client or others.

2. Competence and Professional Development

- Maintain the necessary knowledge, skills, and credentials to provide effective co-occurring treatment services.
- Seek ongoing education and training specific to both substance use and mental health disorders, including evidence-based practices for integrated care.
- Recognize personal and professional limitations and seek consultation or supervision when needed.

3. Integrated and Individualized Care

- Assess and address both substance use and mental health needs in a holistic, integrated manner.
- Develop individualized treatment plans that honor the unique strengths, needs, and cultural backgrounds of each client.
- Collaborate with other healthcare providers, agencies, and support systems to ensure comprehensive care.

4. Non-Discrimination and Cultural Competence

- Provide services equitably, without discrimination based on age, gender identity, race, ethnicity, socioeconomic status, sexual orientation, disability, or any other characteristic.
- Demonstrate cultural competence and sensitivity to the diverse experiences and perspectives of clients and their families.

5. Professional Boundaries and Relationships

- Maintain clear and appropriate professional boundaries with clients, families, and colleagues.
- Avoid dual relationships, exploitation, or conflicts of interest that could impair professional judgment or harm clients.
- Address any boundary concerns promptly and transparently, seeking supervision when needed.

6. Advocacy and Social Responsibility

- Advocate for the rights and access to quality care for individuals with co-occurring disorders.
- Work to reduce stigma and discrimination associated with substance use and mental health conditions.
- Promote policies and practices that improve outcomes for individuals and communities affected by co-occurring disorders.

7. Integrity and Accountability

- Act honestly and transparently in all professional interactions and documentation.
- Take responsibility for personal actions and decisions, and report unethical conduct as required.
- Uphold the standards of the profession and comply with all applicable laws, regulations, and organizational policies.

8. Self-Care and Wellness

- Prioritize personal wellness and self-care to maintain effectiveness and prevent impairment in professional duties.
- Seek support and guidance when experiencing personal challenges that may affect professional competence.

I hereby certify that I have read and agree to abide by the OBLADC Co-Occurring Treatment Code of Ethics. I also understand that failure to abide by the OBLADC Co-Occurring Treatment Code of Ethics may result in the revocation of my certification, license, or intent status to practice as an alcohol/drug counselor.

Print Name: _____

Signature: _____ Date: _____

OKLAHOMA
Board of Licensed
Alcohol and Drug Counselors

P O Box 54388
Oklahoma City, OK 73154-0388

PROFESSIONAL REFERENCE FORM

CONFIDENTIAL

Dear _____

I am applying to the OKLAHOMA LICENSURE BOARD for ALCOHOL AND DRUG COUNSELORS for licensure/certification as a ☐ LADC/MH ☐ CADC. Would you please complete the reference material below for me? I have authorized the Licensure Board to request additional information from you if necessary. Your prompt attention to this would be very much appreciated, as my application will not be processed until the Board receives this recommendation.

Sincerely,

_____
Signature of applicant

NOTE FROM THE LICENSURE BOARD

The Licensure Board believes that license/certification should be based on input from a variety of sources including the observations of persons who have known the applicant professionally. For this reason, all applicants are required to list three references who will complete the Professional Reference Form below. Your evaluation plus that received from other references and the data furnished by the applicant will be used in determining eligibility for licensure/certification. The process can only be as good as you and others make it by careful and truthful reporting.

PLEASE RETURN THE COMPLETED EVALUATION FORM TO THE PERSON REQUESTING IT

To be completed by Applicant

Applicant's Name: _____

Applicant's Address: _____
City State Zip

Applicant's Place of Employment: _____

Applicant's Telephone Number: ( ) _____ ( ) _____
Work phone Home phone

Based on your knowledge of the above-named counselor, rate his/her abilities in each area listed

You will find seventeen (17) abilities which we would like for you to rate 1,2,3,4,5, or Don't Know.

Rating of 1 is equivalent to POOR
Rating of 2 is equivalent to FAIR
Rating of 3 is equivalent to ACCEPTABLE
Rating of 4 is equivalent to GOOD
Rating of 5 is equivalent to EXCELLENT

Abilities To Be Evaluated	Poor 1	2	3	4	Excellent 5	Don't Know
1. Common Sense	1	2	3	4	5	
2. Poise	1	2	3	4	5	
3. Enthusiasm	1	2	3	4	5	
4. Reliability	1	2	3	4	5	
5. Personal and Professional Honesty	1	2	3	4	5	
6. Empathy	1	2	3	4	5	
7. Ability to Work With Others	1	2	3	4	5	
8. Ethics	1	2	3	4	5	
9. Knowledge of Alcohol Abuse Field	1	2	3	4	5	
10. Knowledge of Drug Abuse Field	1	2	3	4	5	
11. Effectiveness of Counseling Approach & Techniques	1	2	3	4	5	
12. Appropriateness of Counseling & Techniques	1	2	3	4	5	
13. Communication Skills	1	2	3	4	5	
14. Ability to Interact With Other Professionals	1	2	3	4	5	
15. Assessment Skills	1	2	3	4	5	
16. Consulting Skills	1	2	3	4	5	
17. Research Skills	1	2	3	4	5	

In the space below, you may add information regarding the applicant's fitness for licensure or certification heretofore addressed. If you have reservations regarding this applicant's fitness for licensure or certification, please do not hesitate to include those concerns.

I hereby certify that this rating is, to the best of my knowledge, truthful and reflects as accurately as possible my knowledge of the applicant.

SIGNATURE **DATE**

THE LICENSURE BOARD RESERVES THE RIGHT TO REQUEST FURTHER INFORMATION FROM YOU CONCERNING THIS APPLICANT.

Return this form to the person requesting it.

OKLAHOMA
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Alcohol and Drug Counselors

P O Box 54388
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Oklahoma City, OK 73154-0388

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Work phone Home phone

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SIGNATURE **DATE**

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OKLAHOMA
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Alcohol and Drug Counselors

P O Box 54388
Oklahoma City, OK 73154
Telephone: (405) 521-0779

SUPERVISOR/SUPERVISEE CONTRACT

SUPERVISEE _____

Home Address _____

City/State/Zip _____ **Home Phone** _____

Email Address _____

EMPLOYING AGENCY/POSITION _____

Agency Address _____

City/State/Zip _____ **Agency Phone** _____

Agency Email _____

Please list your on-site supervisor's name, license type, license number, phone number, and email address:

_____

____**CADC** Position is: ____Part-Time ____Full-Time Number of hours per week: _____
One-year full-time or equivalent part-time of qualifying supervision with CADC. (Attach Job Description)

____**LADC-MH** Position is: ____Part-Time ____Full-Time Number of hours per week: _____
One-year full-time or equivalent part-time of qualifying supervision with CADC. (Attach Job Description)

****Supervisee may not report more than 60 hours per week****

SUPERVISOR _____ **LICENSE NUMBER** _____
____Supervisor employed with Supervisee's Agency ____Supervisor outside agency

EMPLOYING AGENCY/POSITION _____

Agency Address _____

City/State/Zip _____ **Agency Phone** _____

Agency Email _____

Supervisee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Specify Frequency of Supervision:

□A. Supervisees will receive at least 4 hours of face-to-face supervision per month at a rate of one hour per week.

□B. Supervisees and supervisors will meet on a regular schedule of two hours per week, every other week, of face-to-face contact. (Supervisors and supervisees with existing contracts who want to have a regular schedule of every other week face-to-face contact must submit a revised supervision contract indicating the change in schedule.)

□C. When unforeseen circumstances arise that result in a supervisor receiving less than four hours per month, or less than every other week face-to-face contact with a supervisor, the supervisee and supervisor shall provide notice of such circumstances to the board for approval. The plan may include designation of a back-up or alternate supervisor. The supervisee must enter a supervision contract with the alternate supervisor and submit the contract to the board for approval. **See below**

SECONDARY SUPERVISOR _____ **LICENSE NUMBER**_____

____Supervisor employed with Supervisee's agency ____Supervisor outside agency

EMPLOYING AGENCY/POSITION _____

Agency Address _____

City/State/Zip _____ **Agency Phone** _____

Agency Email _____

Supervisee Signature: _____ **Date:** _____

Secondary Supervisor Signature: _____ **Date:** _____

This contract must be submitted prior to beginning of supervision, along with supervisee's official transcript and current job description. It is agreed that the supervisor at times as outlined in these guidelines will provide written evaluations. Copies of the evaluation will be provided to the supervisee. Such evaluation will become part of the supervisee's personnel file if supervision is being provided by the agency, either through a qualified staff member or through a qualified supervisor engaged by the agency. It is agreed that if either party terminates this contract, the Oklahoma State Board of Licensed Alcohol and Drug Counselors will be notified in writing within 3 business days as stated in Oklahoma State Rules (38:10-9-4 (c). The undersigned agree to adhere to the guidelines for supervision provided to both parties. Group supervision is limited to 50 % of the total supervision provided. There is a maximum of six supervisees in a group.

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OKLAHOMA
Board of Licensed
Alcohol and Drug Counselors
PO Box 54388 -- Oklahoma City, OK 73154-0388
Phone: (405) 521-0779

LADC BOARD OFFICE STAFF USE ONLY SECTION

Reviewed by: _____ **Approved:** _____ YES _____ NO

Date supervision may begin: _____

OKLAHOMA
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Alcohol and Drug Counselors

PO Box 54388
Oklahoma City, OK 73154
Telephone: (405) 521-0779

PRACTICUM/TRAINING FORM (300 Hours)

Applicant's Name: _____

Date: _____

LADC/MH ☐ CADC ☐

Dear Supervisor:

The individual indicated above has mailed this Evaluation/Verification Form to you as part of his/her application to the Oklahoma Board of Licensed Alcohol and Drug Counselors for Licensure/Certification as a Drug and Alcohol Counselor
You have been identified as the applicant's primary trainer and/or practicum supervisor for working as a Counselor with Alcoholism and/or Drug Clients. All applicants applying for Licensure/Certification in Oklahoma must document 300 hours of supervised training and/or practicum experience early in or prior to work experience in the field.

Below is A and B where you will find the information reported by this applicant in regard to the training under your supervision.

Your evaluation and verification along with similar information received from other significant professionals and the data furnished by the applicant will be utilized in determining eligibility for Licensure/Certification. This process can only be as good as you and others make it by careful and truthful reporting.

A. SUPERVISED PRACTICAL TRAINING (To Be Completed by Applicant)

Supervised Practical Training includes activities designed to provide training in **the 12 core functions**. These activities are monitored by clinical supervisory personnel who provide **timely positive and negative feedback** to assist the counselor in this learning process. If you received **no formal training**, which would have included a practicum or Internship in alcoholism and drug counseling, the first **300 hours of your past work experience may be acceptable**, however, these 300 hours **may not be recounted** in your **total years** of qualifying work experience. You must have **at least 10 hours in each of the core functions**.

Dates
From _____ **to** _____
Month and Year **Month and Year**
(Do not include these dates in your Supervision Logs)

Please Check TYPES OF TRAINING	On-The-Job Training ☐	Training Program ☐	Past Work Experience ☐

Core Functions Task	Number of Hours	Name of Agency Obtained	Core Functions Task Continued	Number of Hours	Name of Agency Obtained
I. Client Screening			IX. Client Education		
II. Intake			X. Client Follow Up/Referral		
III. Client Assessment			XI. Reports/Record Keeping		
IV. Treatment Planning			XII. Consultation		
V. Client Orientation			[redacted]	[redacted]	[redacted]
VI. Counseling			[redacted]	[redacted]	[redacted]
VII. Case Management			[redacted]	[redacted]	[redacted]
VIII. Crisis Intervention			[redacted]	[redacted]	[redacted]

B. PRACTICAL TRAINING DESCRIBED (To Be Filled Out by Applicant)

In your own words, please describe your supervised practicum training. Include in your description **WHO** trained you and how they trained you. (For example, *joined* ***you for counseling sessions or had you tape sessions, which they later reviewed with you, etc.***) Please be sure to include any supervised practical training you received when and if you changed jobs. (Please **Type** or **Print** in Ink.)
USE BOTTOM OF PAGE.

C. ADDITIONAL COMMENTS, ADDITIONS, AND/OR CORRECTIONS (TO BE FILLED OUT BY SUPERVISOR/TRAINER SIGNING THE VERIFICATION FORM

TO BE SIGNED BY APPLICANT:

I authorize the Oklahoma Licensing Board to seek additional information about my work and counseling skills from the individual signing this form.

_____ _____
Signature of Applicant **Date**

I hereby certify that all the above material is, to the best of my knowledge, true.

_____ _____ _____
Supervisor's Signature **Business Title** **Agency** **Date**

The Oklahoma Board of Licensed Alcohol and Drug Counselors reserve the right to request further information from you.

Return this form to office staff by scanning and emailing it in as a Pdf.

OKLAHOMA
Board of Licensed
Alcohol and Drug Counselors

P O Box 54388
Oklahoma City, OK 73154
Telephone: (405) 521-0779

Employment Verification Form

Applicant Name: _____

Date: _____

The above-named individual is applying to the Oklahoma Board of Licensed Alcohol and Drug Counselors (OBLADC) for certification/licensure as a counselor. Certification/Licensure of alcohol/drug-mental health counselors in the State of Oklahoma is a competency-based process. The information below has been submitted to OBLADC as his/her supervised work experience, delivering direct counseling services to alcohol/drug abuse & mental health clients. Your verification of this work experience, as well as any additional comments you feel might aid in an accurate assessment of this applicant's ability as an alcohol/drug- mental health counselor will play a significant part in the total evaluation process. This process can only be as good as you and others make it by careful and truthful reporting.

The applicant has filled out Part A of this verification form. Part B and C a should be completed by the Program Director/Administrator.

PART A: The applicant reports the following:

• Please select one: _____Counselor _____ Intern or Trainee _____Volunteer
• Period worked (month & year): From:_____ To:_____ Total years:_____ months:_____ Average weekly work hours: _____ (no more than 60 per week)
• Total hours per week in direct client counseling: _____
• Type of counseling: ____individual counseling _____group counseling _____family & other counseling
• _____% of clients with primary and secondary diagnosis of alcohol/drug-mental health abuse
• Name of Agency: _____ Agency Address: _____ Agency phone number: _____
• Applicant title: _____ Clinical supervisor:_____ Administrative supervisor: _____

I AUTHORIZE THE OKLAHOMA BOARD OF LICENSED ALCOHOL AND DRUG COUNSELORS TO SEEK ADDITIONAL INFORMATION ABOUT MY WORK AND COUNSELING AKILLS FROM THE INDIVIDUAL SIGNING THIS VERIFICATION FORM.

Signature of applicant: _____ Date: _____

PART B: Additional information regarding the applicant (to be filled out by Program Director/Administrator):

PART C:

I have read the above information and provided additional information, where necessary, and verified it to be accurate to the best of my knowledge.

Agency Name:_____

Program Director/Administrator: _____

Title: _____

Date:_____

AFFIDAVIT VERIFYING LAWFUL PRESENCE IN THE UNITED STATES

Instructions for Required Affidavit:

All natural persons fourteen (14) years of age or older and present in the United States, applying for a license with the Oklahoma State Board of Licensed Alcohol and Drug Counselors are required, by the provisions of 56 O.S. Supp. 2007 § 71, to provide the Board with verification of lawful presence in the United States by executing one of the Affidavits below before a notary public or other officer authorized to notarize affidavits under State law. The Board's licensing office is staffed with a notary who is available to provide notary service at no cost to Applicants.

Option 1 - Verification of Citizenship

Affidavit of

_____
[Applicant's Name] – **Please Print**

STATE OF OKLAHOMA)
) ss:
COUNTY OF _____)

_____, of lawful age, being first duly sworn, upon
[Applicant's Name] – **Please Print**

oath states, under penalty of perjury, as follows:

I am a United States Citizen. _____
[Signature of Applicant]

Subscribed and sworn to or affirmed before me this ____ day of _____, 20___, by _____.
[Applicant]

_____
NOTARY

My Commission Expires: _____ Commission Number:_____

(Seal)

AFFIDAVIT VERIFYING LAWFUL PRESENCE IN THE UNITED STATES

Instructions for Required Affidavit:

All natural persons fourteen (14) years of age or older and present in the United States, applying for a license with the Oklahoma State Board of Licensed Alcohol and Drug Counselors are required, by the provisions of 56 O.S. Supp. 2007 § 71, to provide the Board with verification of lawful presence in the United States by executing one of the Affidavits below before a notary public or other officer authorized to notarize affidavits under State law. The Board's licensing office is staffed with a notary who is available to provide notary service at no cost to Applicants.

Option 2 - Affidavit Verifying Qualified Alien Status

Affidavit of

_____
[Applicant's Name] – **Please Print**

STATE OF OKLAHOMA)
) ss:
COUNTY OF _____)

_____, of lawful age, being first duly sworn, upon
[Applicant's Name] – **Please Print**

oath states, under penalty of perjury, as follows:

I am a qualified alien under the federal Immigration and Naturalization Act, and I am lawfully present in the United States.

_____
[Signature of Applicant]

Subscribed and sworn to or affirmed before me this ____ day of _____, 20___, by _____.
[Applicant]

_____
NOTARY

My Commission Expires: _____ Commission Number:_____

(Seal)

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