

APPLICANT AND SUPERVISOR AFFIRMATION:

The information requested on this form will be used by the Board of Behavioral Health and Therapy (BBHT) staff to determine whether the applicant and the supervisor meet the requirements of Minnesota Statutes section 148F.035.

APPLICANT AFFIRMATION: I hereby make application to practice alcohol and drug counseling on a temporary basis in Minnesota. I understand that under the temporary permit provisions in Minnesota Statutes section 148F.035, I may practice alcohol and drug counseling if I am directly supervised by a Minnesota Licensed Alcohol and Drug Counselor, or other licensed professional practicing alcohol and drug counseling under Minnesota Statutes section 148F.11. By signing below, I certify that I have read and will comply with the requirements of Minnesota Statutes, Chapter 148F and Minnesota Rules, Chapter 4747. **I understand that approval of this application for temporary permit creates no rights to or expectation of approval from the Board for licensure as an alcohol and drug counselor. I further understand that I am subject to a background check investigation and the Board may suspend or restrict my temporary practice pursuant to requirements in Minnesota Statutes section 148F.09.**

Applicant Signature

Date

SUPERVISOR INFORMATION & AFFIRMATION (Supervisor Must Complete): I request that the above named applicant be authorized to practice alcohol and drug counseling on a temporary basis under my direct supervision for a period not to exceed twelve months unless renewed. I certify that I hold a valid Minnesota alcohol and drug counselor license or am a licensed professional in accordance with Minnesota Statutes section 148F.11. I certify that I have read and will comply with the requirements of Minnesota Statutes, Chapter 148F and Minnesota Rules, Chapter 4747, that the above-named applicant will be under my direct supervision, and that I will be responsible and liable for all actions and omissions of the above-named applicant in connection with alcohol and drug counseling. I understand that I am responsible as supervisor until the Board of Behavioral Health and Therapy receives my written and signed statement that I wish to cease supervision.

Supervisor Name: _____
Last First Middle

License under which you will provide supervision*: ☐ LADC** ☐ _____ License Number: _____
(other)

Name of Supervisor's Employer: _____

Address: _____
Street City State Zip

Supervisor's Signature: _____
Date

Supervisor's Phone Number: _____

* If you are a licensed professional in accordance with Minnesota Statutes section 148F.11, you will need to request that a License Verification be sent directly to BBHT from the licensing authority through which you hold the license.

** LADC supervisors licensed in Minnesota do not need to request a License Verification.