

Licensed Chemical Dependency Counselor Intern Registration Application

For Official Use Only
Budget #ZZ743
Fund #191

Mail to:

Texas Department of State Health Services
Professional Licensing and Certification Unit – MC 2003
P O Box 149347 Austin, TX 78714-9347
(512) 834-6605 FAX (512) 834-6677

PHOTO

IN THIS SPACE SECURELY
ATTACH PHOTO TAKEN
WITHIN THE PAST YEAR

Please write your name and date of
birth on back of this photo

Initial Registration

Subsequent Registration
(refer to 25 Texas Administrative Code §140.413)

Section I

Social Security Number	Last Name First Name Middle Initial

Mailing Address

City	State	ZIP Code	County

()	Female <input type="checkbox"/> Male <input type="checkbox"/>
Home Phone	Gender

()	
Work Phone	Date of Birth
Are You Bilingual? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes please specify: _____

Section II

High School Graduate GED College

Name of College _____

Degree _____ (Associates, Bachelors, etc.)

Major _____ Minor _____

Ethnic Origin: African American Asian Caucasian
 Hispanic Native American Other

Section III Criminal History

In accordance with 25 Texas Administrative Code, Chapter 140, Subchapter I, every applicant is required to submit fingerprints for the purpose of obtaining a criminal history check from both the Department of Public Safety (DPS) and the Federal Bureau of Investigations (FBI). This is accomplished through the Fingerprint Applicant Services of Texas (FAST) process. Enclosed with this application is a "FAST Fingerprint Pass" for you to use to submit your fingerprints. Please follow the instructions on the pass carefully. **Do not request fingerprint cards. Your fingerprints will be submitted electronically. Please include a copy of your receipt or written confirmation of your fingerprint submission with this application.**

Section IV Statement of Understanding

I hereby authorize any organization(s), entities or person(s) named in this application to release to the Texas Department of State Health Services (DSHS) any information they may have regarding me.

I understand that licensure depends on my meeting the requirements and criteria established by DSHS.

I understand that all information provided on this application is true and correct to the best of my knowledge.

I understand that intentionally false or misleading statements on this application will result in my being declared ineligible for licensure.

I understand that data from my application may be used for statistical purposes.

I understand that the licensure documentation will become the property of DSHS.

I understand that all application and licensure fees are non-refundable.

I agree to abide by the ethical standards contained in §140.423(c) of the LCDC rules.

By signing this application I have read the licensure rules at Title 25, Texas Administrative Code, Chapter 140, Subchapter I and accept responsibility for remaining knowledgeable of licensure rules, including revisions.

Applicant's Signature

Date

Subscribed and sworn to before me this _____ day of _____ 20____

Notary Public in and for _____ County, state of Texas.

My certificate expires _____

Notary Public



This document is your **FAST Fingerprint Pass** for a national criminal history record check. Please schedule a fingerprint appointment by visiting www.L1enrollment.com or by calling 1-888-467-2080. You must pay the \$9.95 fee for **FAST** services online with a credit card or onsite with a check or money order. Cash is not accepted! **Do not request fingerprint cards. Your fingerprints will be submitted electronically.**

1. Logon to www.L1enrollment.com
2. Select: **Texas**
3. Select: **Online Scheduling**
4. Select: **English or Espanol**
5. Enter: **First and Last Name**
6. Select: **All Others**
7. Select: **Option A – Electronic Submission**
8. Select: **Yes, I have a FAST Fingerprint Pass**
9. Enter: **TX921170Z**
10. Enter: **Application ID**
11. Follow the prompts to enter requested information.
12. **Bring this completed form with you to your appointment.**

Section One: Qualified Entity Information

ORI#: [TX921170Z](http://www.L1enrollment.com) Application ID: AD-_____ Original TCN: _____
(first initial, last initial, date of birth in MMDDYYYY format) (If resubmission for rejected fingerprints)

Agency/Entity/Organization Name: DSHS – License Chemical Dependency Counselor Program

Section Two: Applicant Name (To be completed by applicant)

Last: _____ First: _____ Middle: _____
(Please print) (Please print) (Please print)

Section Three: Waiver Information (To be signed by applicant)

I certify that all information I provided in relation to this criminal history record check is true and accurate. I authorize the Texas Department of Public Safety (DPS) to access Texas and Federal criminal history record information that pertains to me and disseminate that information to the designated Authorized Agency or Qualified Entity with which I am or am seeking to be employed or to serve as a volunteer, through the DPS Fingerprint-based Applicant Clearinghouse of Texas and as authorized by Texas Government Code Chapter 411 and any other applicable state or federal statute or policy. I authorize the Texas Department of Public Safety to submit my fingerprints and other application information to the FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. I authorize the FBI to disclose potentially pertinent information to the DPS during the processing of this application and for as long hereafter as may be relevant to the activity for which this application is being submitted. I understand that the FBI may also retain my fingerprints and other applicant information in the FBI's permanent collection of fingerprints and related information, where all such data will be subject to comparisons against other submissions received by the FBI and to further disseminations by the FBI as may be authorized under the Federal Privacy Act (5USC 552a(b)). I understand I am entitled to obtain a copy of any criminal history record check and challenge the accuracy and completeness of the information before a final determination is made by the Qualified Entity. I also understand the Qualified Entity may deny me access to children, the elderly, or individuals with disabilities until the criminal history record check is completed.

Signature: _____ Date: _____

Section Four: Service Center Information (To be completed by FAST Enrollment Officer)

Date Prints Taken _____ Amount Charged For Service: _____

Paid by: Check Money Order Visa MasterCard Billing Acct _____

TCN: _____

I HAVE COMPARED THE GOVERNMENT-ISSUED IDENTIFICATION PRESENTED BY THE APPLICANT AND ATTEST THAT TO MY BEST DETERMINATION; I HAVE FINGERPRINTED THE SAME PERSON.

E.O. Name: _____ E.O. Signature: _____
(Please print)