Application for Licensure as a Clinical Social Worker, Marriage & Family Therapist or Mental Health Counselor by Examination

Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridasmentalhealthprofessions.gov
Email: info@floridasmentalhealthprofessions.gov
Phone: (850) 245-4292
FAX: (850) 413-6982

Florida HEALTH
Medical Quality Assurance

Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at

http://www.flhealthsource.gov/valor

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Do Not Write in this Space For Revenue Receipting Only

Select profession:

- ☐ Clinical Social Work (5201) **$180.00**
- ☐ Marriage & Family Therapy (5202) **$180.00**
- ☐ Mental Health Counseling (5203) **$180.00**

Total fee of $180.00 includes the following:

Application Fee	$100.00
Initial Licensure Fee	$75.00
Unlicensed Activity Fee	$5.00

Are you a registered intern in Florida? ☐ Yes ☐ No

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a $80.00 (Initial Licensure Fee and Unlicensed Activity Fee) refund. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

Practice Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website)

_____ _____ _____
Street Apt. No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:
We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part ~~Section~~ 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 ~~CFR~~ 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

B. Do you hold, or have you ever held a license to practice any counseling-related professions or any other health-related license(s)? ☐ Yes ☐ No

C. List all health-related licenses (active, inactive or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

☐ **Submit a License Verification** form to **ALL** state(s) of licensure. License verifications must be received directly from the licensing authority regardless of the status of the license. **A copy of your license will not be accepted** in lieu of official verification from the licensing agency.

D. Do you have any applications for licensure in a counseling-related profession currently pending in any state (including Florida), U.S. territory, or foreign country? ☐ Yes ☐ No

E. List all pending applications for licensure in a counseling-related profession.

License Type	State/Country

4. DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☐ No

Name: _____

5. EDUCATION HISTORY

☐ Complete the appropriate education worksheet for your profession, found at the back of the application (not required for Florida-registered interns). **The completed worksheet must be included with your application.**

A. List all schools at which you completed coursework in specific content areas to receive a master's or doctoral degree in the profession for which you are applying. All schools listed below must be consistent with the schools provided on the education worksheet for your profession.

School Name	Major	Degree Conferred Date (MM/DD/YYYY)	Degree Awarded (if applicable)

☐ Applicants must request an official transcript from the accredited institution(s) from which you received your degree or have taken coursework. **Transcripts must be sent directly to the board office from the registrar's office of the institution and include a degree conferred date or they will not be considered official.** Transcripts may be sent via email if the institution can send official digital transcripts using a secure transcript clearinghouse or parchment service. The transcript download link can be sent directly to info@mentalhealthprofessions.gov. **Not required for Florida-registered interns whose education has been certified complete.**

If the course title on the transcript does not clearly identify the content of the coursework, a course description or syllabus will be required.

B. **For clinical social work applicants only:** Were you an advanced standing student? ☐ Yes ☐ No

☐ **If "Yes,"** you must provide a letter on university letterhead from an official of the school which awarded your master's degree in social work, verifying the specific courses and number of semester hours completed at the baccalaureate level which were used to waive or exempt completion of similar courses at the graduate level.

The following documentation is required for proof of Practicum, Internship, or Field Experience:

☐ An official of the school (Dean, Department Chair) that awarded your graduate degree must provide a letter on university letterhead verifying that the supervised practicum, internship, or field experience was completed. Specific requirements for each profession can be found on the appropriate education worksheet for that profession.

Applicants educated outside the United States or Canada:

☐ *Any document in a language other than English must be translated into English by a board-approved translation/ education evaluation service. Accepted evaluators can be found at https://floridasmentalhealthprofessions.gov/forms/foreign-cred-evaluators.pdf.*

Clinical Social Work- If you received your social work degree from a program outside the U.S. or Canada, documentation must be received that the program was determined to be equivalent to programs approved by the Council on Social Work Education by the International Social Work Degree Recognition and Evaluation Service provided by the Office of Social Work Accreditation (OSWA). To contact the OSWA, please visit http://www.cswe.org or call (703) 683-8080.

Marriage and Family Therapy/Mental Health Counseling- For the board to consider education completed outside the U.S. or Canada, documentation must be received which verifies the institution at which the education was completed was equivalent to an accredited U.S. institution and the coursework met the content and credit hour requirement for graduate level coursework in the U.S. It is the applicant's responsibility to obtain an evaluation from a recognized foreign equivalency determination service that documents the acceptability of the coursework. The board office must receive an original evaluation mailed directly from the educational evaluation service.

Name: _____

The following continuing education courses are required for licensure:

A. Have you completed the required 8-hour Florida Laws and Rules course? ☐ Yes ☐ No

Florida Laws and Rules Course Title	Provider Name	Date Completed (MM/DD/YYYY)

B. Have you completed the required 3-hour HIV/AIDS course? ☐ Yes ☐ No

HIV/AIDS Course Title	Provider Name	Date Completed (MM/DD/YYYY)

If you have not completed the 3-hour HIV/AIDS course, you may submit the HIV/AIDS Affidavit found on page 19 of this application, attesting you will complete the course within six months.

Board-approved providers and courses can be found at www.cebroker.com.

Documentation must be sent to the board office at info@floridasmentalhealthprofessions.gov, or by mail to:

Board *of* Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

6. CLINICAL EXPERIENCE

List in chronological order all professional and supervised experience in the profession for which you are applying.

Dates of Experience (From-To) MM/DD/YYYY	Place of Employment	Hours Worked per Week	Supervisor Name
to			
to			
to			
to			
to			
to			

☐ **Applicants must complete the Verification of Clinical Experience form** documenting two years of post-master's supervised clinical experience. Either you or your supervisor(s) may send the completed form(s) to the board office.

Out-of-State Supervised Experience- Supervisors not licensed in Florida must submit additional information with the Verification of Clinical Experience form:

☐ Licensed supervisors: Submit proof of licensure with the original date of issuance and the expiration date. Most states list this information on their website (print and submit the page) or request a written verification.

☐ Unlicensed supervisors: Submit proof they meet all educational requirements with copies of graduate level transcripts.

Two years of Supervised Clinical Experience is equal to:

☐ Experience
At least 1,500 hours of psychotherapy provided face-to-face with clients, accrued in no less than 100 weeks.

☐ Supervision
At least 100 hours of supervision in no less than 100 weeks, at least 1,500 hours of psychotherapy provided face-to-face with clients, and at least one hour of supervision every two weeks.

Name: _____

7. EXAMINATION HISTORY

For information regarding application deadlines, examination approval, and examination dates, visit floridasmentalhealthprofessions.gov/resources/exam-schedule/.

Have you passed the national clinical examination for the profession in which you are applying? ☐ Yes ☐ No

If "Yes," provide the exam name: _____ Date passed: _____
MM/DD/YYYY

If you have passed the national clinical examination for your profession and did not take the examination as a Florida-registered intern, you must request an official score report to be sent directly to the board office. Scores are only accepted from other state boards and the following:

Licensed Clinical Social Worker scores accepted from the Association of Social Work Boards (ASWB).

Licensed Marriage and Family Therapist scores accepted from the Association of Marital and Family Therapy Regulatory Boards (AMFTRB).

Licensed Mental Health Counselor scores accepted from the National Board of Certified Counselors (NBCC).

Applicants requiring Special Testing Accommodations:

Licensed Clinical Social Work candidates requiring special accommodations must contact the Association of Social Work Boards (ASWB) directly to arrange testing accommodations. Contact ASWB at 800-225-6880 extension 3250 or http://www.aswb.org.

Licensed Marriage and Family Therapy candidates requiring special accommodations must submit an application for special testing accommodations **no later than 60 days prior** to sitting for the examination to the Professional Testing Corporation (PTC). You must submit your request using the Request for Special Needs Accommodations Form found online at http://www.ptcny.com/PDF/PTC_SpecialAccommodationRequestForm.pdf.
You may reach the PTC by phone at 212-356-0660.

Licensed Mental Health Counseling candidates requiring special accommodations must submit a request form to the National Board for Certified Counselors (NBCC). A Computer-Based Testing Special Accommodations Request form is located in the NCMHCE Candidate Handbook, which can be downloaded at the NBCC website at www.nbcc.org.

Name: _____

This information is exempt from public records disclosure.

8. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? ☐ Yes ☐ No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? ☐ Yes ☐ No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? ☐ Yes ☐ No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

☐ **A letter from a Licensed Health Care Practitioner,** who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

☐ **A written self-explanation,** identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

9. DISCIPLINE HISTORY

A. Have you ever been denied a psychotherapy or counseling-related license or the renewal thereof in any state? ☐ Yes ☐ No

B. Have you ever been denied the right to take a psychotherapy or counseling-related licensure examination? ☐ Yes ☐ No

C. Have you ever had a license to practice any profession revoked, suspended, or otherwise acted against in a disciplinary proceeding in any state? ☐ Yes ☐ No

D. Is there currently pending, in any jurisdiction, a complaint or investigation against your professional conduct or competency? ☐ Yes ☐ No

E. Have you ever been involved in, reprimanded for or disciplined by an employer or educational institution for misconduct including fraud, misrepresentation, academic misconduct, theft or sexual harassment? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐Y ☐N
				☐Y ☐N
				☐Y ☐N
				☐Y ☐N

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of the **Administrative Complaint** and **Final Order**.

10. CRIMINAL HISTORY

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. ☐ Yes ☐ No

If you responded "Yes," complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				☐Y ☐N
				☐Y ☐N
				☐Y ☐N

If you responded "Yes" in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

☐ **Final Dispositions** and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

11. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if "Yes," provide supporting documentation)? ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? ☐ Yes ☐ No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 4.

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? ☐ Yes ☐ No

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 5.

   a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No

   b. Did termination occur at least 20 years before the date of this application? ☐ Yes ☐ No

Name: _____

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? ☐ Yes ☐ No

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

☐ **Supporting documentation** including court dispositions or agency orders where applicable.

Documentation for sections 8, 9, 10 and 11 must be sent to the board office at info@floridasmentalhealthprofessions.gov, or by mail to:

Board *of* Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

12. APPLICANT SIGNATURE

I, the undersigned, state that I am the person identified in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067~~ and 775.067~~, F.S.

I understand Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

I hereby acknowledge that I have read the regulations in ch. 491, F.S., and related rules. I understand that I am under a continuing obligation to keep informed of any changes to ch. 491, F.S., and related rules. I further state that I will comply with all requirements for licensure renewal, including continuing education credits.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
You may print this application and sign it or sign digitally. MM/DD/YYYY

Complete verifications must be mailed directly from the licensing agency to:

Board *of* Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

License/Certification Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board seal
* Signature and title of state board official

The following information must be included in all verifications:

* Licensee name * License number * State or jurisdiction of licensure
* Licensure status * Is license in good standing?
* Date of issuance and expiration
* Licensure method (examination, grandfathering, reciprocity/endorsement) If exam provide exam name, exam level, exam date, and score achieved.
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.

Board *of* Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling

CLINICAL SOCIAL WORK
EDUCATION WORKSHEET FOR EXAMINATION

Name: _____

1. GENERAL INFORMATION

You are required to complete 24 semester hours or 32 quarter hours of graduate level coursework in theory of human behavior, and practice methods as courses in clinically oriented services within an accredited school of social work program. (Only one research course may be counted towards the coursework requirement). Do **not** list fieldwork.

Course numbers and titles should be listed as they appear on your official transcripts. **You must submit a course description photocopied from a school catalog or a course syllabus for all courses listed below.**

If you were admitted to an advanced standing program, an official of the school which awarded your master's degree in social work must provide a letter, on university letterhead, verifying the specific courses completed at the baccalaureate level which were used to waive or exempt completion of similar courses at the graduate level.

School Name	Course Number	Course Title	Credit Hours

2. PSYCHOPATHOLOGY

List the graduate level psychopathology course you completed within an accredited school of social work program. You must submit a course description photocopied from a school catalog or a course syllabus for the course listed.

School Name	Course Number	Course Title	Credit Hours

3. ADVANCED SUPERVISED FIELD PLACEMENT

You are required to complete a supervised field placement which was part of your advanced concentration in direct practice, during which you provided clinical services directly to clients. An official of the school (Dean, Department Chair) which awarded your graduate degree must provide a letter on university letterhead verifying:

1) that the supervised field placement was completed during the master's or doctorate program; and

2) the setting in which you provided clinical services directly to clients.

School Name	Course Number	Advanced Supervised Field Placement Course Title	Field Placement Dates: From-To (MM/DD/YYYY)
			to

Submit worksheet with your application.

Board *of* Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling

MARRIAGE AND FAMILY THERAPY
EDUCATION WORKSHEET FOR EXAMINATION

Name: _____

If you graduated from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), check the box verifying your degree. You will not be required to verify your coursework.

☐ I graduated from a COAMFTE accredited program.

If you graduated from a counseling program accredited by the Council for Accreditation of Counseling and Related Education Programs (CACREP), fill out the coursework information below.

1. COURSEWORK VERIFICATION

You must indicate the graduate level course(s) you completed that satisfy the educational requirement in the content areas listed. Course numbers and titles should be listed as they appear on your official transcripts. If the course title on your transcript does not clearly identify the content of the coursework, a course description or syllabus may be required.

Each of the following content areas must have a minimum of three semester hours or four quarter hours in graduate level coursework.

Content Area	School Name	Course Number	Course Title	Credit Hours
Dynamics of Marriage and Family Systems	1.			
	2.			
Marriage Therapy and Counseling Theory and Techniques	1.			
	2.			
Family Therapy and Counseling Theory and Techniques	1.			
	2.			
Individual Human Development Theories Throughout the Life Cycle	1.			
	2.			
Personality Theory or General Counseling Theory and Techniques	1.			
	2.			
Psychopathology	1.			
	2.			
Human Sexuality Theory and Counseling Techniques	1.			
	2.			
Psychosocial Theory	1.			
	2.			
Substance Abuse Theory and Counseling Techniques	1.			
	2.			

Board *of* Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling

MARRIAGE AND FAMILY THERAPY
EDUCATION WORKSHEET FOR EXAMINATION

Name: _____

Content Area	School Name	Course Number	Course Title	Credit Hours
Legal, Ethical, Professional Standards Issues in the Practice of Marriage & Family Therapy				
Diagnosis, Appraisal, Assessment, and Testing for Individual or Interpersonal Disorder or Dysfunction				
Behavioral Research (Course must focus on the interpretation and application of research data as it applies to clinical practice)				

Submit worksheet with your application.

Board *of* Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling

MENTAL HEALTH COUNSELING EDUCATION WORKSHEET FOR EXAMINATION

Name: _____

If the program you graduated from was not accredited by the Council for Accreditation of Counseling and Related Education Programs (CACREP) **or** if the program you graduated from was a CACREP accredited program that was not mental health counseling, then **sections 1, 2, and 3 apply to you.** (There are CACREP accredited programs in community counseling; marital, couple, and family counseling; and school counseling, for example.) If you graduated from a CACREP **mental health counseling program,** then **only section 4** applies to you.

1. GENERAL INFORMATION

Your overall degree program must be a minimum of 60 semester hours or 80 quarter hours. Within the degree program, you'll be required to complete three semester hours or four quarter hours of individualized graduate level coursework at an accredited institution in each of the content areas listed below. Course numbers and titles should be listed as they appear on your official transcripts. **If the course title on your transcript does not clearly identify the content of the coursework, a course description or syllabus will be required.**

2. COURSEWORK VERIFICATION

You must indicate below the graduate level course you completed that satisfies the education requirement in the specific content area. You must have a minimum of three semester hours or four quarter hours to satisfy each content area.

Content Area	School Name	Course Number	Course Title	Credit Hours
Counseling Theories and Practice				
Human Growth and Development				
Diagnosis and Treatment of Psychopathology				
Human Sexuality				
Group Theories and Practice				
Individual Evaluation and Assessment				
Career and Lifestyle Assessment				
Research and Program Evaluation				
Social and Cultural Foundations				
Substance Abuse				
Legal, Ethical, & Professional Standards				

Name: _____

3. UNIVERSITY-SPONSORED SUPERVISED CLINICAL PRACTICUM, INTERNSHIP OR FIELD EXPERIENCE

You must complete at least 700 hours of university-sponsored supervised clinical practicum, internship, or field experience that includes at least 280 hours of direct clinical services as required in the accrediting standards of CACREP for mental health counseling programs.

The accrediting standards of CACREP for these hours are:

- At least 280 of these hours must be in direct service with actual clients that contributes to the development of counseling skills, including experience leading groups
- An average of one hour per week of individual and/or triadic supervision
- The opportunity for the applicant to become familiar with a variety of professional activities and resources in addition to direct service (e.g., record keeping, assessment instruments, supervision, information and referral, in-service and staff meetings)
- The opportunity for the applicant to develop program-appropriate audio/video recordings for use in supervision or to receive live supervision of the applicant's interactions with clients
- Evaluation of the applicant's counseling performance throughout the practicum/internship, including a formal evaluation after the completion of the practicum/internship hours

An official of the school (Dean, Department Chair) which awarded your graduate degree must provide a letter **on university letterhead** verifying that the supervised practicum/internship was completed in accordance with CACREP standards. **The practicum letter should also include the following:**

a. Course Title(s) of Practicum/Internship/Field Experience
b. Course Number(s)
c. School or Site Where Experience was Completed
d. Dates of Practicum/Internship or Field Experience
e. Total Number of Clock Hours Completed
f. Total Number of Direct Client Service Hours Completed

This requirement may be met by supervised practice experience which took place outside the academic arena that met the CACREP standards and was under the supervision of a qualified supervisor or the equivalent.

4. GRADUATE OF A CACREP MENTAL HEALTH COUNSELING PROGRAM

If you graduated from a **mental health counseling program** accredited by CACREP, your overall degree program must be a minimum of 60 semester hours or 80 quarter hours, including a course in human sexuality and a course in substance abuse.

Indicate below the graduate level course you completed that satisfies the two specific content areas. You must have a minimum of three semester hours or four quarter hours in each content area.

Content Area	School Name	Course Number	Course Title	Credit Hours
Human Sexuality				
Substance Abuse				

Submit worksheet with your application.

Board *of* Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling

HIV/AIDS AFFIDAVIT

Pursuant to s. 491.0065, F.S., and Rule 64B4-8.002, Florida Administrative Code, all initial licensure applicants are required to complete an approved education course on human immunodeficiency virus (HIV)and acquired immune deficiency syndrome (AIDS). The course must provide a minimum of three hours of HIV/AIDS education, including education on protocols and procedures applicable to HIV counseling, testing, reporting and partner notification.

An applicant who has not taken the course at the time of licensure shall, upon submission of an affidavit showing good cause, be allowed six months to complete this requirement. If you have already completed this course, please send proof with your application. If you have not yet completed the course, fill out this affidavit, have it notarized, and return it with your application.

Your application is incomplete without this affidavit or proof of completion of the HIV/AIDS course.

APPLICANT STATEMENT

I, _____, am of legal age and have personal knowledge of the matters stated in
(Applicant Full Name)
this affidavit. I will complete an approved course which provides a minimum of three hours of HIV/AIDS education within the first six months of my licensure by the Department of Health.

Applicant Signature _____ Date _____
MM/DD/YYYY

NOTARY SIGNATURE

Before me, the undersigned authority, personally appeared _____ who
(Applicant Full Name)
deposes and affirms the above statement is true and correct.

State of _____ County of _____

Sworn to and/or subscribed before me this _____ day of _____, 20_____

By _____ whose identity is known to me by _____

Notary Signature _____ Printed Name of Notary _____

[NOTARY SEAL]

Submit form with application, email to info@floridasmentalhealthprofessions.gov, or mail to:

Board *of* Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

Verification of Clinical Experience

Form must be completed by the supervisor.

Applicant Name: _____

Florida Intern Registration Number/Other State License Number: _____

Select profession: ☐ Clinical Social Work ☐ Marriage & Family Therapy ☐ Mental Health Counseling

1. SUPERVISOR INFORMATION

Supervisor Name: _____

Email Address: _____

License Type	State	License Number

Supervisors licensed outside of Florida must provide a license verification

2. SUPERVISED CLINICAL EXPERIENCE

I have read and understand Rule 64B4-2, Florida Administrative Code (F.A.C.), which states, in part:

An intern shall be credited for the time of supervision required by s. 491.005, F.S., if the intern:

a) Received at least 100 hours of supervision in no less than 100 weeks; and
b) Provided at least 1500 hours of face-to-face psychotherapy with clients; and
c) Received at least one hour of supervision every two weeks

A. Dates of supervision: Start Date: _____ MM/DD/YYYY End Date: _____ *Provide specific date* - MM/DD/YYYY

B. The applicant received _____ hours of supervision, with at least one hour of supervision every two weeks.

C. The applicant provided psychotherapy face-to-face with clients for a total of _____ hours.

Select one of the following:

I intend to provide supervision until the registered intern is fully licensed pursuant to s. 491.0045(3), F.A.C. If this changes, I will notify the board office of the date supervision ended.

I am no longer providing this registered intern with supervision as of: _____ MM/DD/YYYY

3. SUPERVISOR STATEMENT

As the qualified supervisor of this intern, select the answer below that reflects your conclusion of their ability to practice and/or counsel independently.

Has the applicant met the minimum standards of performance in professional activities as measured against generally prevailing peer performance, pursuant to s. 491.009(1)(r), F.S.? ☐ Yes ☐ No

If "No," you must provide further information to explain why this requirement has not been met.

Supervisor Signature: _____ Date: _____ MM/DD/YYYY