

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



**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](http://www.floridasmentalhealthprofessions.gov)**

**Email: [info@floridasmentalhealthprofessions.gov](mailto:info@floridasmentalhealthprofessions.gov)**

**Phone: (850) 245-4292**

**FAX: (850) 413-6982**





**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 Receiving Only

An individual **must** have an application for licensure by exam or endorsement in a mental health profession on file with the board office to qualify for a provisional license. This application is sent to applicants who have applied for licensure and the board has determined they qualify for provisional licensure.

### Select profession:

- |   |                 |                              |
|---|-----------------|------------------------------|
| <input type="checkbox"/> Provisional Clinical Social Work (5201)      | <b>\$100.00</b> | <b>Licensure Application</b> |
| <input type="checkbox"/> Provisional Marriage & Family Therapy (5202) | <b>\$100.00</b> | <b>File Number: _____</b>    |
| <input type="checkbox"/> Provisional Mental Health Counseling (5203)  | <b>\$100.00</b> |                              |

Fee must be paid in the form of a cashier's check or money order, made payable to the Department of Health. The \$100.00 application fee is non-refundable.

### 1. PERSONAL INFORMATION (List name as it was provided on the licensure application.)

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 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 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  Hispanic or Latino  White  
 American Indian or Alaska Native  Black or African American  Asian  
 Two or More Races

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](http://www.ssa.gov) or by calling 1-800-772-1213.

Name: \_\_\_\_\_

**3. APPLICANT BACKGROUND**

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

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**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: \_\_\_\_\_

**This information is exempt from public records disclosure.**

**5. 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.

Have you submitted all required Health History documentation to the board office?

Yes  No  N/A

Applicants who have submitted their Health History documentation with their full licensure application are **not required to resubmit it.**

Name: \_\_\_\_\_

**6. 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?
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> 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.

**7. 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?
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> 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: \_\_\_\_\_

## 8. 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," please 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?  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 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.

Have you submitted all required Discipline and/or Criminal History documentation to the board office?  
 Yes  No  N/A

Applicants who have submitted their Criminal History, Discipline History, Criminal and Medicaid/Medicare Fraud History documentation with their full licensure application are **not required to resubmit it**.

Documentation for sections 5, 6, 7 and 8 must be submitted to [info@floridasmentalhealthprofessions.gov](mailto:info@floridasmentalhealthprofessions.gov), or mailed 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

#### 9. APPLICANT SIGNATURE

I understand that by submitting this completed application and fee, I will be provisionally licensed for a period of no longer than 24 months. It is my responsibility as a provisional licensee to supplement my application if any material changes in circumstances or conditions occur which may affect the board's decision concerning my eligibility for examination or licensure. Supplementation is required by s. 456.072, F.S. and s. 456.013(1)(a), F.S. Failure to do so may result in disciplinary action by the board including denial of licensure.

I hereby acknowledge that I have read 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.

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