

# Application for Limited 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**





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Do Not Write in this Space  
For Revenue Receiving Only

You must read the laws and rules to determine your eligibility prior to applying. The laws and rules may be accessed through our website at [floridasmentalhealthprofessions.gov/resources](http://floridasmentalhealthprofessions.gov/resources). The requirements for limited licensure are in section (s.) 456.015, Florida Statutes (F.S.), and Rule 64B4-3.009, Florida Administrative Code (F.A.C.).

<b>Select profession</b>		<b>Select the option applicable to your proposed practice setting</b>	
<input type="checkbox"/> Clinical Social Work (5201)	<input type="checkbox"/> Marriage & Family Therapy (5202)	<input type="checkbox"/> Paid Employee	<b>\$25.00 application fee</b>
<input type="checkbox"/> Mental Health Counseling (5203)		<input type="checkbox"/> Volunteer	<b>No Fee- Must submit Fee Waiver Affidavit</b>

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. The \$25.00 application fee is non-refundable.

## 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 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  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, s. 456.013(1)(a), 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**

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), other than the license(s) listed above.

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

**5. PRACTICE SETTING**

Select the setting of your place of practice in Florida:

- State Mental Institution
- State Institution for the Mentally Disabled
- Department of Corrections
- Health Manpower Shortage Area established by the U.S. Department of Health and Human Services
- I do not currently have a place of practice

Place of Employment \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

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

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

**6. 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: \_\_\_\_\_

**7. DISCIPLINE HISTORY**

- A. Have you ever been denied a license to practice any counseling-related profession, or any other health care profession, or the renewal thereof in any state?  Yes  No
- B. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature, including, but not limited to, a charge of violation of a practice act, unprofessional or unethical conduct?  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

**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.

**8. 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: \_\_\_\_\_

**9. 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 6, 7, 8, and 9, must be sent to the board office at [info@floridasmentalhealthprofessions.gov](mailto: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

#### 10. 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, F.S.

I understand that 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**



**AFFIDAVIT FOR LIMITED LICENSE APPLICANT**

**This form is required for all applicants.**

Pursuant to s. 456.015, F.S., any person desiring to obtain a limited license must submit an affidavit stating that they have been licensed to practice in any jurisdiction in the United States for at least ten years in the profession for which they seek a limited license.

The affidavit must also state that they have retired or intend to retire from the practice of that profession and intend to practice only pursuant to the restrictions of the limited license granted. The application is incomplete without this affidavit.

1. I, \_\_\_\_\_, am of legal age and have personal knowledge of the matters  
(Applicant Full Name)  
stated in this affidavit.
2. I affirm that I have practiced \_\_\_\_\_ as a licensed \_\_\_\_\_  
(Name of Profession) (Title of License)  
for at least ten years in the United States.
3. I affirm that I retired, or I intend to retire on \_\_\_\_\_ from the practice of \_\_\_\_\_.  
(MM/DD/YYYY) (Name of Profession)
4. I affirm that I will only practice as specified in Rule 64B4-3.009, F.A.C., if granted a limited license in Florida.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_  
MM/DD/YYYY

Before me, the undersigned authority, personally appeared \_\_\_\_\_ who  
(Applicant Full Name)  
deposes and affirms the above statements are 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]

**Form must be submitted with your application.**

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



**LIMITED LICENSE FEE WAIVER AFFIDAVIT**

**This form must be completed by your employer or prospective employer.**

Pursuant to s. 456.015, F.S., and Rule 64B4-3.009, F.A.C., if a person applying for a limited license submits a notarized statement from the employing agency or institution stating that they will not receive monetary compensation for any services involving the practice of clinical social work, marriage and family therapy, and mental health counseling, the licensure fees shall be waived.

I, \_\_\_\_\_, being first duly sworn, state that the clinical social worker, marriage  
(Name of Employer)  
and family therapist, or mental health counselor, \_\_\_\_\_, will **not** receive monetary  
(Name of Applicant)  
compensation for any service involving the practice of clinical social work, marriage and family therapy, or mental health  
counseling from:

Agency/Institution Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Title: \_\_\_\_\_

Employer Signature: \_\_\_\_\_

Before me, the undersigned authority, personally appeared \_\_\_\_\_ who  
(Name of Employer)  
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]

**Form must be submitted with your application.**