



**BOARD OF CLINICAL SOCIAL WORK,  
MARRIAGE AND FAMILY THERAPY AND  
MENTAL HEALTH COUNSELING**

**APPLICATION FOR LICENSURE**

**EXAMINATION  
ENDORSEMENT**

## APPLICATION FOR LICENSURE INSTRUCTIONS

Chapter 491, Florida Statutes (F.S.), and Rule Chapter 64B4, Florida Administrative Code (F.A.C.), are the laws and rules that regulate clinical social workers, marriage and family therapists, and mental health counselors.

### LICENSURE BY EXAMINATION REQUIREMENTS

- A master's or doctoral degree and coursework in specific content areas
- A supervised clinical practicum, internship, or field experience
- Two years of supervised experience in the profession for which licensure is applied
- Passing score on the national clinical examination
- Complete an approved 8-hour continuing education Laws & Rules Course
- Complete an approved 2-hour Prevention of Medical Errors Course
- Complete a 3-hour course on HIV/AIDS

Please review the laws and rules to determine eligibility. The laws and rules can be found on our web site at [www.doh.state.fl.us/mqa/491](http://www.doh.state.fl.us/mqa/491) and clicking on "Statutes/Rules".

Clinical Social Work	s. 491.005(1),(2), F.S., and Rule Chapter 64B4, F.A.C.
Marriage and Family Therapy	s. 491.005(3), F.S., and Rule Chapter 64B4, F.A.C.
Mental Health Counseling	s. 491.005(4), F.S., and Rule Chapter 64B4, F.A.C.

### LICENSURE BY ENDORSEMENT REQUIREMENTS

**Endorsement applicants must still meet the national exam requirements for licensure in Florida.**

- Holds an active valid license to practice and has actively practiced the profession for which licensure is applied in another state for 3 of the last 5 years
- A master's or doctoral degree and coursework in specific content areas
- A supervised clinical practicum, internship, or field experience
- Has passed the national clinical examination
- A license in good standing that is not under investigation or found to have committed any act which would constitute a violation of Chapter 491, F.S.
- Complete an approved 8-hour continuing education Laws & Rules Course
- Complete an approved 2-hour Prevention of Medical Errors Course
- Complete a 3-hour course on HIV/AIDS

Please review the laws and rules to determine eligibility. The laws and rules can be found on our web site at [www.doh.state.fl.us/mqa/491](http://www.doh.state.fl.us/mqa/491) and clicking on "Statutes/Rules".

CSW, MFT, and MHC	s. 491.006, F.S., and Rule 64B4, F.A.C.
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### **I. EXAMINATION INFORMATION AND APPLICATION DEADLINES\***

To become eligible to sit for the national examination, you must first submit the application for licensure and fees with supporting documentation for Board review. The Board sends approved candidates an exam approval letter with appropriate registration materials.

#### **CLINICAL SOCIAL WORK – ASWB (Association of Social Work Boards) CLINICAL Level Exam**

The national examination is given weekly, Monday through Friday, by computer at various locations around Florida. There are no completion deadlines. Approved candidates schedule and pay for the national examination directly through ASWB. The exam may be re-taken every 90 days. A study prep guide may be purchased from ASWB at 1-800-225-6880, by mail request to: ASWB, 400 South Ridge Parkway, Suite B, Culpepper, Virginia 22701, or online at [www.aswb.org](http://www.aswb.org). Remember that Florida candidates must request the **clinical level** study guide.

#### **MARRIAGE & FAMILY THERAPY – National Exam**

Application deadlines, registration deadlines, and examination dates are available on our web site at [www.doh.state.fl.us/mqa/491](http://www.doh.state.fl.us/mqa/491) and click on "Exam Information and Dates".

Application for the national MFT examination must be submitted by the *postmarked* deadline. MFT exam candidates must make sure that all necessary supporting documentation is received in the Board office by the *completion deadline*.

The national exam is given by computer at various locations around Florida. Approved candidates register to take the exam during the 28-day testing "window" through Professional Examination Services (PES). The exam fee is paid directly to PES. Registered candidates schedule an appointment through Prometric or Sylvan test centers. The Examination Advisory Committee of the Association of Marital and Family Therapy Regulatory Boards (AMFTRB) and the Professional Examination Services (PES) developed this examination. The AMFTRB offers an online practice version of the national MFT exam for purchase at [www.amftrb.org](http://www.amftrb.org).

### **MENTAL HEALTH COUNSELOR – National Clinical Mental Health Counseling Exam (NCMHCE)**

The national examination is given the first two full weeks of every month, Monday through Friday, by computer at various locations around Florida. Approved candidates register and pay for the exam directly through the National Board for Certified Counselors (NBCC). Registered candidates with NBCC will schedule an appointment through Applied Measurements Professionals, Inc. (AMP) test centers. The exam may be re-taken every 90 days. The NCMHCE "Handbook for State Credentialing" can be viewed or printed at [www.goAMP.com](http://www.goAMP.com). NBCC has a booklet of sample test scenarios for purchase by phone at (336) 547-0607 or [www.nbcc.org](http://www.nbcc.org).

\*Candidates who have already passed the national exam who have **not** been licensed in another state must request a copy of their **official** national exam score report be mailed directly to our office from the national test service. (If you **are** licensed in another state and have passed the national exam, the licensure verification form, which is part of this packet, that will be submitted by your licensing board may indicate that you passed the exam and an official score report may not be necessary).

### **SPECIAL TESTING ACCOMMODATIONS**

(Mental Health Counselors and Marriage and Family Therapists Only \* )

#### **A. SPECIAL TESTING ACCOMMODATIONS DUE TO DISABILITY**

Rules regarding examination procedures for candidates with disabilities are outlined in Rule 64B-1.005, F.A.C. In accordance with Rule 64B-1.005, F.A.C., the Department will provide reasonable and appropriate special testing accommodations to candidates with physical or learning disabilities to the extent permitted by cost, examination administration constraints, examination security considerations and availability of resources. Candidates requesting special testing accommodations must file a completed application (Part I and Part II) with Testing Services at least 60 days prior to the examination date for which the accommodation is requested. It is the responsibility of the candidate to provide adequate documentation of his/her disability.

#### **B. SPECIAL TESTING ACCOMMODATIONS DUE TO RELIGIOUS CONFLICTS**

Modification to reporting times or alternate test dates may be requested by candidates who, due to their religious beliefs, cannot attend the examination at the scheduled reporting time(s), or on the scheduled date(s). Candidates requesting such accommodation must make application with Testing Services at least 60 days prior to the examination date for which the accommodation is requested. Each request should be accompanied by a letter from a religious leader specifying the religious restrictions that apply.

**IF YOU NEED A SPECIAL ACCOMMODATION**, please download an application from the testing web site at <http://www.doh.state.fl.us/mqa/exam/spectest.htm>. If you do not have the ability to download the application forms, please contact Testing Services, Bureau of Operations at 850-245-4252 to request an application for special testing accommodations well in advance of the deadline.

\* **Clinical Social Work candidates** requiring special accommodations need to contact the Association of Social Work Boards (ASWB) directly to arrange testing accommodations. Contact ASWB at 800-225-6880 or <http://www.aswb.org>.

## **II. CONTINUING EDUCATION REQUIREMENTS FOR LICENSURE**

Prior to licensure you must complete an 8-hour laws and rules course and a 2-hour course on the prevention of medical errors. The laws and rules and the prevention of medical errors course requirements are met by providers specifically approved for these courses. These courses may be taken before, during, or after you submit a licensure application. A list of approved laws and rules course providers and a list of approved medical errors course providers may be obtained from our web site at [www.doh.state.fl.us/mqa/491](http://www.doh.state.fl.us/mqa/491). It is your responsibility to register with and pay the providers directly. A certificate for completion of a course is given by the C.E. Provider. A copy of your certificate of completion is acceptable as proof that you completed the course.

A 3-hour course on human immunodeficiency virus and acquired immune deficiency syndrome is required prior to licensure. Pursuant to s. 491.0065, F.S., an applicant who has not taken a course at the time of licensure shall, upon submission of an affidavit showing good cause, be allowed 6 months to complete this requirement. Submit a copy of your certificate of completion with your application for licensure OR submit a completed HIV/AIDS Affidavit form, which is included in this packet.

## **III. FEES (All Professions)**

**Make checks payable to the Department of Health** and securely attach to the application. The required fees listed below include the application fee and the initial licensure fee of \$105.

FEES FOR LICENSURE BY EXAMINATION	\$205.00	[\$105 + \$100 APPLICATION FEE]
FEES FOR LICENSURE BY ENDORSEMENT	\$405.00	[\$105 + \$300 APPLICATION FEE]

## **IV. OFFICIAL TRANSCRIPTS/COURSE DESCRIPTIONS**

**(Not required if you are a registered intern whose education has been certified as complete.)**

You must request an official transcript from the accredited institution(s) from which you received your degree or have taken coursework. Transcripts must be provided for all coursework listed on your education worksheet. These transcripts must be sent directly to the Board office from the registrar's office of the institution or they will not be considered official. You must submit course descriptions and/or syllabi for every course listed on the education worksheet.

### **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. Please review the specific requirements for your profession on the education worksheet.

### **CSW ADVANCED STANDING PROGRAMS**

Clinical social work applicants who completed an advanced standing program will need a letter from an official of the school which awarded your master's degree in social work, 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.

### **FOREIGN EDUCATION for CSW Applicants**

If you received your social work degree from a program outside the U.S. or Canada, documentation must be received that it was determined to have been a program equivalent to programs approved by the Council on Social Work Education by the Foreign Equivalency Determination Service of the Council on Social Work Education.

### **FOREIGN EDUCATION for MFT and MHC Applicants**

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 educational evaluation service that documents the acceptability of the coursework. The Board office must receive an original evaluation mailed directly from the educational evaluation service.

## DOCUMENTS IN A FOREIGN LANGUAGE

A certified translator who is not related to the applicant must translate any document in a foreign language into ENGLISH.

## V. COMPLETING THE FORMS (ALL COMPLETED FORMS MUST BE ORIGINAL, INCLUDING SIGNATURES)

### APPLICATION FOR LICENSURE [6 pages]

Complete all forms by printing neatly in ballpoint pen or typing the information on the forms. It is your responsibility to notify this office in writing if the answer to any application question changes, even if the application is already approved or you have already taken the exam.

#### Section I. Applicant Profile Data:

Your "practice location address" will show on the Internet license verification screen. Our licensure database requires two addresses for each licensee. One is the mailing address and the other is the practice location address. The "mailing address" is used whenever documents, renewals, etc. are mailed to the applicant/licensee. Our Internet license lookup provides the public with information on licensed health care practitioners in the state of Florida, including an "address of record". The "practice location address" from the licensure database will show as the "address of record" on the Internet. If you only provide one address, it will be used for both the mailing address and the practice location address. Please note that the practice location address must be a street address.

#### Section II. Applicant Licensure Status:

List all counseling related professional licenses, including inactive or expired licenses issued from any state, U.S. territory, or foreign country.

#### Section III. Professional or Supervised Experience:

**Endorsement Candidates** – List your professional clinical experience within the last five years, beginning with your current employment.

**Exam Candidates** – Your supervised experience should be listed beginning with your current employment. Do not attach a résumé. Do not list experience that is not in the field. If you had more than one supervisor during the same time, you must insert a brief explanation.

#### Section IV. Education:

List the degree(s) you hold, beginning at the master's level. Identify your program of study at the college or university where you received this degree. Include the month and year in which the degree was received.

#### Section V. Applicant History – Professional:

If you answer "yes" to any question in this section, you must provide complete details. A "yes" answer does not mean the application will be denied, however, failure to provide the correct information may result in licensure denial.

#### Section VI. Applicant History – Pursuant to Section 456.0635, Florida Statutes:

**IMPORTANT NOTICE:** Effective July 1, 2012, section 456.0635, Florida Statutes, provides that health care boards or the department **shall refuse** to issue a license, certificate or registration and **shall refuse** to admit a candidate for examination if the applicant:

1. Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S., (relating to social and economic assistance), Chapter 817, F.S., (relating to fraudulent practices), Chapter 893, F.S., (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction unless the candidate or applicant has successfully completed a drug court program for that felony and provides proof that the plea has been withdrawn or the charges have been dismissed. Any such conviction or plea shall exclude the applicant or candidate from licensure, examination, certification, or registration, unless the sentence and any subsequent period of probation for such conviction or plea ended:

- For the felonies of the first or second degree, more than 15 years from the date of the plea, sentence and completion of any subsequent probation;
  - For the felonies of the third degree, more than 10 years from the date of the plea, sentence and completion of any subsequent probation;
  - For the felonies of the third degree under section 893.13(6)(a), F.S., more than five years from the date of the plea, sentence and completion of any subsequent probation;
2. Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues), unless the sentence and any subsequent period of probation for such conviction or pleas ended more than 15 years prior to the date of the application;
  3. Has been terminated for cause from the Florida Medicaid program pursuant to section 409.913, F.S., unless the candidate or applicant has been in good standing with the Florida Medicaid program for the most recent five years;
  4. Has been terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program, unless the candidate or applicant has been in good standing with a state Medicaid program for the most recent five years and the termination occurred at least 20 years before the date of the application;
  5. Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

**NOTE:** This section **does not apply** to candidates or applicants for initial licensure or certification who were enrolled in an educational or training program on or before July 1, 2009, which was recognized by a board or, if there is no board, recognized by the department, and who applied for licensure after July 1, 2012.

Section VII. Applicant History – General:

If you answer yes, you must provide complete details and certified copies of court records/dispositions.

Section VIII. Certification:

Your signature is required. By signing you are attesting that you have provided true and correct information on the application and supporting documents, as well as having read the laws and rules.

Section IX. Social Security Number: Your Social Security number is required.

Section X. Applicant History – Health:

The Board reviews each applicant's history to determine that the applicant is able to practice the profession with reasonable skill and competence. If you have a history of serious, chronic, or recent mental health problems or addiction to drugs, you must submit a current mental health status report. Mental health status reports must come from a licensed mental health professional, with which you have no personal or professional relationship.

**The report should include: a description and summary of the diagnosis, onset, course of treatment, medications, inpatient treatments, outpatient treatments, group settings, factors which have triggered setbacks, compliance with treatment, prognosis, and recommendations for continued treatment.**

**EDUCATION WORKSHEET [Not required if you are a Registered Intern in Florida.]**

Complete the appropriate education worksheet for your profession, and submit an official transcript and course descriptions (or syllabi) for each course listed on this worksheet.

## LICENSE VERIFICATION FORM

**This form is required if you hold or have ever held a license in another state, U.S. territory, or foreign country.** You must mail this form to the office that issued the license or certification. That office must complete and mail the form directly to the Board office. It will not be considered official if received from the applicant.

### **SUPERVISED EXPERIENCE [Endorsement Applicants do not need to complete this form]**

Applicants for licensure by examination must document two years of post-master's supervised clinical experience on the **Supervised Experience Attestation Form**. Fill in your name on the top portion of the form before giving the form to your supervisor(s) to complete and sign. 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 will need to submit additional information with the supervised experience form.

- **Licensed supervisors:** Submit proof of licensure with the original date of issuance and the expiration date. Most states list this information on a web site (print the page) or you can request a written verification.
- **Unlicensed supervisors:** Need to document they meet all educational requirements with copies of graduate level transcripts.

#### Two Years Of Supervised Clinical Experience Is Equal To:

Experience hours: Working a minimum of 1500 hours providing psychotherapy face-to-face with clients, in no less than 100 weeks.

Supervision hours: One hour of supervision per 15 hours of psychotherapy face-to-face with clients, with a minimum of 1 hour of supervision every two weeks.

Please refer to Rule Chapter 64B4-2, F.A.C., for rules on supervised experience, specifically:

- 64B4-2.001, F.A.C. Definition of Experience
- 64B4-2.002, F.A.C. Definition of Supervision
- 64B4-2.025, F.A.C. Definition of Qualified Supervisor
- 64B4-2.003, F.A.C., Conflict of Interest in Supervision
- 64B4-5.009, F.A.C. Supervision by a Disciplined Practitioner



## Application For Licensure

### I. APPLICANT PROFILE DATA (PLEASE TYPE OR PRINT IN BLACK INK)

Name	Last	First	Middle	DO NOT WRITE IN THIS SPACE FOR OFFICE USE ONLY
Mailing Address	Street Address or P.O. Box		Apt. No.	
	City	State	Zip	
*Practice Location Address	Street Address Required		Apt. No.	
	City	State	Zip	
Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES" list name(s)				(Check <u>One</u> ) <input type="checkbox"/> CLINICAL SOCIAL WORK (5201) <input type="checkbox"/> MARRIAGE & FAMILY THERAPY (5202) <input type="checkbox"/> MENTAL HEALTH COUNSELING (5203)
Home Telephone: area code (     )		Business Telephone: area code (     )		Are you a registered intern in Florida? <input type="checkbox"/> YES <input type="checkbox"/> NO
E-Mail Address:			Date of birth: ____/____/____	
Place of Birth: (City, State)			Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.				
Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Other _____				
<b>SPECIAL TESTING ACCOMMODATIONS –See Application Instructions</b>				
<b>* <u>Your Practice Location Address Will Show On The Internet License Verification</u></b>				
Our Internet license verification provides the public with information on licensed health care practitioners in the State of Florida, including an "address of record". The "location address" from the licensure database will show as the "address of record" on the Internet.				



APPLICANT NAME \_\_\_\_\_

**II. APPLICANT LICENSURE STATUS**

A. Do you hold or have you ever held a license to practice any counseling-related professions in any state, U.S. territory, or foreign country?  YES  NO

If YES, list all licenses and the issuing state, territory, or foreign country:

B. 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

If YES, list all pending applications and the issuing state, territory, or foreign country:

**III. PROFESSIONAL or SUPERVISED EXPERIENCE**

**Endorsement applicants:** List your professional clinical experience within the last five years.  
**Exam applicants:** List your supervised experience.

Dates of Experience	Place of Employment	Hours Worked Per Week	Name of Supervisor
1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____
3. _____	3. _____	3. _____	3. _____
4. _____	4. _____	4. _____	4. _____
5. _____	5. _____	5. _____	5. _____
6. _____	6. _____	6. _____	6. _____
7. _____	7. _____	7. _____	7. _____
8. _____	8. _____	8. _____	8. _____
9. _____	9. _____	9. _____	9. _____

APPLICANT NAME \_\_\_\_\_

<b>IV. EDUCATION</b>			
List all schools used on your Education Worksheet.			
Degree	Major	School	Date of Graduation
1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____
3. _____	3. _____	3. _____	3. _____
4. _____	4. _____	4. _____	4. _____
<b>V. APPLICANT HISTORY – PROFESSIONAL</b>			
A.	Have you ever been denied a psychotherapy or counseling-related license or the renewal thereof in any state?		<input type="checkbox"/> YES <input type="checkbox"/> NO
B.	Have you ever been denied the right to take a psychotherapy or counseling-related licensure examination?		<input type="checkbox"/> YES <input type="checkbox"/> 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?		<input type="checkbox"/> YES <input type="checkbox"/> NO
D.	Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was alleged negligence, malpractice or lack of professional competence?		<input type="checkbox"/> YES <input type="checkbox"/> NO
E.	Is there currently pending, in any jurisdiction, a complaint against your professional conduct or competency in a psychotherapy or counseling-related profession?		<input type="checkbox"/> YES <input type="checkbox"/> NO
F.	Have you ever been involved in, reprimanded for or disciplined by an employer or educational institution for misconduct including:		
	1. Acts of dishonesty, fraud, or deceit		1. <input type="checkbox"/> YES <input type="checkbox"/> NO
	2. Lying on a resume or misrepresentation		2. <input type="checkbox"/> YES <input type="checkbox"/> NO
	3. Academic misconduct, including acts such as cheating or plagiarism		3. <input type="checkbox"/> YES <input type="checkbox"/> NO
	4. Theft		4. <input type="checkbox"/> YES <input type="checkbox"/> NO
	5. Sexual harassment		5. <input type="checkbox"/> YES <input type="checkbox"/> NO
If you answered "YES" to any question in Section VI, you must provide the Board complete details.			

<p><b>VI. APPLICANT HISTORY - Pursuant to Section 456.0635(2), Florida Statutes,</b>  <b>IMPORTANT NOTICE:</b> Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide 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 includes court dispositions or agency orders where applicable.</p>	
1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded "no", skip to # 2.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).	<input type="checkbox"/> YES <input type="checkbox"/> NO
c. If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?	<input type="checkbox"/> YES <input type="checkbox"/> 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).	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 3a.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If "No", do not answer 4a or 4b.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
a. Have you been in good standing with a state Medicaid program for the most recent five years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. Did the termination occur at least 20 years before the date of this application?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. If "yes" to any of the questions 1 through 5 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? (If "yes", please provide official documentation verifying your enrollment status.)	<input type="checkbox"/> YES <input type="checkbox"/> NO

**VII. APPLICANT HISTORY – GENERAL**

Have you ever been convicted of, or entered a plea of guilty or nolo contendere (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 by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question.  YES  NO

If you answer YES, you must explain in detail on a separate sheet. In your explanation, include dates, jurisdictions, offenses, specific circumstances, and dispositions. You must include a certified copy of the court records/dispositions.

**VIII. CERTIFICATION**

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all government agencies and instrumentalities (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals, and groups listed above any information which is material to my application.

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for examination or licensure. Such supplement is required by Sections 456.072, F.S. and 456.013(1)(2), F.S. Failure to do so may result in disciplinary action by the Board or denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind. I declare that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to s. 456.067, F.S., or criminal penalties pursuant to s. 775.082, s. 775.083, or s. 775.085, F.S. Should I furnish any false information on this application, I hereby acknowledge that such act may constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida.

I hereby acknowledge that I have read the regulations in Chapter 491, F.S., and related rules. I understand that I am under a continuing obligation to keep informed of any changes to Chapter 491, F.S., and related rules.

I understand that pursuant to Section 456.013(1)(a), F.S., an incomplete application shall expire one (1) year after initial filing.

I further state that I will comply with all requirements for licensure renewal, including continuing education credits.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

DEPARTMENT OF HEALTH

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

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013(1)(a), Florida Statutes.

Name: Last First Middle

IX. Social Security Number:

X. APPLICANT HISTORY – HEALTH
If you answer "YES" to any of the following questions, you must submit a current mental health status report from a licensed mental health professional, wherein this professional practitioner opines that you are able to practice with reasonable skill and safety to patients or clients.
A. In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past 5 years?
B. In the last 5 years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?
C. During the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice your profession within the past 5 years?
D. In the last 5 years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last 5 years?
E. During the last 5 years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice your profession within the past 5 years?
F. During the last 5 years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice your profession?

**EDUCATION WORKSHEET  
CLINICAL SOCIAL WORK**

Print clearly or type the following information.

APPLICANT NAME \_\_\_\_\_

**I. 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	COURSE NUMBER	COURSE TITLE	CREDIT HOURS

**II. 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	COURSE NUMBER	COURSE TITLE	CREDIT HOURS

**III. 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**.

ADVANCED SUPERVISED FIELD PLACEMENT COURSE TITLE	COURSE NUMBER	SCHOOL	DATES

**EDUCATION WORKSHEET**  
**MARRIAGE AND FAMILY THERAPY**

Print clearly or type the following information.

APPLICANT NAME \_\_\_\_\_

**I. 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. Photocopied course descriptions from a school catalog or a course syllabus will be required for each course.

You are required to complete 36 semester hours or 48 quarter hours of graduate level coursework.

Each of the following content areas must have a minimum of 3 semester hours or 4-quarter hours in graduate level coursework.

CONTENT AREA	SCHOOL	COURSE NUMBER	COURSE TITLE
Dynamics of Marriage & Family Systems	1. _____ 2. _____	1. _____ 2. _____	1. _____ 2. _____
Marriage Therapy & Counseling Theory & Techniques	1. _____ 2. _____	1. _____ 2. _____	1. _____ 2. _____
Family Therapy & Counseling Theory & Techniques	1. _____ 2. _____	1. _____ 2. _____	1. _____ 2. _____
Individual Human Development Theories Throughout the Life Cycle	1. _____ 2. _____	1. _____ 2. _____	1. _____ 2. _____
Personality Theory or General Counseling Theory & Techniques	1. _____ 2. _____	1. _____ 2. _____	1. _____ 2. _____
Psychopathology	1. _____ 2. _____	1. _____ 2. _____	1. _____ 2. _____

Human Sexuality Theory & Counseling Techniques	1. _____ 2. _____	1. _____ 2. _____	1. _____ 2. _____
Psychosocial Theory	1. _____ 2. _____	1. _____ 2. _____	1. _____ 2. _____
Substance Abuse Theory & Counseling Techniques	1. _____ 2. _____	1. _____ 2. _____	1. _____ 2. _____

The following courses must be a minimum of one graduate-level course of 3 semester hours or 4 quarter hours.

Legal, Ethical, Professional Standards Issues in the Practice of Marriage & Family Therapy	1. _____	1. _____	1. _____
Diagnosis, Appraisal, Assessment, and Testing for Individual or Interpersonal Disorder or Dysfunction	1. _____	1. _____	1. _____
Behavioral Research (Course must focus on the interpretation and application of research data as it applies to clinical practice)	1. _____	1. _____	1. _____

## II. SUPERVISED CLINICAL PRACTICUM, INTERNSHIP, FIELD EXPERIENCE

You are required to complete a minimum of one supervised practicum, internship, or field experience in a marriage and family counseling setting, during which you provided 180 direct client contact hours of marriage and family services under the supervision of a qualified supervisor.

This requirement may be met by a supervised practice experience which took place outside the academic arena but is certified (by the University) as equivalent to a graduate-level practicum with 180 direct client contact hours of marriage and family services offered within an academic program of an accredited college or university. 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 was completed in a **marriage and family counseling setting, during which you provided 180 direct client contact hours of marriage and family services.**

The practicum letter should also include the following:

- a. Course Title of Practicum/Internship/Field Experience
- b. Course Number
- c. Setting (was it a marriage and family counseling setting)
- d. Total Number of Direct Client Contact Hours in Marriage and Family Services



**EDUCATION WORKSHEET**  
**MENTAL HEALTH COUNSELING**

APPLICANT 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 I, II, and III 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 section IV applies to you

**I. 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 3 semester hours or 4 quarter hours of individualized graduate level coursework at an accredited college or university in each of the content areas listed below. Course numbers and titles should be listed as they appear on your official transcripts. You must submit photocopies of course descriptions from a school catalog or a course syllabus for each course listed.

**II. 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 3 semester hours or 4 quarter hours to satisfy each content area.

Content Area	School	Course Number	Course Title
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			
Counseling in Community Settings			
Substance Abuse			
Legal, Ethical & Professional Standards			

**III. UNIVERSITY SPONSORED SUPERVISED CLINICAL PRACTICUM, INTERNSHIP OR FIELD EXPERIENCE.**

You are required to complete at least 1,000 hours of university-sponsored supervised clinical practicum, internship, or field experience as required in the accrediting standards of the Council for Accreditation of Counseling and Related Education Programs (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
- An average of 1 1/2 hours per week of group 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

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.

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**IV.** If you graduated from a **mental health counseling program** accredited by the Council for the Accreditation of Counseling and Related Educational Programs (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 3 semester hours or 4 quarter hours in each content area.

Content Area	School	Course Number	Course Title
Human Sexuality			
Substance Abuse			



**CERTIFICATION/LICENSE VERIFICATION**

Print clearly or type the following information.

APPLICANT NAME \_\_\_\_\_

Clinical Social Work Applicant       Marriage & Family Therapy Applicant       Mental Health Counseling Applicant

Applicant's Address:	
Title of License:	License Number:
<p><b>THE FOLLOWING SECTIONS MUST BE COMPLETED BY THE STATE LICENSING BOARD OFFICE AND MAILED DIRECTLY TO:</b></p> <p align="center">BOARD OF CLINICAL SOCIAL WORK, MARRIAGE &amp; FAMILY THERAPY, AND MENTAL HEALTH COUNSELORS 4052 BALD CYPRESS WAY, BIN #C08 TALLAHASSEE, FLORIDA 32399-3258</p>	
The individual listed above has applied for licensure in Florida. Before further consideration is given to this application, we need the information requested on this form.	
Title of License:	License Number:
Original Issue Date:	Expiration Date:
License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Temporary <input type="checkbox"/> Other (Explain)	
Licensure Method: <input type="checkbox"/> Grandfathering <input type="checkbox"/> Reciprocity/Endorsement <input type="checkbox"/> Examination	
If licensed by examination, complete the following: Name of Exam:	
Level of Exam:	Date of Exam:      Score Achieved:
Has any disciplinary action been taken against this license? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If "YES", please provide our office with any documentation regarding the disciplinary action.	
Affix Board Seal	Signature:
	Title:
	Date:
	Phone Number:
	Board of:
	State of:

# HIV/AIDS AFFIDAVIT

Pursuant to s. 491.0065, F.S., and Rule 64B4-8.002, F.A.C., all initial licensure applicants are required to complete an approved education course on human immunodeficiency virus and acquired immune deficiency syndrome. 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 6 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, please fill out this affidavit, have it notarized, and return with your application. Your application is incomplete without this affidavit or proof of the HIV/AIDS course.

Before me, the undersigned authority, personally appeared \_\_\_\_\_  
Print Applicant's Full Name  
who deposes and says that the following statements are true and correct:

1. I \_\_\_\_\_ am of legal age and have personal  
Print Applicant's Full Name  
knowledge of the matters stated in this affidavit.
2. 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.

\_\_\_\_\_  
Signature of Applicant

Sworn to and subscribed before this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
Day Month Year

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
(Print or Stamp Commissioned Name of Notary Public)

Personally Known \_\_\_\_\_ OR Produced Identification \_\_\_\_\_

Type of Identification Produced \_\_\_\_\_



**MAKE COPIES OF ALL DOCUMENTS**

**(For your records) prior to mailing the originals to the board office.**

**MAIL APPLICATION PACKET AND FEE TO:**

BOARD OF CLINICAL SOCIAL WORK,  
MARRIAGE & FAMILY THERAPY, AND  
MENTAL HEALTH COUNSELING  
PO Box 6330  
TALLAHASSEE, FL 32314-6330

**MAIL ANY OTHER CORRESPONDENCE TO:**

BOARD OF CLINICAL SOCIAL WORK,  
MARRIAGE & FAMILY THERAPY, AND  
MENTAL HEALTH COUNSELING  
4052 BALD CYPRESS WAY, BIN #C08  
TALLAHASSEE, FL 32399-3258

If information is mailed from a source other than the applicant, the applicant's full name must appear on the correspondence or documentation.

If you have further questions you may contact the application reviewers at (850) 245-4474 between the hours of 8:00 AM and 5:00 PM EST.

**PLEASE NOTE:**

**YOUR PRACTICE LOCATION ADDRESS WILL SHOW ON THE INTERNET LICENSURE LOOKUP SCREEN.** Our licensure database requires two addresses for each licensee. One is the mailing address and the other is the practice location address. The "mailing address" is used whenever documents, newsletters, etc. are mailed to the applicant/licensee. Our Internet license lookup provides the public with information on licensed health care practitioners in the state of Florida, including an "address of record". The "practice location address" from the licensure database will show as the "address of record" on the Internet. If you only provide one address, it will be used for both the mailing address and the practice location address. Please note that the practice location address must be a street address.

**DISCLOSURE OF SOCIAL SECURITY NUMBER**

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, Sections 653 and 654; and Sections 456.013(12), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to assure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L 193, Section 317.



**SUPERVISED EXPERIENCE ATTESTATION FORM**

Print clearly or type the following information:

Applicant's Name \_\_\_\_\_ Intern Registration No. \_\_\_\_\_  
 Clinical Social Work       Marriage & Family Therapy       Mental Health Counseling

Supervisor's General Information (to be completed by supervisor)			
Supervisor's Name:		Phone:	
Address:			
License/Certification Title	State	Original Licensure Date	License Number
Other Professional Credential	Organization	Original Certificate Date	Certification Number

Supervised Experience Affirmation (to be completed by supervisor)
<p>I have read and understand Rule Chapter 64B4-2, F.A.C. I provided at least one (1) hour of supervision per fifteen (15) hours of psychotherapy face-to-face with clients provided by the intern, with a minimum of one (1) hour of supervision every two (2) weeks. Supervision was provided from _____ / _____ / _____ to _____ / _____ / _____ for a total of _____ weeks.</p> <p>The applicant provided psychotherapy face-to-face with clients for _____ hours per week.</p> <p align="center"><i>Each blank line in this section must be filled in.</i></p>

**ONE BOX BELOW MUST BE CHECKED!**

<p>As a professional licensee overseeing the supervision of this intern, do you have any information regarding this registered intern's ability to practice and/or counsel independently? Please check one of the following that most closely reflects your opinion as the supervisor overseeing the internship.</p> <p><input type="checkbox"/> <u>Has met the minimum standards of performance in professional activities when measured against generally prevailing peer performance, pursuant to Section 491.009(1)(r), Florida Statutes.</u></p> <p><input type="checkbox"/> <u>Has not met the minimum standards of performance in professional activities when measured against generally prevailing peer performance, pursuant to Section 491.009(1)(r), Florida Statutes.</u></p> <p><b>If you have chosen "has not met", you must provide further information as to why this requirement has not been met.</b></p>
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Supervisor's Signature (must be original signature) \_\_\_\_\_ Date \_\_\_\_\_

**This form is to be COMPLETED (not just signed) by the SUPERVISOR!**