DEPARTMENT OF HEALTH

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

APPLICATION FOR LICENSURE

EXAMINATION ENDORSEMENT

Department of Health
Florida Board of CSW/MFT/MHC
4052 Bald Cypress Way, C-08
Tallahassee, FL 32399-3258
Telephone: (850) 245-4474
www.floridasmentalhealthprofessions.gov
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Rule 64B4-3.001
DH-MQA 1174 (Revised 11/18)

APPLICATION FOR LICENSURE INSTRUCTIONS

Chapter 491, Florida Statutes (F.S.), and 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 clinical experience in the profession for which licensure is applied
- Passing score on the national clinical examination
- Complete a Board approved 8-hour continuing education Laws & Rules Course
- Complete a 3-hour course on HIV/AIDS from an approved CE provider

Please review the laws and rules to determine eligibility. The laws and rules can be found on our website at http://floridasmentalhealthprofessions.gov and clicking on "Resources".

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

LICENSURE BY ENDORSEMENT REQUIREMENTS

Please note: Endorsement applicants must meet the examination requirements and the educational requirements for licensure. They are not required to document the post-master's experience.

- 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
- Active 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.
- A master's or doctoral degree and coursework in specific content areas
- A supervised clinical practicum, internship, or field experience
- Passing score on the national clinical examination
- Complete a Board approved 8-hour continuing education Laws & Rules Course
- Complete a 3-hour course on HIV/AIDS from an approved CE provider

Please review the laws and rules to determine eligibility. The laws and rules can be found on our website at http://floridasmentalhealthprofessions.gov and clicking on "Resources".

CSW, MFT, and MHC	Section 491.006, F.S.
CSW, MFT, and MHC	Educational Requirements in s. 491.005, F.S. (see specific section as listed in exam requirements above)

I. EXAMINATION INFORMATION:

Application deadlines, registration deadlines, and examination dates are available on our website at http://floridasmentalhealthprofessions.gov and click on "Resources" then "Exam Schedule".

CLINICAL SOCIAL WORK

CLINICAL SOCIAL WORK – ASWB (Association of Social Work Boards) **CLINICAL Level Exam**
To become eligible to sit for the national examination, applicant must have a minimum of two years of post-master's clinical social work experience. Applicant must submit the application for licensure and fees with supporting documentation for review to receive approval from the Board to sit for the exam. Candidates who have already passed the national **clinical** exam prior to submitting application must request a copy of their **official** national exam score report be mailed directly to our office from the ASWB.

The national examination is offered weekly, Mon-Sat by individual appointment computer-based format Worldwide. 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. NOTE: Florida candidates must request the **clinical level** study guide.

MARRIAGE & FAMILY THERAPY

MARRIAGE & FAMILY THERAPY – National Exam provided by the Association of Marriage & Family Therapy Regulatory Boards (AMFTRB)

Applicant must submit the application for licensure and fees with supporting documentation for review to receive approval from the Board to sit for the exam. Candidates who have already passed the national **clinical** exam prior to submitting application must request a copy of their **official** national exam score report be mailed directly to our office from the AMFTRB.

To register, please visit https://secure.ptcny.com/apply/. Complete the examination application using your confidential Florida Approval Code and submit examination/testing fee payment. Applications are not considered complete until all information has been provided and payment is received. Within six (6) weeks prior to the start of the testing period, Professional Testing Corporation (PTC)* sends your "Scheduling Authorization" via email. The "Scheduling Authorization" Notice includes an authorization number and information on how to set up your examination location, date, and time through PSI. Retain this document. You must present your current driver's license, passport or U.S. military ID at the test center at the time of your test appointment. Temporary/paper driver licenses will not be accepted.

The AMFTRB offers an online practice version of the national MFT exam for purchase at www.amftrb.org.

MENTAL HEALTH COUNSELING

MENTAL HEALTH COUNSELOR – National Clinical Mental Health Counseling Exam (NCMHCE) provided by the National Board of Certified Counselors (NBCC)
Board approval is **not** required to register for the NCMHCE. For information on how to register, please go to www.nbcc.org and highlight "Examinations" then click on "Register for a State Licensure Examination". Do not contact the Board Office to register for the exam.

The national clinical examination is given the first two full weeks of every month, Monday through Friday, by computer in all states and major metropolitan areas. The exam may be re-taken every 90 days. The NCMHCE "Candidate Handbook for State Credentialing" can be viewed or printed at the NBCC website. NBCC has a booklet of sample test scenarios for purchase by phone at (336) 547-0607 or www.nbcc.org.

SPECIAL TESTING ACCOMMODATIONS

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.

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

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

II. CONTINUING EDUCATION REQUIREMENTS FOR LICENSURE

- 8-Hour Florida Laws & Rules Course from a Board approved provider listed on www.cebroker.com

Prior to licensure you must complete an 8-hour laws and rules course. A copy of your certificate of completion is acceptable as proof that you completed the course.

- 3-Hour HIV/AIDs Course from a Board approved provider listed on www. cebroker.com

A 3-hour course on human immunodeficiency virus and acquired immune deficiency syndrome is required prior to licensure. 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)

Application Fee (non-refundable):	$100.00
Licensure Fee:	$75.00
Unlicensed Activity Fee:	$5.00
TOTAL FEE:	**$180.00**

The fee must accompany the application. Please make check or money order made payable to the Department of Health in the amount of $180.00 and mail with application, supporting documentation, and credentials to:

DEPARTMENT OF HEALTH
P.O. BOX 6330
TALLAHASSEE, FLORIDA 32314-6330

NOTE: The application fee is non-refundable.

Any supporting documentation and credentials mailed **separately** from the application should be mailed to:

DEPARTMENT OF HEALTH
BOARD OF CSW/MFT/MHC
4052 BALD CYPRESS WAY, BIN C08
TALLAHASSEE, FLORIDA 32399-3258

IV. OFFICIAL TRANSCRIPTS (ALL PROFESSIONS)

NOTE: Not required if you are a registered intern whose education has been certified complete.

You must request an official transcript from the regionally accredited institution(s) from which you received your degree or have taken coursework. 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. **If the course title on your transcript does not clearly identify the content of the coursework, a course description or syllabus will be required.**

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.

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.

CLINICAL SOCIAL WORK

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

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 International Social Work Degree Recognition and Evaluation Service provided by the Office of Social Work Accreditation (OSWA) . To contact the OSWA, please visit www.cswe.org or call (703) 683-8080.

MARRIAGE & FAMILY AND MENTAL HEALTH COUNSELING

FOREIGN EDUCATION

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 a regionally accredited U.S. institution and the coursework met the content and credit hour requirement for graduate level coursework in the U.S. It is the applicant's responsibility to obtain an evaluation from a recognized foreign equivalency determination service that documents the acceptability of the coursework. The board office must receive an original evaluation mailed directly from the educational evaluation service.

V. EDUCATION WORKSHEET

[Not required if you are a Registered Intern in Florida.]
Complete the appropriate education worksheet for your profession.

VI. 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.

VII. VERIFICATION OF CLINICAL EXPERIENCE FORM

[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 **Verification of Clinical Experience** 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. The form is available on our website http://floridasmentalhealthprofessions.gov and clicking on "Resources" then "Forms".

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 website (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: Consists of at least 1500 hours of providing psychotherapy face-to-face with clients, accrued in no less than 100 weeks.

Supervision: Received at least 100 hours of supervision in no less than 100 weeks; and, provided at least 1500 hours of face-to-face psychotherapy with clients; and, received at least 1 hour of supervision every two weeks.

Experience is defined in Rule 64B4-2.001, F.A.C., and supervision is defined in Rule 64B4-2.002, F.A.C.

DEPARTMENT OF HEALTH
Board of Clinical Social Work
Marriage and Family Therapy
& Mental Health Counseling
PO BOX 6330
Tallahassee, FL 32314

Application For Licensure

I. APPLICANT PROFILE DATA

Name	Last First Middle	
Mailing Address	Street Address or P.O. Box Apt. No.	
	City State Zip **(Provide the address where mail and your license should be sent.)**	DO NOT WRITE IN THIS SPACE FOR OFFICE USE ONLY
*Practice Location Address	Street Address Required	
	City State Zip **(Required for licensure. This address will be posted on the Department of Health's website.)**	(Check One) ❑ LICENSURE BY EXAMINATION ❑ LICENSURE BY ENDORSEMENT

Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name? ❑ YES ❑ NO
If "YES" list name(s) below:

(Check One)
❑ CLINICAL SOCIAL WORK (5201)
❑ MARRIAGE & FAMILY THERAPY (5202)
❑ MENTAL HEALTH COUNSELING (5203)

Primary Telephone:	Business Telephone:
area code ( )	area code ( )

Are you a registered intern in Florida?
❑ YES ❑ NO

Email Address:

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office.

Email Notification: If you want to be notified of the status of your application by email please check the "Yes" box and write your email address on the line provided below. If you choose this form of notification, you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the Board office.
☐ Yes ☐ No

Date of birth:
_____/_____/_____

Gender: ❑ Male ❑ Female

Have you passed the national clinical examination? ❑ YES ❑ NO

Name of Exam you passed:
_____

Equal Opportunity Data: 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 FR 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.

SEX: ☐Male ☐ Female U.S. Citizen: ☐ Yes ☐ No RACE: ☐ White ☐ Black ☐ Asian/Pacific☐Hispanic ☐ Other_____

Rule 64B4-3.001
DH-MQA 1174 (Revised 11/18)

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 <u>all</u> 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 <u>all</u> pending applications and the issuing state, territory, or foreign country:

III. PROFESSIONAL or SUPERVISED EXPERIENCE

Exam applicants only: This section is not required for endorsement applicants.

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 _____

IV. EDUCATION

List all schools used on your Education Worksheet.

Degree (if applicable)	Major	Name of School	Degree Conferred Date
			/ /
			/ /
			/ /
			/ /

For clinical social work applicants only. Were you an advanced standing student? ❑ YES ❑ NO

V. APPLICANT HISTORY – PROFESSIONAL

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 against your professional conduct or competency in a psychotherapy or counseling-related profession?	❑ YES ❑ NO
E.	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.❑ YES ❑ NO
	2. Lying on a resume or misrepresentation	2.❑ YES ❑ NO
	3. Academic misconduct, including acts such as cheating or plagiarism	3.❑ YES ❑ NO
	4. Theft	4.❑ YES ❑ NO
	5. Sexual harassment	5.❑ YES ❑ NO

If you answered "YES" to any question in Section V, you must provide the Board complete details.

APPLICANT NAME _____

VI. APPLICANT HISTORY - Pursuant to Section 456.0635(2), Florida Statutes,

IMPORTANT NOTICE: 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.

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.)	❑YES ❑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 or conviction, and completion of any sentence or subsequent period of probation?	❑YES ❑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).	❑YES ❑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?	❑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, 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)? (If "No", do not answer 2a.)	❑YES ❑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?	❑YES ❑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.)	❑YES ❑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?	❑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? (If "No", do not answer 4a or 4b.)	❑YES ❑NO
a.	Have you been in good standing with a state Medicaid program for the most recent five years?	❑YES ❑NO
b.	Did the termination occur at least 20 years before the date of this application?	❑YES ❑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?	❑YES ❑NO

APPLICANT NAME _____

VII. APPLICANT HISTORY – GENERAL

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a 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 or conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. ☐ YES ☐ NO

If you answered "Yes" to the question above you are required to send the following items:

☐ **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.

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. 775.084, 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

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 USCA § 666 (a)(13); and Sections 456.013, 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.

Name: _____
Last **First** **Middle**

IX. Social Security Number: _____

X. APPLICANT HISTORY – HEALTH	
A. Do you have any condition that currently impairs your ability to practice your profession with reasonable skill and safety?	❑ YES ❑ NO
B. Are you using medications, other drugs, narcotics, or intoxicating chemicals that impair your ability to practice your profession with reasonable skill and safety?	❑ YES ❑ NO
If you answered "yes" to either of the above questions, please provide a letter from a licensed health care practitioner, who is qualified by skill and training to address your condition, which explains the impact your condition may have on your ability to practice your profession with reasonable skill and safety, and stating either that you are safe to practice your profession without restriction or indicating what restrictions are necessary. If necessary, you may attach additional sheets. Documentation must be current within the last year. If you fail to disclose the information requested in this section, your application may be denied.	

Rule 64B4-3.001
DH-MQA 1174 (Revised 11/18)

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

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 <u>one graduate-level course</u> 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. <u>SUPERVISED CLINICAL PRACTICUM, INTERNSHIP, FIELD EXPERIENCE</u>

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 a regionally accredited institution in each of the content areas listed below. Course numbers and titles should be listed as they appear on your official transcripts. If the course title on your transcript does not clearly identify the content of the coursework, a course description or syllabus will be required.

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 must complete at least 1,000 hours of university-sponsored supervised clinical practicum, internship, or field experience as required in the accrediting standards of CACREP for mental health counseling programs.

The accrediting standards of CACREP for these hours are:

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

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

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

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 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			

DEPARTMENT OF HEALTH

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:
THE FOLLOWING SECTIONS MUST BE COMPLETED BY THE STATE LICENSING BOARD OFFICE AND MAILED DIRECTLY TO: BOARD OF CLINICAL SOCIAL WORK, MARRIAGE & FAMILY THERAPY, AND MENTAL HEALTH COUNSELORS 4052 BALD CYPRESS WAY, BIN #C08 TALLAHASSEE, FLORIDA 32399-3258
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: ❑ Active ❑ Inactive ❑ Temporary ❑ Other (Explain)
Licensure Method: ❑ Grandfathering ❑ Reciprocity/Endorsement ❑ 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? ❑ YES ❑ 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 _____