The Commonwealth of Massachusetts
Division of Professional Licensure
Board of Allied Mental Health and
Human Services Professions
1000 Washington Street, Suite 710
Boston, MA 02118-6100

APPLICATION INFORMATION FOR LICENSURE AS A MENTAL HEALTH COUNSELOR

Prior to completing the application, it is strongly recommended that all applicants obtain a copy of 262 CMR from the State Bookstore, Room 116, State House, Boston, MA 02133, (617) 727-2834, or online at www.mass.gov/dpl/boards/mh, to verify that all educational, exam, experience and supervision requirements are met. It is also recommended that applicants maintain a copy of their application for their records.

All applicants must pass the National Clinical Mental Health Examination (NCMHCE) in order to become licensed. You may obtain exam registration materials from the above website. If you have already passed the exam, submit an official score report (copy of your report is acceptable) with your application. Exam scores expire after 5 years, unless you currently hold a license in another state.

There is a non-refundable application fee of **$117.00**, which must be submitted in the form of a check or money order payable to the Commonwealth of Massachusetts. The application fee must accompany the completed application.

If all licensure requirements have been met, notification will be sent, and the initial licensure fee will be assessed. If it is determined that your application does not meet the requirements, you will be notified in writing.

All application materials should be submitted to:

Board of Allied Mental Health and Human Services Professions
1000 Washington Street, Suite 710
Boston, MA 02118-6100

ALL APPLICANTS MUST COMPLETE AND INCLUDE THE CHECKLIST PROVIDED AT THE END OF THIS APPLICATION

Should you have any questions about the application process, please contact Board staff at 617-727-0084 or via email at amh.board@state.ma.us.

Please be aware that if you submit an application and it is determined by the Board that it is incomplete, or that you have failed to meet the regulatory requirements for licensure, the Board will provide you six months to complete your application or submit the information needed to demonstrate that you meet the regulatory requirements, which will be communicated to you in a written letter from the Board. After six months, if your application is still incomplete, or if you have still failed to demonstrate that you meet the regulatory requirements for licensure, you will be issued a letter from the Board indicating that your application has been closed or denied. If your application is closed or denied, you would need to re-apply for licensure by submitting a complete application to the Board and by paying a new application fee.

Reciprocal Recognition

Any applicant who holds a license, certification or registration as a mental health counselor, or the equivalent thereof as determined by the Board, issued by another state or jurisdiction, may apply to the Board for licensure as a mental health counselor by reciprocal recognition.

☐ If you are applying for licensure by Reciprocal Recognition, please check this box. If you check this box, note that you must still complete this application. You must also:

1. Attach written proof, in a form acceptable to the Board, that your license, certification, or registration as a mental health counselor is in good standing with the licensing authority that issued it;
2. Written proof (e.g., licensing regulations) that the requirements or standards for that license, certification or registration are substantially equivalent to or exceed the standards of the Commonwealth (these may generally be obtained from the state Board that issued your license);
3. Written proof that the applicant received a passing score on the NCMHCE in accordance with 262 CMR 2.03(2)(c); and,
4. Written proof that the applicant has been actively practicing mental health counseling with a license continuously for at least three years full-time, or the part-time equivalent in the state or jurisdiction that issued the license, certification, or registration.

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MENTAL HEALTH COUNSELOR LICENSURE APPLICATION

Please attach recent

2" x 2"

Head and shoulder photograph

NON-REFUNDABLE APPLICATION FEE:
$117.00

1. Name: _____
Last **First** **Middle** **Maiden**

2. Mailing Address: _____
No. **Street** **Apt. No.**

_____
City/Town **State** **Zip Code**

NOTE: *The mailing address above will be a* ***matter of public record****. It will appear on your license and will be used for all board correspondence. The mailing address and the business address provided below may be the same.*

3. Business: _____
Company Name

_____
Street .

_____
City/Town **State** **Zip Code**

4. Date of Birth _____

5. Telephone No: Day _____**Evening** _____

6. Email: _____
Do you consent to receiving information about your application from the Board via email (e.g., incomplete notifications): Yes_____ No _____

7. **Pursuant to G.L. c. 62C, s. 49A, I have filed all state tax returns and paid all state taxes required under law: ☐ Yes ☐ No If no, please explain _____**
_____

If you have ever held a license in another state, please complete the information below.				
State	**License Number**	**Issue Date**	**Current**	**Lapsed**
A letter of standing from each state listed must be sent to the Board separately.				

DISCIPLINARY HISTORY

If you answer "Yes" to any of the following questions, please attach a full explanation.

A. Has any disciplinary action been taken against you by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes __ No __

B. Are you the subject of pending disciplinary action by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes __ No __

C. Have you voluntarily surrendered or resigned a professional license to a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes __ No __

D. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction? Yes ___ No ___

E. Have you ever been convicted of a felony or misdemeanor in the United States or any country or foreign jurisdiction, other than a traffic violation for which a fine of less than $200 was assessed? Yes ___ No ___

The Board is registered under the provisions of M.G.L c. 6 §172 to receive Criminal Offender Record Information (CORI) for the purpose of screening current licensees and otherwise qualified prospective license applicants. CORI must be checked as part of your licensing process. No convictions contained in a CORI are automatic disqualifiers. In order to complete the CORI check process, please fill out the Criminal Offender Record Information Acknowledgment Form on Pages 18 & 19.

EDUCATION				
College or University	**Degree**	**Year**	**Major**	**Credits**
A. Masters				
B. Post-Master's Credits (non-CAGS)				
C. Second Master's Degree				
D. CAGS or other post-master's certificate				
E. Doctoral Degree				
Official transcripts must be provided from all graduate institutions.				

Please list the date you passed the National Clinical Mental Health Counseling Examination (NCMHCE):

_____/_____/_____

SUPERVISED CLINICAL EXPERIENCE:

Practicum Pre-Master's Degree Clinical Experience

Dates of Clinical Experience: From _____ to _____

Name and Address of Facility _____

_____

Your Title _____

Name of Supervisor_____ Supervisor's Title _____

Internship Pre-Master's Degree Clinical Experience

Dates of Clinical Experience: From _____ to _____

Name and Address of Facility _____

_____

Your Title_____

Name of Supervisor _____ Supervisor's Title _____

Post-Master's Degree Clinical Experience

Dates of Clinical Experience: From _____ to _____

Name and Address of Facility _____

_____

Your Title _____

Name of Supervisor _____ Supervisor's Title _____

(Use additional paper to list additional sites and supervisors)

AFFIDAVIT:

Pursuant to G.L. c. 119 s. 51A and G.L. c. 112, s. 1A, my signature on this application is my certification that I understand my obligation to report the abuse or neglect of children and that failure to do so may result in criminal punishment including fines and/or imprisonment.

The applicant named on this application agrees to abide by the rules and regulations for Licensed Mental Health Counselors and attests that all statements are truthful and are made under the pains and penalties of perjury.

_____ _____

Signature of Applicant *Date*

Applicant's Name_____

ACADEMIC REQUIREMENT FORM

A minimum of three semester credits, or four quarter credits of graduate-level courses must be taken in each of the ten content areas listed below. Each course taken may only be used to fill one requirement. All courses must focus on Mental Health Counseling. Please review your transcript and specify the course number which corresponds to the course content area listed below. **After you have completed this form, please have a Department Head, Faculty Advisor or Program Director attest to the identified courses' compliance with the regulations as stated below. Please duplicate this form for every graduate program that you have attended. Each graduate program should complete a new and separate form.**

Course Content Area Description	Course Number
Counseling Theory. Examination of the major theories, principles & techniques of Mental Health Counseling & their application to professional counseling settings. Understanding & applying theoretical perspectives with clients.	
Human Growth and Development. Understanding the nature & needs of individuals at all developmental stages of life. Understanding major theories of physical, cognitive, affective and social development & their application to Mental Health Counseling practice.	
Psychopathology. Identification & diagnosis and mental health treatment planning for abnormal, deviant, or psychopathological behavior, includes assessments and treatment procedures.	
Social and Cultural Foundations. Theories of multicultural counseling, issues and trends of a multicultural and diverse society. Foundational knowledge & skills needed to provide Mental Health Counseling services to diverse populations in a culturally competent manner.	
Clinical Skills. Understanding of the theoretical bases of the counseling processes, Mental Health Counseling techniques, and their therapeutic applications. Understanding & practice of counseling skills necessary for the mental health counselor.	
Group Work. Theoretical & experiential understandings of group development, purpose, dynamics, group counseling methods and skills, as well as leadership styles. Understanding of the dynamics and processes of Mental Health (therapeutic, psychosocial, psycho-educational) groups.	

Special Treatment Issues. Areas relevant to the practice of Mental Health Counseling, *i.e*. psychopharmacology, substance abuse, school or career issues, marriage & family treatment, sexuality & lifestyle choices, treating special populations.	
Appraisal. Individual & group educational and psychometric theories and approaches to appraisal. Examination of the various instruments and methods of psychological appraisal and assessment including, but not limited to, cognitive, affective, and personality assessment utilized by the mental health counselor. The function of measurement and evaluation, purposes of testing, reliability & validity.	
Research and Evaluation. Understanding social science research, evaluative methodologies & strategies, types of research, program evaluation, needs assessments, ethical and legal considerations.	
Professional Orientation. Understanding of professional roles & functions of Mental Health Counselors, with particular emphasis on legal & ethical standards. Ethical case conceptualization, analysis & decision making as it relates to clinical practice. Knowledge and understanding of the standards set by the code of ethics of the American Counseling Association & the American Mental Health Counselors Association. Understanding of licensure and regulatory practices.	

In addition, all applicants must have a minimum of 60 semester credits or 80 quarter credits in counseling or a related field as stated in 262 CMR 2.02. Please note the total number of credits completed during this program that are in counseling or a related field here_____. Please note whether these credits are semester values or quarter values._____

This section to be signed and verified by a Department Chair, Faculty Advisor or Program Director:

I have read the course content area requirements for this license as stated above and certify that the identified courses meet requisite criteria. The undersigned states that under the pains and penalties of perjury, the above statements are true and correct.

_____ _____

Signature **Date**

Please check one:

- o **I am a Department Chair**
- o **I am a Faculty Advisor for this student**
- o **I am a Program Director**

PRE-MASTERS PRACTICUM FORM

Name of Applicant: _____

INSTRUCTIONS**: Please duplicate this form as necessary. See following page for the definition of Approved Supervisor. *PLEASE PRINT CLEARLY OR TYPE.***

MINIMUM REQUIREMENTS**: A seven week period at the academic campus or Clinical Field Experience Site in which the applicant accrued 100 clock hours, which includes:**

(1) 40 contact hours of Direct Client Contact Experience in Clinical Field Experience Sites conforming to the Mental Health Counseling scope of practice as defined under 262 CMR 2.02 or peer role plays and laboratory experience in individual, group, couple and family interactions; and,

(2) 25 supervisory contact hours of supervision with:

(a) A minimum of 10 Supervisory Contact Hours of Individual Supervision;

(b) A minimum of 5 Supervisory Contact Hours of Group Supervision, with no more than ten supervisees in group; and,

(c) The remaining 10 Supervisory Contact Hours in either Individual or Group Supervision.

***Please be reminded: A required component of the application for licensure is that all applicants provide documentation of receiving 50 Supervisory Contact Hours of the 200 total Supervisory Contact Hours of supervision required (pre- or post-Master's degree) by a Licensed Mental Health Counselor or an equivalently Licensed Mental Health Counselor from another state or jurisdiction.**

Remainder of Form to be completed by each Approved Supervisor for this site. (Copies of this form can be made).

Name of Supervisor: _____
Supervisor's Title: _____
Supervisor's License Type and Number: _____
Supervisor's phone number: _____

Name/Address of Clinical Facility/ Academic Site: _____
_____

Dates of Supervision of the Applicant: From:____/____/_____ To: ___/_____/_____(month/date/year)

The applicant worked _____ hours per week for _____weeks for a total of _____MH experience hours

Number of direct, face-to-face, clinical contact experience hours completed during this period: _____

Number of supervisory contact hours provided during this period by this supervisor:
Individual: _____ Group: _____

Has any disciplinary action been taken against you by any of the following (if yes, please submit detailed explanation):

Professional Association or Organization:	**Yes: ____**	**No: ____**
Governmental Authority (e.g. Professional Licensing Board):	**Yes: ____**	**No: ____**
Third Party Insurance Carrier:	**Yes: ____**	**No: ____**
Credentialing Board:	**Yes: ____**	**No: ____**

I have read the definitions of Approved Supervisor listed in 262 CMR and/or below and believe that I qualify as an approved supervisor. The undersigned states that under the pains and penalties of perjury, the above statements are true and correct.

Signature of Approved Supervisor **Date**

Definition of an Approved Supervisor (Post-June 5, 2015):

An approved supervisor is a practitioner with three years of Full Time or the equivalent Part Time post-licensure clinical Mental Health Counseling experience who is also either:

(a) a Massachusetts Licensed Mental Health Counselor;

(b) a Massachusetts licensed independent clinical social worker;

(c) a Massachusetts licensed marriage and family therapist;

(d) a Massachusetts licensed psychologist with Health Services Provider Certification;

(e) a Massachusetts licensed physician with a sub-specialization in psychiatry;

(f) a Massachusetts licensed nurse practitioner with a sub-specialization in psychiatry; or,

(g) where practice and supervision occur outside of the Commonwealth, an individual who is an independently licensed mental health practitioner with a license or registration equivalent to on listed under 262 CMR 2.02(a)-(f).

I have read the definitions of Approved Supervisor, which were in effect prior to June 5, 2015 as listed below and believe that I qualify as an approved supervisor. The undersigned states that under the pains and penalties of perjury, the above statements are true and correct.

Signature of Approved Supervisor **Date**

Definition of an Approved Supervisor (Pre-June 5, 2015):

An approved supervisor is a mental health practitioner who meets the qualifications listed under subcategory (a), (b), (c), (d), or (e); all of these approved supervisors must have five (5) years of full time or the equivalent part time postgraduate clinical mental health counseling experience.

(a) LMHC; a currently licensed mental health counselor.

(b) A CCMHC; a Certified Clinical Mental Health Counselor who holds a currently valid certificate.

(c) A **licensed** mental health practitioner who:

1. has a master's degree in social work (LICSW) and is licensed for independent clinical practice;
2. has a master's degree in marriage and family therapy; (LMFT)
3. has a doctoral degree in clinical, counseling or developmental psychology or a medical degree with a sub-specialization in psychiatry (Psychologist or Psychiatrist).

(d) A **licensed** mental health practitioner who has:

1. a master's or doctoral degree in rehabilitation counseling, pastoral counseling, psychiatric nursing, developmental or educational psychology, or related fields **and;**
2. successfully completed a Supervised Clinical Experience; **and**
3. achieved a passing score on the NCMHCE licensure examination.

(e) An out of state supervisor who is a licensed mental health practitioner (in states that have licensure in their discipline) and who meets the qualifications for licensure for independent clinical practice in Massachusetts in his/her respective discipline.

(f) For the specific purpose of the college supervision (e.g. support seminars) of students in a practicum or internship, an approved supervisor may be a mental health practitioner who:

1. holds a teaching or supervisory position in an educational institution which trains mental health counselors; and
2. holds a graduate degree in mental health counseling or a related field.

Site supervisors for practica and internships must meet the qualifications for Approved Supervisor (a), (b), (c), (d), or (e).

MASSACHUSETTS SUPERVISOR: Please list which of the above describes your license:

_____ ***LICENSE/CERTIFICATE #*** _____

***OUT OF STATE SUPERVISOR*:** Please attest that you meet the qualifications for individual clinical practice in Massachusetts by your signature below.

License # _____ State_____ Licensure type_____

APPLICANT'S NAME:

_____

PRE-MASTERS INTERNSHIP FORM

Name of Applicant: _____

INSTRUCTIONS**: Please duplicate this form as necessary. See following page for the definition of Approved Supervisor. *PLEASE PRINT CLEARLY OR TYPE.***

MINIMUM REQUIREMENTS**: A distinctly defined, post-Practicum, supervised curricular experience that totals a minimum of 600 clock hours, which must include:**

(1) 240 contact hours of Direct Client Contact Experience in Clinical Field Experience Sites conforming to the Mental Health Counseling scope of practice defined under 262 CMR 2.02; and,

(2) 45 Supervisory Contact Hours of supervision with:

(a) A minimum of 15 Supervisory Contact Hours of Individual Supervision;

(b) A minimum of 15 Supervisory Contact Hours of Group Supervision, with no more than ten supervisees in group.

(c) The remaining 15 supervisory contact hours may be either Individual or Group Supervision.

***Please be reminded: A required component of the application for licensure is that all applicants provide documentation of receiving 50 Supervisory Contact Hours of the 200 total Supervisory Contact Hours of supervision required (pre- or post-Master's degree) by a Licensed Mental Health Counselor or an equivalently Licensed Mental Health Counselor from another state or jurisdiction.**

Remainder of Form to be completed by each Approved Supervisor for this site. (Copies of this form can be made).

Name of Supervisor: _____
Supervisor's Title: _____
Supervisor's License Type and Number:_____
Supervisor's phone number: _____

Name/Address of Clinical Facility: _____
_____

Dates of Supervision of the Applicant: From:____/____/_____To:___/_____/_____(month/date/year)

The applicant worked _____ hours per week for _____weeks for a total of _____MH experience hours

Number of direct, face-to-face, clinical contact experience hours completed during this period: _____

Number of supervisory contact hours provided during this period by this supervisor:
Individual: _____ Group: _____

Has any disciplinary action been taken against you by any of the following (if yes, please submit detailed explanation):

Professional Association or Organization:	**Yes: ____**	**No: ____**
Governmental Authority (e.g. Professional Licensing Board):	**Yes: ____**	**No: ____**
Third Party Insurance Carrier:	**Yes: ____**	**No: ____**
Credentialing Board:	**Yes: ____**	**No: ____**

I have read the definitions of Approved Supervisor listed in 262 CMR and/or below and believe that I qualify as an approved supervisor. The undersigned states that under the pains and penalties of perjury, the above statements are true and correct.

_____

Signature of Approved Supervisor **Date**

Definition of an Approved Supervisor (Post-June 5, 2015):

An approved supervisor is a practitioner with three years of Full Time or the equivalent Part Time post-licensure clinical Mental Health Counseling experience who is also either:

(a) a Massachusetts Licensed Mental Health Counselor;

(b) a Massachusetts licensed independent clinical social worker;

(c) a Massachusetts licensed marriage and family therapist;

(d) a Massachusetts licensed psychologist with Health Services Provider Certification;

(e) a Massachusetts licensed physician with a sub-specialization in psychiatry;

(f) a Massachusetts licensed nurse practitioner with a sub-specialization in psychiatry; or,

(g) where practice and supervision occur outside of the Commonwealth, an individual who is an independently licensed mental health practitioner with a license or registration equivalent to on listed under 262 CMR 2.02(a)-(f).

I have read the definitions of Approved Supervisor, which were in effect prior to June 5, 2015 as listed below and believe that I qualify as an approved supervisor. The undersigned states that under the pains and penalties of perjury, the above statements are true and correct.

_____

Signature of Approved Supervisor **Date**

Definition of an Approved Supervisor (Pre-June 5, 2015):

An approved supervisor is a mental health practitioner who meets the qualifications listed under subcategory (a), (b), (c), (d), or (e); all of these approved supervisors must have five (5) years of full time or the equivalent part time postgraduate clinical mental health counseling experience.

(b) LMHC; a currently licensed mental health counselor.

(b) A CCMHC; a Certified Clinical Mental Health Counselor who holds a currently valid certificate.

(c) A **licensed** mental health practitioner who:

1. has a master's degree in social work (LICSW) and is licensed for independent clinical practice;
2. has a master's degree in marriage and family therapy; (LMFT)
3. has a doctoral degree in clinical, counseling or developmental psychology or a medical degree with a sub-specialization in psychiatry (Psychologist or Psychiatrist).

(d) A **licensed** mental health practitioner who has:

1. a master's or doctoral degree in rehabilitation counseling, pastoral counseling, psychiatric nursing, developmental or educational psychology, or related fields **and;**
2. successfully completed a Supervised Clinical Experience; **and**
3. achieved a passing score on the NCMHCE licensure examination.

(e) An out of state supervisor who is a licensed mental health practitioner (in states that have licensure in their discipline) and who meets the qualifications for licensure for independent clinical practice in Massachusetts in his/her respective discipline.

(f) For the specific purpose of the college supervision (e.g. support seminars) of students in a practicum or internship, an approved supervisor may be a mental health practitioner who:

3. holds a teaching or supervisory position in an educational institution which trains mental health counselors; and
4. holds a graduate degree in mental health counseling or a related field.

Site supervisors for practica and internships must meet the qualifications for Approved Supervisor (a), (b), (c), (d), or (e).

MASSACHUSETTS SUPERVISOR: Please list which of the above describes your license:

_____ ***LICENSE/CERTIFICATE #*** _____

***OUT OF STATE SUPERVISOR*:** Please attest that you meet the qualifications for individual clinical practice in Massachusetts by your signature below.

License # _____ State_____ Licensure type_____

APPLICANT'S NAME: _____

POST-MASTERS CLINICAL EXPERIENCE FORM

Name of Applicant: _____

INSTRUCTIONS**: Please duplicate this form as necessary. See following page for the definition of Approved Supervisor. *PLEASE PRINT CLEARLY OR TYPE.***

MINIMUM REQUIREMENTS**: A minimum of 2 years and maximum of 8 years of full-time, or equivalent part-time experience in which the applicant:**

(1) **Accrues 3360 total hours which includes the following minimums:**
   - **a. 960 Contact Hours of Direct Client Contact Experience, of which:**
     - **i. A minimum of 610 Direct Client Contact Experience Contact Hours are in individual, couples, or family counseling; and,**
     - **ii. A maximum of 350 Direct Client Contact Experience Contact Hours may be in group counseling.**

(2) **130 supervisory contact hours of supervision of which:**
   - **a. At least 75 hours must be in Individual Supervision;**
   - **b. A minimum of 1 Supervisory Contact Hour of supervision for every 16 Contact Hours of Direct Client Contact Experience;**
   - **c. If working Part Time, supervision that is pro-rated no less than one Supervisory Contact Hour bi-weekly.**

***Please be reminded: A required component of the application for licensure is that all applicants provide documentation of receiving 50 Supervisory Contact Hours of the 200 total Supervisory Contact Hours of supervision required (pre- or post-Master's degree) by a Licensed Mental Health Counselor or an equivalently Licensed Mental Health Counselor from another state or jurisdiction.**

Remainder of Form to be completed by each Approved Supervisor for this site. (Copies of this form can be made).

Name of Supervisor: _____
Supervisor's Title: _____
Supervisor's License Type and Number: _____
Supervisor's phone number: _____
Name/Address of Clinical Facility: _____
_____

Dates of Supervision of the Applicant: From:____/____/_____To:___/_____/_____(month/date/year)

The applicant worked _____ hours per week for _____weeks for a total of _____MH experience hours

Number of direct, face-to-face, clinical contact experience hours completed during this period:
Individual/Couples/Family: _____ Group: _____ Total:_____

Number of supervisory contact hours provided during this period by this supervisor:
Individual: _____ Group: _____

Has any disciplinary action been taken against you by any of the following (if yes, please submit detailed explanation):

Professional Association or Organization:	**Yes: ____**	**No: ____**
Governmental Authority (e.g. Professional Licensing Board):	**Yes: ____**	**No: ____**
Third Party Insurance Carrier:	**Yes: ____**	**No: ____**
Credentialing Board:	**Yes: ____**	**No: ____**

I have read the definitions of Approved Supervisor listed in 262 CMR and/or below and believe that I qualify as an approved supervisor. The undersigned states that under the pains and penalties of perjury, the above statements are true and correct.

_____

Signature of Approved Supervisor **Date**

Definition of an Approved Supervisor (Post-June 5, 2015):

An approved supervisor is a practitioner with three years of Full Time or the equivalent Part Time post-licensure clinical Mental Health Counseling experience who is also either:

(a) a Massachusetts Licensed Mental Health Counselor;

(b) a Massachusetts licensed independent clinical social worker;

(c) a Massachusetts licensed marriage and family therapist;

(d) a Massachusetts licensed psychologist with Health Services Provider Certification;

(e) a Massachusetts licensed physician with a sub-specialization in psychiatry;

(f) a Massachusetts licensed nurse practitioner with a sub-specialization in psychiatry; or,

(g) where practice and supervision occur outside of the Commonwealth, an individual who is an independently licensed mental health practitioner with a license or registration equivalent to on listed under 262 CMR 2.02(a)-(f).

*Please note that if the applicant obtained post-master's supervised experience under a supervisor with whom s/he began supervision before June 5, 2015 and this supervisor meets the previous definition of "Approved Supervisor," this supervisor may still qualify for licensure using this supervision and experience so long as the supervision and experience began prior to June 5, 2015.

I have read the definitions of Approved Supervisor, which were in effect prior to June 5, 2015 as listed below and believe that I qualify as an approved supervisor. The undersigned states that under the pains and penalties of perjury, the above statements are true and correct and that this supervision began prior to June 5, 2015.

_____

Signature of Approved Supervisor **Date**

Definition of an Approved Supervisor (Pre-June 5, 2015):

An approved supervisor is a mental health practitioner who meets the qualifications listed under subcategory (a), (b), (c), (d), or (e); all of these approved supervisors must have five (5) years of full time or the equivalent part time postgraduate clinical mental health counseling experience.

(a) LMHC; a currently licensed mental health counselor.

(b) A CCMHC; a Certified Clinical Mental Health Counselor who holds a currently valid certificate.

(c) A **licensed** mental health practitioner who:

1. has a master's degree in social work (LICSW) and is licensed for independent clinical practice;
2. has a master's degree in marriage and family therapy; (LMFT)
3. has a doctoral degree in clinical, counseling or developmental psychology or a medical degree with a sub-specialization in psychiatry (Psychologist or Psychiatrist).

(d) A **licensed** mental health practitioner who has:

1. a master's or doctoral degree in rehabilitation counseling, pastoral counseling, psychiatric nursing, developmental or educational psychology, or related fields **and;**
2. successfully completed a Supervised Clinical Experience; **and**
3. achieved a passing score on the NCMHCE licensure examination.

(e) An out of state supervisor who is a licensed mental health practitioner (in states that have licensure in their discipline) and who meets the qualifications for licensure for independent clinical practice in Massachusetts in his/her respective discipline.

(f) For the specific purpose of the college supervision (e.g. support seminars) of students in a practicum or internship, an approved supervisor may be a mental health practitioner who:

5. holds a teaching or supervisory position in an educational institution which trains mental health counselors; and
6. holds a graduate degree in mental health counseling or a related field.

Site supervisors for practica and internships must meet the qualifications for Approved Supervisor (a), (b), (c), (d), or (e).

MASSACHUSETTS SUPERVISOR: Please list which of the above describes your license:

_____ ***LICENSE/CERTIFICATE #*** _____

***OUT OF STATE SUPERVISOR*:** Please attest that you meet the qualifications for individual clinical practice in Massachusetts by your signature below.

License # _____ State_____ Licensure type_____

APPLICANT'S NAME: _____

The Commonwealth of Massachusetts
Division of Professional Licensure
Board of Registration of Allied Mental Health and
Human Services Professions
1000 Washington Street, Suite 710
Boston, MA 02118-6100

PROFESSIONAL REFERENCE FORM

INSTRUCTIONS: All applicants must submit a minimum of TWO professional references. Please duplicate this form as necessary and provide it to your post-master's supervisor, as well as, your most recent supervisor (if this is also your post-master's supervisor, then provide it to your next most recent supervisor). *PLEASE PRINT CLEARLY OR TYPE AND SUBMIT ORIGINAL SIGNED DOCUMENT.*

I, _____, hereby authorize _____
(applicant's name) (reference's name)
(hereinafter "the reference") to provide the Board of Registration of Allied Mental Health and Human Service Professionals with all information of any kind that the reference may, in his or her absolute discretion, deem relevant to my qualifications as an applicant. I hereby release and discharge the professional reference from all claims arising out of the provision of such information.

Applicant's signature: _____Date: _____

Remainder of Form to be completed by Approved Supervisor

General information for references completing this form:

- The Board assumes that you, in recommending this applicant, will be willing to interpret or to substantiate to the Board your recommendation, should the Board desire to contact you. The Board will keep all information confidential to the maximum extent permitted by law.
- Complete this reference form only if the applicant has signed the above waiver of liability.

Reference's name: _____ Title: _____

Reference's license type: _____ License number/Jurisdiction: _____

Length of time the reference has known the applicant: from _____ to _____

1.) Extent of knowledge of applicant's professional and ethical behavior:
☐Thorough ☐Moderate ☐Limited

2.) Based on my experience, to the best of my knowledge, the applicant is an individual of good moral character:
☐Yes ☐No *(if no, please explain on a separate sheet)*

3.) Quality and extent of endorsement:
☐Without reservation ☐With reservation ☐No recommendation
(if "with reservation" or "no recommendation", please explain on a separate sheet)

_____
Signature of Reference **Date**

The Commonwealth of Massachusetts
Division of Professional Licensure
Board of Registration of Allied Mental Health and Human Services Professions
1000 Washington Street, Suite 710
Boston, MA 02118-6100

PROFESSIONAL REFERENCE FORM

INSTRUCTIONS: All applicants must submit a minimum of TWO professional references. Please duplicate this form as necessary and provide it to your post-master's supervisor, as well as, your most recent supervisor (if this is also your post-master's supervisor, then provide it to your next most recent supervisor). *PLEASE PRINT CLEARLY OR TYPE AND SUBMIT ORIGINAL SIGNED DOCUMENT.*

I, _____, hereby authorize _____
(applicant's name) (reference's name)
(hereinafter "the reference") to provide the Board of Registration of Allied Mental Health and Human Service Professionals with all information of any kind that the reference may, in his or her absolute discretion, deem relevant to my qualifications as an applicant. I hereby release and discharge the professional reference from all claims arising out of the provision of such information.

Applicant's signature: _____Date: _____

Remainder of Form to be completed by Approved Supervisor

General information for references completing this form:

- The Board assumes that you, in recommending this applicant, will be willing to interpret or to substantiate to the Board your recommendation, should the Board desire to contact you. The Board will keep all information confidential to the maximum extent permitted by law.
- Complete this reference form only if the applicant has signed the above waiver of liability.

Reference's name: _____ Title: _____

Reference's license type: _____ License number/Jurisdiction: _____

Length of time the reference has known the applicant: from _____ to _____

4.) Extent of knowledge of applicant's professional and ethical behavior:
☐Thorough ☐Moderate ☐Limited

5.) Based on my experience, to the best of my knowledge, the applicant is an individual of good moral character:
☐Yes ☐No *(if no, please explain on a separate sheet)*

6.) Quality and extent of endorsement:
☐Without reservation ☐With reservation ☐No recommendation
(if "with reservation" or "no recommendation", please explain on a separate sheet)

_____
Signature of Reference **Date**

CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT FORM

The Division of Professional Licensure by itself and on behalf of boards of registration pursuant to M.G.L. c. 13, §9 [hereinafter, "Division of Professional Licensure"] is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective license applicants and current licensees.

As a license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Services ("DCJIS"). I hereby acknowledge and provide permission to the Division of Professional Licensure to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing the Division of Professional Licensure written notice of my intent to withdraw consent to a CORI check.

FOR LICENSING PURPOSES ONLY:

The Division of Professional Licensure may conduct subsequent CORI checks within one year of the date this Form was signed by me provided, however, that the Division of Professional Licensure must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

_____ _____

Signature Date

NOTE: DPL CANNOT ACCEPT THIS TWO-PAGE CORI ACKNOWLEDGMENT FORM UNLESS IT IS EITHER (1) SIGNED IN PERSON AT THE BOARD'S OFFICES IN THE PRESENCE OF A DPL EMPLOYEE WHO HAS VERIFIED THE APPLICANT'S IDENTITY THROUGH ACCEPTABLE IDENTIFICATION, OR (2) SIGNED IN THE PRESENCE OF A NOTARY PUBLIC WHO HAS LIKEWISE VERIFIED IDENTITY AND THEN MAILED OR OTHERWISE DELIVERED TO THE BOARD'S OFFICES AT THE ADDRESS SET FORTH ABOVE.

SUBJECT INFORMATION: (A red asterisk (*) denotes a required field)

_____

*Last Name *First Name Middle Name Suffix

_____

*Maiden Name (or other name(s) by which you have been known)

_____ _____

*Date of Birth Place of Birth

*Last Six Digits of Your Social Security Number: _____ - _____

Sex: _____ Height: ____ ft. ____ in. Eye Color: _____

Driver's License or ID Number: _____ State of Issue: _____

Current and Former Addresses:

_____

Street Number & Name City/Town State Zip

_____

Street Number & Name City/Town State Zip

_____

IDENTITY VERIFICATION SECTION: If this form is submitted by hand at DPL Offices, Section A must be completed. Otherwise, Section B must be completed.

SECTION A: VERIFICATION BY DPL EMPLOYEE: I hereby certify that I verified the identity of the above-referenced subject by reviewing the following form(s) of government-issued identification:[1]

☐ Passport ☐ State Issued driver's license ☐ Military identification ☐ State-issued identification card

VERIFIED BY: _____

Name of Verifying DPL Employee (Please Print)

_____

Signature of Verifying DPL Employee Date

_____

SECTION B: VERIFICATION BY NOTARY:

On this _____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____ (name of document signer), and proved to me through satisfactory evidence of identification, which was the following:†

☐ Passport ☐ State-issued driver's license ☐ Military identification ☐ State-issued identification card

to be the person whose name is signed on the preceding or attached document, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose.

_____

Notary Public: Notary Commission Expires On

[1] If a subject does not have an acceptable government-issued identification, his or her identity shall be verified by other forms of documentation as determined by DCJIS. 803 CMR 2.09(2).

Licensed Mental Health Counselor Application Checklist: (Be sure to include this with your completed application)

Prior to submitting an application, please make sure the following information is included and / or documented:

__ Completed application w/ photo.

__ Check/Money Order for non-refundable application fee $117.00.
Additional licensure fee of $155.00 will be assessed when all requirements have been met.

__ Official, sealed Transcript(s) (Non-Baccalaureate degrees only).

__Completed Pre and Post Master's Experience forms (Originals only-- photocopies are not accepted).

__ Score report for the NCMHCE.

__ If currently or previously licensed in another State, official letter of verification from that State in sealed envelope.

__Two Professional Reference forms completed by two most recent supervisors (Originals only photocopies are not accepted).

__ Completed Criminal Offender Record Information Request Form, including notarization.

***Please be reminded: A required component of the application for licensure is that all applicants provide documentation of receiving 50 Supervisory Contact Hours of the 200 total Supervisory Contact Hours of supervision required (pre- or post-Master's degree) by a Licensed Mental Health Counselor or an equivalently Licensed Mental Health Counselor from another state or jurisdiction.**

MANDATORY

My social security number is:

☐☐☐-☐☐-☐☐☐☐ Pursuant to G.L. c. 62C, § 47A, the Division of Professional Licensure is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you comply with the tax laws of the Commonwealth.