

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.

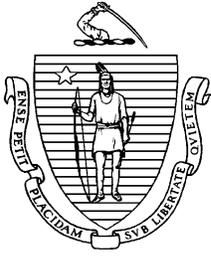
Please be aware that if you submit an application and it is determined by the Board that it is incomplete, or that you have failed to meet the regulatory requirements for licensure, the Board will provide you six months to complete your application or submit the information needed to demonstrate that 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.



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

**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. 62, 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

COURSEWORK REQUIREMENTS FORM

REQUIRED COURSES

A minimum of three semester credits, or four quarter credits, 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.

Course Content Area	Course Number on Transcript
Counseling Theory	
Human Growth and Development	
Psychopathology	
Social and Cultural Foundations	
Clinical Skills	
Group Work	
Special Treatment Issues	
Appraisal	
Research and Evaluation	
Professional Orientation	

ELECTIVE COURSES

Graduate level courses other than required graduate level courses must be elective courses which include knowledge and skills in the practice of Mental Health Counseling. These courses may be one or more semester/quarter credits. Appropriate courses may include but are not limited to any of the courses listed in the above Required Courses section as well as those listed below. Please review your transcript and specify the course number which corresponds to the course content area listed below. If you are not sure which course content area your elective course fulfills, please include the course number as it appears on your transcript in the blank spaces below.

Course Content Area	Course Number on Transcript
Best Practices for Maintaining and Terminating Counseling and Psychotherapy	
Consultation Skills	
Outreach and Prevention Strategies	
Diagnosis and Treatment Issues	
Working with Special Populations	
Professional Identity and Practice Issues, including Historical Perspectives	
Mental Health Regulations and Policy	
Management of Community Mental Health Programs	

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 Approved Supervisor

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:

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).

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

<i>LICENSE/CERTIFICATE #</i>

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 Approved Supervisor

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:

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).

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 Approved Supervisor

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):

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

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).

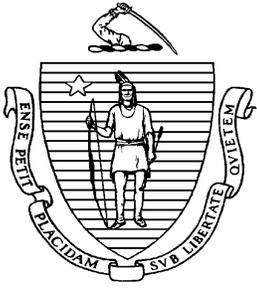
MASSACHUSETTS SUPERVISOR: Please list which of the above describes your license:

_____ <i>LICENSE/CERTIFICATE #</i> _____
--

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: _____



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.

Waiver of Liability: (Must be completed by licensure applicant)

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)

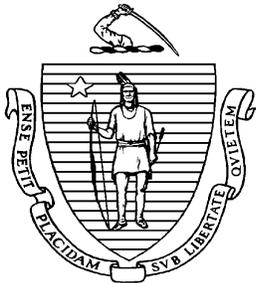
3.) Quality and extent of endorsement:

Without reservation With reservation No recommendation

(if “with reservation” or “no recommendation”, please explain on a separate sheet)

Signature of Reference

Date



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.

Waiver of Liability: (Must be completed by licensure applicant)

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.