

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

## **APPLICATION INFORMATION FOR LICENSURE AS A REHABILITATION COUNSELOR**

Please Read the Following Information Prior to Completing the Application.

Prior to completing the application, obtain a copy of 262 CMR from the State Bookstore, Room 116, State House, Boston, MA 02133, (617) 727-2834, or online at <http://www.mass.gov/dpl/boards/mh>

### **EXAMINATION INFORMATION**

All applicants must pass the Certified Rehabilitation Counselor Examination in order to be approved for licensure. You may take the examination without applying for CRC designation. If you have not yet taken the examination, please see #8 of the application for registration deadlines. If you have already passed the examination, please submit an official score report with your application.

### **IMPORTANT POINTS:**

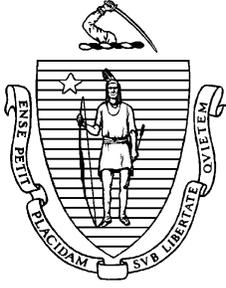
- All applicants must include two professional reference forms (provided in this application) completed by the two most recent supervisors.
- Carefully review both the regulations and the application before filling out the application to ensure that all requirements have been met.
- Post-Master Experience and Supervision Requirements: A minimum of two years full-time, post-master's degree supervised clinical experience or equivalent part-time, work experience in rehabilitation counseling in a clinic or hospital licensed by the Department of Mental Health or accredited by the Joint Commission on Accreditation of Hospitals or in an equivalent center or institute, or under the direction of an approved supervisor. Applicants who have completed a qualifying master's degree consisting of a 48 semester hour program of study which included an internship may be credited a maximum of ½ of the total number of hours of the internship experience toward the clinical experience requirement.
- Applicants are urged to make a copy of their application for their personal records.

Submit the completed application, supporting documentation, and **NON-REFUNDABLE** application fee of **\$117.00** to the Board at the address listed above. The Board will not advise individuals as to their eligibility for licensure until a complete application with supporting documentation has been reviewed. Licensure eligibility can only be determined through the application process.

Once your application is approved, an initial license fee will be assessed.

*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.*

**Be sure to complete and include the application checklist provided at the end of this packet.**



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Please attach recent passport type

**REHABILITATION COUNSELOR  
LICENSURE APPLICATION**

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.  
\_\_\_\_\_  
Town State Zip Code

3. Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

4. Tel. No. Day: \_\_\_\_\_ Evening: \_\_\_\_\_

5. Email address: \_\_\_\_\_  
Do you consent to receiving information about your application from the Board via email (e.g., incomplete notifications): Yes \_\_\_\_\_ No \_\_\_\_\_

6. Graduate School Attended: \_\_\_\_\_ Degree: \_\_\_\_\_

Total Credits: \_\_\_\_\_ Major: \_\_\_\_\_ Date Conferred: \_\_\_\_\_

***NOTE: Official sealed graduate level transcript(s) must be included with application, demonstrating completion of a minimum of 48 semester credits in rehabilitation counseling.***

**7. DISCIPLINARY HISTORY**

**Revised 3/2015**

If you answer "YES" to any of the following questions (A - F), please attach a complete 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 ever voluntarily surrendered or resigned a professional license to a licensing /certification board 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 foreign jurisdiction, other than a traffic violation for which a fine of less than \$100.00 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 Page 12 & 13.

## 8. PROFESSIONAL LICENSES/REGISTRATIONS

List any professional licenses/registration you hold or held in the United States or any country or foreign jurisdiction and the state/jurisdiction from which the license/registration was issued along with the license number: **Official letter of standing from each state listed must accompany this application.**

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## 9. CERTIFICATION STATUS:

A. Do you have a current certification/membership as a Certified Rehabilitation Counselor by the Commission on Rehabilitation Counselor Certification? \_\_\_\_Yes \_\_\_\_No If yes, please attach a copy of your certification.

B. Have you already taken the Certified Rehabilitation Counselor Examination (CRC) \_\_\_\_Yes \_\_\_\_No  
If yes, be sure to submit an official score report with your application and include the exam date.

Please list the date you passed the exam \_\_\_\_/\_\_\_\_/\_\_\_\_

C. If "No" to above, please indicate the date on which you will be taking the examination:

\_\_\_\_\_  
(Official score report must be received)

## 10. PRE-MASTER'S DEGREE SUPERVISED CLINICAL EXPERIENCE (Internship)

A distinctly defined, post-practicum, supervised curricular experience intended to enable the rehabilitation counselor to refine and enhance basic rehabilitation counseling skills, develop more advanced rehabilitation counseling skills, and integrate professional knowledge and skills pertinent to the initial post-graduate professional experience must be documented. Provide copies of the "Statement of Supervised Clinical Experience" to your approved supervisor(s) to document hours of experience and supervision. Attach additional information as necessary.

Name of Facility: \_\_\_\_\_  
Address of Facility: \_\_\_\_\_

Your Title: \_\_\_\_\_ Dates of Supervision \_\_\_\_\_

Name and Title of Supervisor: \_\_\_\_\_

Nature of Clinical Experience:

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### **11. POST-MASTER'S WORK EXPERIENCE**

Provide the "Statement of Supervised Clinical Experience" to your approved supervisor(s) to document required hours of supervised clinical experience. Return completed form(s) with this application. Attach additional information in this format as necessary to document required hours.

Name of Facility: \_\_\_\_\_  
Address of Facility: \_\_\_\_\_

Your Title: \_\_\_\_\_ Dates of Supervision \_\_\_\_\_

Name and Title of Supervisor: \_\_\_\_\_

Nature of Clinical Experience:

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**12.** Pursuant to M.G.L., Chapter 62C, S. 49A, I have filed all state tax returns and paid all state taxes required under law. \_\_\_ Yes \_\_\_ No.

If no, please explain (documentation of compliance with DOR requirements is required): \_\_\_\_\_  
\_\_\_\_\_

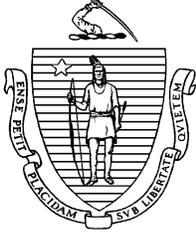
### **AFFIDAVIT**

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 Rehabilitation Counselors and attests that all statements are truthful and are made under the pains and penalties of perjury.

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

\_\_\_\_\_  
Date



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**STATEMENT OF SUPERVISED CLINICAL EXPERIENCE**  
**INTERNSHIP**

Please duplicate this form (**two pages**) as necessary to document the required internship (distinctly defined, post-practicum, supervised curricular experience intended to enable the rehabilitation counselor to refine and enhance basic rehabilitation counseling skills, develop more advanced rehabilitation counseling skills, and integrate professional knowledge and skills pertinent to the initial post-graduate professional experience). See following page for definition of Approved Supervisor.

Name of Applicant: \_\_\_\_\_

**Remainder of Form to be completed by Approved Supervisor**  
**(be sure to sign on the following page)**

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

Description of Applicant's Duties: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dates of Supervision provided to the Applicant: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_ (month/date/year)

The applicant worked \_\_\_ hours per week for \_\_\_ weeks for a total of \_\_\_\_\_ rehab experience hours

Number of Supervision 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: \_\_\_

**Supervisor Attestation:**

I have read the definitions of Approved Supervisor provided 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.**

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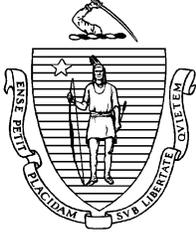
Signature of Approved Supervisor

Date

**DEFINITION OF APPROVED SUPERVISOR (262 CMR)**

A supervisor must possess the qualifications of one of the categories below in order to be acceptable as an Approved Supervisor by the Board. See 262 CMR.

- a) A rehabilitation counselor currently certified as a CRC by the CRCC;
- b) A currently licensed rehabilitation counselor, or an individual who meets the qualifications for licensure as a rehabilitation counselor by the Board; or
- c) A person who has a minimum of five years of clinical experience in rehabilitation counseling and either:
  - 1. A master's degree in rehabilitation counseling or related field;
  - 2. A doctorate in psychology; or
  - 3. A medical degree with a subspecialization in psychiatry.



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**STATEMENT OF SUPERVISED CLINICAL EXPERIENCE**  
**POST-MASTERS**

Please duplicate this form (two pages) as necessary to document the required Post-Master’s supervised clinical experience (A minimum of two years full-time, post-master’s degree supervised clinical experience or equivalent part-time, work experience in rehabilitation counseling in a clinic or hospital licensed by the Department of Mental Health or accredited by the Joint Commission on Accreditation of Hospitals or in an equivalent center or institute, or under the direction of an approved supervisor. See following page for definition of Approved Supervisor.

Name of Applicant: \_\_\_\_\_

**Remainder of Form to be completed by Approved Supervisor  
 (be sure to sign on the following page)**

Name of Supervisor: \_\_\_\_\_  
 Supervisor’s Title: \_\_\_\_\_  
 Supervisor’s License Type and Number: \_\_\_\_\_  
 Supervisor’s phone number: \_\_\_\_\_  
 Name/Address of Clinical Facility: \_\_\_\_\_

Description of Applicant’s Duties: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Dates of Supervision provided to the Applicant: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_ (month/date/year)

The applicant worked \_\_\_ hours per week for \_\_\_ weeks for a total of \_\_\_\_\_ rehab experience hours

Number of Supervision 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: \_\_\_

**Supervisor Attestation:**

I have read the definitions of Approved Supervisor provided 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.**

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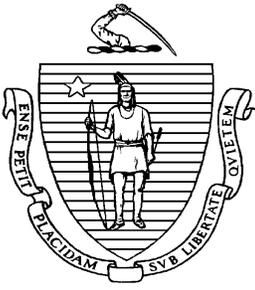
Signature of Approved Supervisor

Date

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A supervisor must possess the qualifications of one of the categories below in order to be acceptable as an Approved Supervisor by the Board. See 262 CMR.

- d) A rehabilitation counselor currently certified as a CRC by the CRCC;
- e) A currently licensed rehabilitation counselor, or an individual who meets the qualifications for licensure as a rehabilitation counselor by the Board; or
- f) A person who has a minimum of five years of clinical experience in rehabilitation counseling and either:
  - 4. A master's degree in rehabilitation counseling or related field;
  - 5. A doctorate in psychology; or
  - 6. A medical degree with a subspecialization in psychiatry.



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**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 \_\_\_\_\_

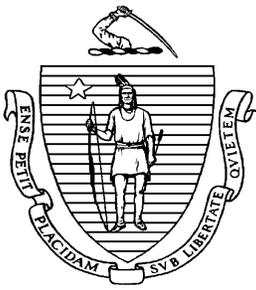
Extent of knowledge of applicant’s professional and ethical behavior: Thorough Moderate Limited

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)

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



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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 \_\_\_\_\_

Extent of knowledge of applicant's professional and ethical behavior: Thorough Moderate Limited

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)

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.**



# Licensed Rehabilitation Counselor Application Checklist:

(Please include this form with your completed application)

## 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 are in compliance with the tax laws of the Commonwealth.

Be sure you have included:

Completed application w/ photo.

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

Check/Money Order for \$117.00 non-refundable application fee payable to Comm. of Massachusetts. *Please note that an initial licensure fee of \$155.00 will be due when all requirements have been met and is separate from the application fee.*

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

If currently certified as a Certified Rehabilitation Counselor by the Commission on Rehabilitation Counselor Certification, copy of current certificate.

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

If previously passed the CRC examination, verification of examination results and date taken.

Completed Criminal Offender Record Information Request Form, including notarization.