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) 701-8683, 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.

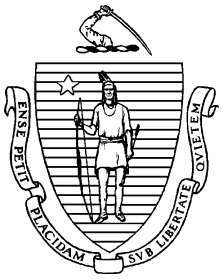
Submit the completed application, supporting documentation, and NON-REFUNDABLE application fee of **$117.00** to the Board at the address listed above. The Board will not advise individuals as to their eligibility for licensure until a complete application with supporting documentation has been reviewed.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

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

Important Message Regarding Application Reviews by Staff

Board staff will review your application, and if your application is complete and you are eligible for licensure, staff will email you with instructions to pay the $155 license fee to get your license. If your application is missing information, staff will email you to provide detailed descriptions of what is missing and will review your application again 30 days after notifying you. If any information is still missing after 30 days, your application will be closed as incomplete. You will have to pay another application fee if you wish to reapply. All verifications and transcripts should be delivered close to when you apply. Staff will review an application no more than two times and, outside of those reviews, cannot answer questions about specific applications, including whether forms have been completed correctly or if the Board has received certain documents.

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.

DISCIPINARY HISTORY

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 anyforeign jurisdiction, other than a traffic violation for which a fine of less than $100.00 was assessed?
YES_____NO____

F. Have you taken a Board-approved training in Domestic and Sexual Violence?
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.

7. 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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8. 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_____/___/_____

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

_____

(Official score report must be received)

9. 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:

_____

_____

_____

_____

9. 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:

_____

_____

_____

_____

10. 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

The Commonwealth of Massachusetts
Division of Professional Licensure
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1000 Washington Street, Suite 710
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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.**

_____

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 licensureas 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.**

_____

Signature of Approved Supervisor Date

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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 licensureas 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;
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   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: _____

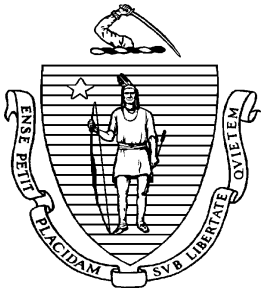
Length of time the reference has known the applicant: from_____to _____

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.**
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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

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 <u>not</u> 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 From, includingnotarization.

COMMONWEALTH OF MASSACHUSETTS
1000 Washington Street, Suite 710
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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:

I understand that the Division of Professional Licensure may conduct a subsequent CORI check within one year of the date this Form was signed by me.

By signing below, I provide my consent to an initial CORI check and a subsequent CORI check, both within one year of the date of this Form, and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

_____ _____
Signature Date

Please provide the name of the board of registration and license type for which you are applying or currently hold:

_____ _____
Board of Registration License Type

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 FORTHABOVE.

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

* 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:[1]

☐ 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).