

The Commonwealth of Massachusetts
Department of Public Health
Board of Allied Mental Health and Human Services Professions
250 Washington Street
Boston, MA 02108
(617) 624-6199
amh.board@mass.gov

Licensed Rehabilitation Counselor Application Checklist

I. How to Apply: You Must Apply Online

Applications are only accepted through the [Massachusetts Department of Public Health Health Professions Licensing System](#). Information on how to apply is available [here](#).

After your application is reviewed, you will be notified by email of any deficiencies in your application, with instructions to pay the \$155 license fee to get your license.

II. Application Documents

Before applying online, all applicants must have the following to upload:

- A head and shoulders photograph of yourself
- A notarized [Criminal Offender Record Information Form](#)
- You must use a credit card or checking account to pay the non-refundable application fee of \$117.
- A Statement of Supervised Clinical Experience: Internship and a Statement of Supervised Clinical Experience: Post-Master's (forms appended to this checklist)
- Two professional references (form appended to this checklist)

You also must arrange for the following to be emailed (to amh.board@mass.gov) or mailed (at the address above) to the Board:

- If you currently hold or have previously held a professional license in another jurisdiction, regardless of its status, please arrange for an official license verification to be sent to the Board by the issuing entity. Please contact the Board for further directions in the event the entity that licensed you does not issue verifications and only offers an online license lookup. A copy of your license is not an acceptable alternative.
- Arrange for your graduate school(s) to send an official transcript of the graduate education you are submitting to meet the licensing requirements to amh.board@mass.gov or to the mailing address above.
- Arrange for the [Commission on Rehabilitation Counselor Certification](#) to send your official Certified Rehabilitation Counselor Examination score report to the Board.
- You must complete a board-approved training in domestic and sexual violence before you apply. Please see [chapter260training.org](#) to take the free online training.



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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)

<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: _____

Supervisor Attestation:

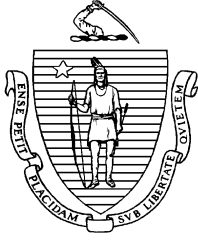
I have read the definitions of Approved Supervisor provided below and believe that I qualify as an Approved Supervisor. **The undersigned states that under the pains and penalties of perjury, the above statements are true and correct.**

 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 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)

<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: ____

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.**

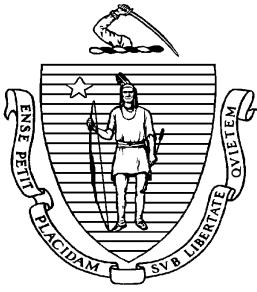
 Signature of Approved Supervisor

 Date

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- 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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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).

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