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.

Documentation completed in pencil or which includes strike-outs or white-out will not be accepted.

All applicants must pass the National Clinical Mental Health Examination (NCMHCE) in order to become licensed. You may obtain exam registration materials from the National Board for Certified Counselors (NBCC) at www.nbcc.org. If you have already passed the exam in MA, submit a copy of your report with your application. If you took the exam out of state, please submit an official sealed score report from the NBCC 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. To ensure an efficient application review please submit all application materials in one complete packet to the board.

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.
**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 (i.e. a current resume).
MENTAL HEALTH COUNSELOR
Licensure Application

Please attach recent here:

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 professional license in another state, please complete the information below.

<table>
<thead>
<tr>
<th>State</th>
<th>License Number</th>
<th>Issue Date</th>
<th>Current</th>
<th>Lapsed</th>
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</table>

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**

<table>
<thead>
<tr>
<th>College or University</th>
<th>Degree</th>
<th>Year</th>
<th>Major</th>
<th>Credits</th>
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<tbody>
<tr>
<td>A. Masters</td>
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<tr>
<td>B. Post-Master’s Credits (non-CAGS)</td>
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<tr>
<td>C. Second Master’s Degree</td>
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<tr>
<td>D. CAGS or other post-master’s certificate</td>
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<tr>
<td>E. Doctoral Degree</td>
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</tbody>
</table>

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.**

<table>
<thead>
<tr>
<th>Course Content Area Description</th>
<th>Course Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Counseling Theory.</strong> Examination of the major theories, principles &amp; techniques of Mental Health Counseling &amp; their application to professional counseling settings. Understanding &amp; applying theoretical perspectives with clients.</td>
<td></td>
</tr>
<tr>
<td><strong>Human Growth and Development.</strong> Understanding the nature &amp; needs of individuals at all developmental stages of life. Understanding major theories of physical, cognitive, affective and social development &amp; their application to Mental Health Counseling practice.</td>
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</tr>
<tr>
<td><strong>Psychopathology.</strong> Identification &amp; diagnosis and mental health treatment planning for abnormal, deviant, or psychopathological behavior, includes assessments and treatment procedures.</td>
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<tr>
<td><strong>Social and Cultural Foundations.</strong> Theories of multicultural counseling, issues and trends of a multicultural and diverse society. Foundational knowledge &amp; skills needed to provide Mental Health Counseling services to diverse populations in a culturally competent manner.</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Skills.</strong> Understanding of the theoretical bases of the counseling processes, Mental Health Counseling techniques, and their therapeutic applications. Understanding &amp; practice of counseling skills necessary for the mental health counselor.</td>
<td></td>
</tr>
<tr>
<td><strong>Group Work.</strong> Theoretical &amp; 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.</td>
<td></td>
</tr>
</tbody>
</table>
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.

_______________________________________________     ____________________
Print name                                      Signature                        Date

Please check one:
○ I am a Department Chair
○ I am a Faculty Advisor for this student
○ 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. DO NOT ALTER THE FORM IN ANY MANNER. Forms with white-out, cross-out or copies will not be accepted.

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 75 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 Graduation year: ______________________

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______________________________
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, DO NOT ALTER THE FORM IN ANY
MANNER. Forms with white-out, cross-out or copies will not be accepted.

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 75 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 Graduation year: _________________________________
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: _______

Revised 08/30/2017
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: ____________________________________________________________

Revised 08/30/2017
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. DO NOT ALTER THE FORM IN ANY MANNER. Forms with white-out, cross-out or copies will not be accepted.

MINIMUM REQUIREMENTS: A minimum of 2 years and maximum of 8 years of full-time, or equivalent part-time experience.

Full Time experience is defined as 35 hours per week, 48 weeks per year. The full time practice of clinical Mental Health Counseling must include at least ten Contact Hours per week of Direct Client Contact Experience.

Your experience must include:

(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 supervisor 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 75 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 Graduation year: ________________________

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 one 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:** ______________________________
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
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☐ 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)

__________________________________________ Date

Signature of Reference
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:

<table>
<thead>
<tr>
<th>Street Number &amp; Name</th>
<th>City/Town</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

☐ 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 75 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.