

STATE OF UTAH
DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING
APPLICATION FOR LICENSURE

**ASSOCIATE CLINICAL MENTAL HEALTH COUNSELOR,
ASSOCIATE CLINICAL MENTAL HEALTH COUNSELOR EXTERN,
OR CLINICAL MENTAL HEALTH COUNSELOR**

APPLICATION INSTRUCTIONS AND INFORMATION

General Statement: The Utah Division of Occupational and Professional Licensing (DOPL) desires to provide courteous and timely service to all applicants for licensure. To facilitate the application process, **submit a complete application form including all applicable supporting documents and fees.** Failure to submit a complete application and supply all necessary information will delay processing and may result in denial of licensure. The fees are for processing your application and will not be refunded. **Please read all instructions carefully.**

Address of Record: The address you provide on this application will be your address of record. All correspondence from DOPL will be sent to that address. You are responsible to directly notify DOPL of any change to your address of record. Do not rely on a forwarding order.

Social Security Number: Your social security number is classified as a private record under the Utah Government Records Access and Management Act. It is used by DOPL as an individual identifier. It is also used for child support enforcement pursuant to Subsection 78-32-17(3) and is mandatory pursuant to Subsection 58-1-301(1), Utah Code Ann., which implements 42 U.S.C. 666(a)(13). If an SSN is not provided, the application is incomplete and may be denied.

SUPPORTING DOCUMENTS AND FEES:

If you are applying for licensure as an associate clinical mental health counselor (ACMHC), complete the following in addition to submitting a completed application:

1. Submit official transcript(s) documenting receiving a master's or doctoral degree in mental health counseling. If you received a degree in clinical mental health counseling from a program accredited by the Council for Accreditation of Counseling and Related Education Programs (CACREP), you do not need to complete the education course section of this application.

If your degree is not in clinical mental health counseling or is not CACREP-accredited, you must complete the education section of this application to verify that you fulfill the specific course requirements, and attach information about each course (such as a course description or syllabus).

NOTE: If submitting college transcripts, have the school send them directly to DOPL. You may also have the school send them to you for inclusion with your application so long as it is in a sealed envelope, bearing the school's stamp or seal on the envelope flap.

NOTE: If you do not meet the educational requirements listed above, you may be eligible for an externship license. See "Additional Important Information" below for details.

2. Submit Qualifying Questionnaire (included with application).
3. Submit an **\$85.00** non-refundable application-processing fee, made payable to "DOPL.

If you are applying for licensure as a clinical mental health counselor (CMHC), complete the following in addition to submitting a completed application:

1. Submit official transcript(s) documenting awarding of a master's or doctorate degree in mental health counseling. If you completed a degree in clinical mental health counseling from a program accredited by the Council for Accreditation of Counseling and Related Education Programs (CACREP), you do not need to complete the education course section of this application.

If your degree is not in clinical mental health counseling or is not accredited by CACREP, you must complete the education section of this application to verify that you fulfill the specific course requirements, and attach information about each course, such as a course description or syllabus.

NOTE: If submitting college transcripts, have the school send them directly to DOPL. You may also have the school send them to you for inclusion with your application so long as it is in a sealed envelope, bearing the school's stamp or seal on the envelope flap.

NOTE: If you submitted your transcripts as part of your application for licensure as an associate clinical mental health counselor in Utah, you do not need to resubmit them with your application for licensure as a clinical mental health counselor.

2. Submit Qualifying Questionnaire (included with application).
3. Submit a completed "Verification of Supervised Experience" form (*attached to this application*) from each of your supervisors to document a total of 4,000 hours of supervised experience — 1,000 hours of which are in mental health therapy. Request that each supervisor submit a form to you to be included with your application.
4. Submit documentation of your passing score on the National Counseling Examination (NCE).
5. Submit documentation of your passing score on the National Clinical Mental Health Counseling Examination (NCMHCE).
6. Submit a **\$120.00** non-refundable application-processing fee, made payable to "DOPL."

If you are applying for licensure as a clinical mental health counselor (CMHC) by endorsement, complete the following in addition to submitting a completed application:

1. Using the "Request for Verification of License" form (*attached to this application*), submit verification of licensure from a jurisdiction in which you are currently licensed as a clinical mental health counselor. Request that the verifying jurisdiction complete the form and mail or fax it directly to DOPL, or return it to you for submission with your application. The jurisdiction may also submit their own verification form as long as it provides the same information requested in the form included in this application.
2. Using the "Verification of Active Practice as a Clinical Mental Health Counselor" form (*attached to this application*), submit documentation showing that you have been actively engaged in the lawful practice of clinical mental health counseling including mental health therapy for not less than 4,000 hours, of which not less than 1,000 hours are in the practice of mental health therapy.
3. Submit Qualifying Questionnaire (included with application).
4. Submit a **\$120.00** non-refundable application-processing fee, made payable to "DOPL."

ADDITIONAL IMPORTANT INFORMATION:

1. **Examinations:** To obtain information regarding the National Counseling Examination (NCE) or the National Clinical Mental Health Counseling Examination (NCMHCE), the Candidate Handbook for State Credentialing is available at www.nbcc.org. You may also contact them at (336) 547-0607.
2. **Examination Fees:** There are separate fees for all exams. It is the responsibility of the applicant to submit the fees directly to the testing agency.
3. **Code of Ethics:** All clinical mental health counselors are required to abide by the American Mental Health Counselor Code of Ethics. This document is available at www.amhca.org.
4. **Current Documents:** Applications, statutes, rules, and forms are occasionally changed. Go to www.dopl.utah.gov to ensure you have the most recent version of these documents.
5. **Degree Requirements:** In order to meet the education requirements, you must have a master's or doctoral degree in mental health counseling, or an equivalent degree from an institution of higher education accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), or that had accreditation recognized by the Council for Higher Education Accreditation (CHEA) of the American Council on Education at the time the degree was conferred. The degree must include at least 60 semester (90 quarter) hours of graduate studies and include the core course work specified in rule. Transcripts must verify the date your degree was awarded.
6. **Externship:** A person who applies for licensure who has a degree in mental health counseling or a related field but who is found to be deficient in course work may be issued an externship license. An extern license expires upon issuance of the associate license or 3 years from the date of issuance, whichever comes first. The extern license requires a payment of an \$85 application fee, and is not renewable. If an extern does not complete the education requirement and obtain associate licensure within the 3-year time period, they will be required to discontinue practice until they have completed the education and have been granted an associate license.
7. **“Practice of mental health therapy”** means treatment or prevention of mental illness, including:
 - ❑ Conducting a professional evaluation of an individual's condition of mental health, mental illness, or emotional disorder;
 - ❑ Establishing a diagnosis in accordance with established written standards generally recognized in the professions of mental health therapy;
 - ❑ Prescribing a plan for the prevention or treatment of a condition of mental illness or emotional disorder; and
 - ❑ Engaging in the conduct of professional intervention, including psychotherapy by the application of established methods and procedures generally recognized in the professions of mental health therapy.
8. **Requirements to be a Mental Health Therapy Supervisor:** In order for an individual to be qualified as an associate clinical mental health counselor supervisor, he/she must be currently licensed and in good standing as a licensed clinical mental health counselor, psychiatrist, psychologist, licensed clinical social worker, registered psychiatric mental health nurse specialist, or marriage and family therapist. He/she shall have engaged in the lawful practice as a licensee engaged in the practice of mental health therapy for 2 years prior to beginning supervision activities. A mental health therapy supervisor can supervise no more than 3 supervisees at any given time unless approved by the Board and DOPL.

9. **Supervised Clinical Mental Health Counseling and Mental Health Therapy Experience:** Upon completion of the required education, 4,000 hours of supervised clinical mental health counseling and mental health therapy experience is required for licensure. This experience includes at least 1,000 hours of supervised experience in mental health therapy and 100 hours of face-to-face supervision. Additionally, this experience must be obtained while holding the associate clinical mental health counselor license. The “Verification of Supervised Experience” form must be completed by your supervisor upon completion of the required experience.
10. **Endorsement:** To qualify for licensure by endorsement, an applicant must document that he/she is currently licensed in good standing in another state, and has been actively engaged in the lawful practice of clinical mental health counseling for not less than 4,000 hours.
11. **Continuing Education:** Clinical mental health counselors and associate CMHCs must complete at least 40 hours of continuing education (CE) during each 2-year period. At least 6 of the 40 hours must be in ethics or law. This requirement is pro-rated for new licensees.
12. **License Extension – Associate Clinical Mental Health Counselor:** An associate CMHC license is issued for a period of 3 years. It is generally expected that associates will complete the 4,000 hours of experience during that time period and become licensed as a clinical mental health counselor within 3 years. This license cannot be extended unless the individual presents satisfactory evidence that reasonable progress is being made toward passing the exams, or is otherwise on a course reasonably expected to lead to licensure; however the extension may not exceed 2 years past the date the minimum supervised experience requirement has been completed.
13. **License Renewal – Licensed Clinical Mental Health Counselor:** All clinical mental health counselor licenses expire on September 30th of every even-numbered year.
 Unlike many other states, Utah’s renewal schedule is not based on the licensee’s date of initial licensure. In Utah, all licenses in each profession expire on the same day every 2 years. Therefore, the length of a licensee’s first renewal cycle depends on how far into the current renewal cycle initial licensure was obtained. Each renewal cycle thereafter is for a full 2 years. Additionally, the fee paid with this application is an application processing fee only. It does not include a renewal fee. Each licensee is responsible to renew **PRIOR** to the expiration date shown on the current license. Approximately 2 months prior to the expiration date shown on the license, renewal information is sent to each licensee’s last address of record, as provided to DOPL.
14. **Updating Address Information:** It is your responsibility to maintain a current address with DOPL. If your address is incorrect, you will not receive renewal notices or other correspondence. Address changes can be made online at www.dopl.utah.gov.
15. **Name Change:** If you have been licensed by DOPL under any other name, please submit official documentation of your name change (*i.e. a copy of a marriage license or divorce decree*).
16. **Submit Completed Application to:**

| | |
|---|--|
| By U.S. Mail | Division of Occupational & Professional Licensing P.O. Box 146741 Salt Lake City UT 84114-6741 |
| By Express Mail or In Person | Division of Occupational & Professional Licensing, 1 st Floor Lobby 160 E 300 S Salt Lake City UT 84111-2305 |

18. **Telephone Numbers:** (801) 530-6628
(866) 275-3675 – Toll-free in Utah
19. **E-mail:** doplureau3@utah.gov

APPLICATION FOR LICENSURE

- License Applying For: ASSOCIATE CLINICAL MENTAL HEALTH COUNSELOR
 ASSOCIATE CLINICAL MENTAL HEALTH COUNSELOR EXTERN
 LICENSED CLINICAL MENTAL HEALTH COUNSELOR
 LICENSED CLINICAL MENTAL HEALTH COUNSELOR,
 BY ENDORSEMENT FROM ANOTHER STATE

| | | | | |
|--|----------------|-----------------|-------------|--------------|
| ***Please list your <u>full legal name</u> as it appears on your driver's license, Social Security Card, etc.*** | | | | |
| Last Name: | | First Name: | | Middle Name: |
| Social Security Number: - - | | Maiden Name: | | |
| I certify under penalty of perjury that: | | | | |
| <input type="checkbox"/> I am a citizen of the United States, and I have a valid U.S. Driver's License or U.S. State ID. Driver's License/State ID Number: _____ State: _____ | | | | |
| <input type="checkbox"/> I am a citizen of the United States currently living outside the United States, and do not have a valid U.S. Driver's License or U.S. State ID. Please attach a legible copy of your valid passport or other documentation to verify you are a legal citizen of the United States. | | | | |
| <input type="checkbox"/> I am a non-citizen of the United States who is lawfully present in the United States, and I have a valid U.S. Driver's License or U.S. State ID. Driver's License/State ID Number: _____ State: _____ | | | | |
| <input type="checkbox"/> I am a non-citizen of the United States, who is lawfully present in the United States and I do not have a valid U.S. Driver's License or U.S. State ID. Please attach a legible copy of your current and valid government-issued document showing evidence of authorization to work in the United States. | | | | |
| <input type="checkbox"/> I am a foreign national not physically present in the United States. | | | | |
| Mailing Address: | | | | |
| City: | | | State: | ZIP: |
| <input type="checkbox"/> Male | Date of Birth: | Phone #: | E-Mail: | |
| <input type="checkbox"/> Female | | | | |
| List all other licenses, registrations, or certifications issued by any state which you now hold or have ever held in any profession. <i>(Use additional sheets if necessary)</i> | | | | |
| Profession: | | Issuing State: | | |
| License Number: | | License Status: | Issue Date: | |
| Profession: | | Issuing State: | | |
| License Number: | | License Status: | Issue Date: | |
| Profession: | | Issuing State: | | |
| License Number: | | License Status: | Issue Date: | |
| Profession: | | Issuing State: | | |
| License Number: | | License Status: | Issue Date: | |

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: _____
 Date License/Certificate Approved: ___/___/___
 Approved By: _____
 Date License/Certificate Denied: ___/___/___
 Denied By: _____
 Reason for Denial/Other Comments: _____

AFFIDAVIT and RELEASE AUTHORIZATION

1. I certify that am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, forgery, misrepresentation, omission of material fact; is truthful, correct, and complete; discloses all material facts regarding the applicant; and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, institutions, organization, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division of Occupational and Professional Licensing to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which you are applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

Signature of Applicant: _____ Date of Signature: ___/___/_____

EDUCATION REQUIREMENT (*Attach additional sheets if necessary*):

School Name: _____ Degree Received: _____

Location: _____

Dates Attended: _____ To: _____ Date of Graduation: ___/___/___

School Name: _____ Degree Received: _____

Location: _____

Dates Attended: _____ To: _____ Date of Graduation: ___/___/___

EXAMINATION REQUIREMENT:

Answer “Yes” or “No”.

_____ National Counseling Exam – Date(s) Taken: ___/___/___

_____ National Mental Health Counseling Exam – Date(s) Taken: ___/___/___

QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer the questions. Do not leave any question blank.

(Note: If you have formally expunged a criminal record you do not need to disclose that criminal history.)

| | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Have you ever been denied the right to sit for a licensure examination? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Are you currently under investigation or is any disciplinary action pending against you now by any licensing agency? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Have you ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending against you by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. Is any action related to your conduct or patient care pending against you now at any hospital or health care facility? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Have you been named as a defendant in a malpractice suit? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions or conditions imposed by any malpractice carrier? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. If you become licensed in the occupation/profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Have you ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug use or abuse within the past five (5) years? |

| | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Are you currently using or have you recently (<i>within the last 90 days</i>) used any drugs (<i>including recreational drugs</i>) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Do you currently have any criminal action pending? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 22. Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 23. Have you, in the past ten (10) years, been allowed to plea guilty or no contest to any criminal charge that was later dismissed (<i>i.e. plea-in-abeyance or deferred sentence</i>)? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 24. Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction or on probation/parole in any jurisdiction? |
| <div data-bbox="207 1073 305 1167" data-label="Image"> </div> | <p>If you answered “yes” to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered “yes” to Questions 20, 21, 22, 23, or 24 you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).</p> <p>If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.</p> <p>If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.</p> <p>A “Yes” answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.</p> |

EDUCATIONAL COURSE REQUIREMENTS:

Do not complete this section if you graduated from a CACREP-accredited mental health counseling program, or if you are currently licensed as an associate clinical mental health counselor (ACMHC) in Utah.

List **ALL** of your graduate course work in each of the areas. List each course title **as it appears on your transcript**. Use each course only once. A complete description of the educational course requirements can be found in the Clinical Mental Health Counselor Licensing Act Rule, R156-60c, available at www.dopl.utah.gov.

Professional Orientation and Ethical Practice (*minimum 2 semester or 3 quarter hours*)

Total Hours: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

NOTE: Courses meeting this requirement must be based on standards of the American Counseling Association (ACA), the American Mental Health Counselors Association (AMHCA), or the National Board of Certified Counselors (NBCC).

Social and Cultural Diversity (*minimum 2 semester or 3 quarter hours*)

Total Hours: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Group Work (*minimum 2 semester or 3 quarter hours*)

Total Hours: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Human Growth and Development Across the Life Span (*minimum 2 semester or 3 quarter hours*)

Total Hours: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Career Development (*minimum 2 semester or 3 quarter hours*)

Total Hours: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Helping Relationships, Including Theory and Skills in Counseling and Psychotherapy with Individuals, Couples, or Families *(minimum 6 semester or 8 quarter hours)*

Total Hours: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Substance Use Disorders or Addictive or Compulsive Behaviors *(minimum 2 semester or 3 quarter hours)*

Total Hours: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Psychometric Test and Measurement Theory (*minimum 2 semester or 3 quarter hours*)

Total Hours: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Assessment of Mental Status (*minimum 4 semester or 6 quarter hours*)

Total Hours: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

NOTE: These courses must provide instruction in appraisal of DSM maladaptive and psychopathological behavior.

Research and Evaluation in Clinical Mental Health Counseling *(minimum 2 semester or 3 quarter hours)*

Total Hours: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Internship and/or Practicum *(minimum 4 semester or 6 quarter hours, which includes at least 1,000 clock hours of supervised experience, of which at least 400 must be in the provision of mental health therapy)*

Total Hours: _____

Please describe the setting(s) in which the internship and/or practicum occurred, including:

Placement site(s): _____

Site supervisor(s): _____

Site supervisor(s)' license type(s) and license number(s): _____

Dates of internship and/or practicum: _____

Number of clock hours: _____

Services provided: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

NOTE: Placement site must be an agency that engages in the practice of mental health therapy. Site supervisor must be licensed as a mental health therapist for at least 2 years prior to beginning supervision activities.

Other Counseling Courses (minimum of 30 semester or 46 quarter hours of courses related to the practice of counseling; up to 6 semester hours of project, thesis, and dissertation hours may be counted for this area)

Total Hours: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

Course Title:

Year: _____ School: _____

Course #: _____ Semester/Quarter Hours: _____ Credits Received: _____

VERIFICATION OF SUPERVISED EXPERIENCE

TO BE COMPLETED BY EACH SUPERVISOR OF THE REQUIRED SUPERVISED EXPERIENCE HOURS (do not complete this form if applying for the associate license):

Applicant Name: _____

Supervisor's Name: _____

Supervisor's License Issued: State: _____ Profession: _____ Year: _____

Facility Name where experience took place: _____

Facility Street Address: _____

City: _____ State: _____ Zip: _____

Inclusive dates of supervised experience: From ___/___/___ To ___/___/___

Supervised experience of face-to-face mental health therapy with clients (must be completed as an employee of an agency that engages in mental health therapy)

(Minimum 1,000 hours): _____

Direct supervision (*minimum 100 hours*): _____

Other hours of Clinical Mental Health Counselor training: _____

Total hours of Clinical Mental Health Counselor training (*minimum 4,000*): **TOTAL:** _____

The hours worked and supervised are reported on the basis of:

Supervisor's appointment calendars or records

Supervisor's best recollection

Nature of Applicant's Duties: _____

(Continued on the next page)

I do hereby certify that the applicant for licensure as a clinical mental health counselor has:
(Check the appropriate line)

- Successfully completed the above hours of supervised clinical mental health counselor experience.
- Has not successfully completed the above hours of supervised experience.

I further certify that the applicant:

- Is qualified and competent to practice mental health therapy as a clinical mental health counselor.
- Is not qualified and competent to practice mental health therapy as a clinical mental health counselor.

If applicant is not qualified, please explain the nature of the problem and recommendations for remediation.
(Attach additional pages as needed)

I certify that I am an approved licensed mental health therapist in good standing, and I am a qualified supervisor in accordance with Statute and Rules, including having engaged in at least 4,000 hours of mental health therapy prior to beginning supervising activities. I further certify that I am professionally responsible for the acts and practices of the applicant that are a part of the required supervised experience.

Signature of Supervisor: _____

Date of Signature: ___/___/___

Division of Occupational and Professional Licensing
P.O. Box 146741, or 160 East 300 South
Salt Lake City, Utah 84114-6741
Fax: (801) 530-6511

REQUEST FOR VERIFICATION OF LICENSE

(Use this form to verify licensure from another state, if applicable.)

PART 1 - TO BE COMPLETED BY THE APPLICANT:

Complete the first section of the form and submit it to the state that is verifying information for you. Request that the verifying state complete the form and return it to you for submission with your application. If a verifying state insists on submitting the verification directly to DOPL, indicate that fact in the appropriate section of the application.

Applicant Name: _____

Street Address: _____

City: _____

State: _____ Zip: _____

I am requesting licensure in the state of Utah as a _____

I am/have been licensed in your state under the name _____

My social security number is _____

My date of birth is ___/___/___

My license number in your state is/was _____

I have enclosed the necessary license verification fee in the amount of \$ _____

Signature of Applicant: _____

Date of Signature: ___/___/___

(Continued on the next page)

PART 2 - TO BE COMPLETED BY THE VERIFYING AGENCY:

Please furnish the information requested, sign and verify the document, and mail or fax it directly to DOPL or place the completed form in an envelope, seal the envelope and provide it to the applicant in person or by mail. The applicant will include the verification of licensure with his/her Utah application. Thank you.

Name of Verifying State: _____

Name of Licensee (*as it appears in verifying state's records*): _____

Classification of License Issued: _____

License Number: _____ Current Status: _____

Original Date of Licensure: _____ Expiration Date: ___/___/___

Continuously Licensed:

Yes No, please explain: _____

Licensed By:

Exam, Type: _____ Date: ___/___/___

Endorsement – from what state? _____

Waiver: _____

Examination Scores: _____

Education Required For Licensure: _____

Disciplinary Action or Pending Disciplinary Action:

No Yes, please provide certified copies of all Petitions, Orders, etc.

Signature: _____ Title: _____

Agency: _____

Date of Signature: ___/___/___

(SEAL)

Division of Occupational and Professional Licensing
P.O. Box 146741, or 160 East 300 South
Salt Lake City, Utah 84114-6741
Fax: (801) 530-6511

VERIFICATION OF ACTIVE PRACTICE AS A CLINICAL MENTAL HEALTH COUNSELOR

(For Endorsement Only)

TO BE COMPLETED BY THE EMPLOYER or HUMAN RESOURCE PERSONNEL:

Name of Applicant: _____

License Number: _____ State of Licensure: _____

Name of Person Verifying Employment: _____

Relationship to Applicant: _____

Name of Employer: _____

Employer Address: _____

Employer Phone Number: _____

Describe the applicant's employment setting and responsibilities:

Dates applicant was employed with this agency or private practice:

_____/_____/_____ to _____/_____/_____

Has applicant been engaged in practice of clinical mental health counseling for at least 4,000 hours of which not less than 1,000 hours are in the practice of mental health therapy? Yes No

What was the applicant's schedule? Full-time Part-time

(Continued on the next page)

Is the applicant still employed with agency? Yes No

If no, is the applicant re-hirable? Yes No

This document is proof that the applicant has been actively engaged in the lawful practice of clinical mental health counseling including mental health therapy for not less than 4,000.

Name: _____ Title: _____

Signature: _____

Date of Signature: ___/___/___