State of Utah
Department of Commerce
Division of Occupational and Professional Licensing

Clinical Mental Health Counselor

APPLICANT INFORMATION

Full Legal Name: ______________________________
First *Middle* *Last*

All Previous Legal Names: ______________________________

Other DOPL Licenses Held: ______________________________

SSN: ____________ **Date of Birth:** ____________ **Gender:** ☐ Male ☐ Female

Address: ______________________________
Street Address (including Apt/Unit/Ste #) and/or PO Box

____
City *State* *ZIP Code*

Phone: ____________ **Email:** ____________

Please Select ONE:

☐ I am a United States citizen OR a non-citizen of the United States who is lawfully present.
☐ I am a foreign national not physically present in the United States.
☐ None of the above, please explain: ______________________________

Driver License or State ID Card: ______________________________
State of Issue *License Number* *Expiration Date*

NOTE: If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of authorization to work in the United States.

AFFIDAVIT AND RELEASE

1. I certify that I 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 all supporting document(s) are true and correct, 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, organizations, governmental agencies, or any others not specifically listed, 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 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 I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

5. I certify that I do not currently pose a direct threat to myself, to my clients, or to the public health, safety or welfare because of any circumstance or condition.

6. I understand that I am responsible to update the Division of any changes relating to my license/certification/registration.

Signature of Applicant: ______________________________ Date: ____________

QUALIFYING QUESTIONNAIRE

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

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.

1.	☐ Yes ☐ No	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?
2.	☐ Yes ☐ No	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 professional licensing agency or criminal or administrative jurisdiction?
3.	☐ Yes ☐ No	Are you currently under investigation or is any disciplinary action pending against you now by any *local, state or federal licensing, enforcement or regulatory agency?*
4.	☐ Yes ☐ No	Have you ever been declared by any court to be incompetent by reason of mental defect or disease and not restored?
5.	☐ Yes ☐ No	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?
6.	☐ Yes ☐ No	Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug or alcohol use or abuse within the past five (5) years?
7.	☐ Yes ☐ No	Are you currently using or have you recently (*within 90 days*) used any drugs (*including recreational drugs*) without a valid prescription, the possession or distribution of which is unlawful under applicable state or federal laws?
8.	☐ Yes ☐ No	Have you ever unlawfully used any drugs for which you have not successfully completed, or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?
9.	☐ Yes ☐ No	Do you currently have any criminal action pending?*
10.	☐ Yes ☐ No	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? *
11.	☐ Yes ☐ No	Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?*
12.	☐ Yes ☐ No	Have you ever been incarcerated for any reason in any correctional facility (*domestic or foreign*) in any jurisdiction or on probation/parole in any jurisdiction?*

***NOTE:* Charges that were later dismissed and motor vehicle offenses such as driving while impaired or intoxicated must be disclosed; however, minor traffic offenses such as parking or speeding violations need not be listed.**

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 **9,10,11** or **12** you must submit the following for **EACH** and **EVERY** incident:

- Personal account of the incident
- police report(s)
- court record(s)
- probation/parole officer report(s)

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.

PROFESSIONAL LICENSES

List all other licenses, registrations or certification issued by any state which you now hold or have ever held in any profession. *(Use additional sheets if necessary.)*

Profession: ______________________ **License Number:** ______________

Issuing State: __________ **License Status:** __________ **Issue Date:** __________

Profession: ______________________ **License Number:** ______________

Issuing State: __________ **License Status:** __________ **Issue Date:** __________

MEDICAL QUALIFYING QUESTIONNAIRE

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

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.

1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: ____________________

2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: ____________________

3. Is any action pending against you now by:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: ____________________

4. ☐ Yes ☐ No Have you been named as a defendant in a malpractice suit?

5. ☐ Yes ☐ No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered **"Yes"** to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. *NPDB website: http://www/npdb.hrsa.gov.*

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.

COURSEWORK REQUIREMENTS

Applicants with an active Utah Associate CMHC License are not required to complete this section. Out-of-state applicants with a degree in clinical mental health counseling from a CACREP accredited program are also not required to complete this section. Skip to page 6.

Use each course only once. (Use additional sheets if necessary.)

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

Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

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

Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

Group Counseling and Group Work (minimum 2 semester or 3 quarter hours)

Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

Human Growth and Development: *(minimum 2 semester or 3 quarter hours)*

Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

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

Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

Counseling and Helping Relationships: *(minimum 6 semester or 8 quarter hours)*

Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

Substance-related and Addictive Disorders: *(minimum 2 semester or 3 quarter hours)*

Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

Assessment and Testing: *(minimum 2 semester or 3 quarter hours)*

Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

Mental Status Examination and the Appraisal of DSM Maladaptive and Psychopathological Behavior:
(minimum 4 semester or 6 quarter hours)

Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

Research and Program Evaluation: *(minimum 2 semester or 3 quarter hours)*

Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

Continued on next page.

COURSEWORK REQUIREMENTS (continued)

Coursework related to the practice of counseling: (minimum 34 semester or 52 quarter hours of coursework related to the practice of counseling. Up to 6 semester or 8 quarter hours of project, thesis and dissertation may be counted.)

Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

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Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

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Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

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.)*

Course Title: ______________________ Course # __________ University: ____________________

Course Title: ______________________ Course # __________ University: ____________________

Complete the following regarding your Internship/Practicum, use additional sheets if necessary:

Placement Site: ______________________________ Total supervised hours: __________ Hours directly with client: __________

Description of services provided: ____

____

____

Supervisor Name: ______________________ Supervisor License #: ____________________

Placement Site: ______________________________ Total supervised hours: __________ Hours directly with client: __________

Description of services provided: ____

____

____

Supervisor Name: ______________________ Supervisor License #: ____________________

NOTE: *You can expedite the review process by providing a copy of the graduate catalog course description and/or syllabus of any identified course.*

Verification of Post-Graduate Supervised Experience

Each supervisor must complete a separate form. The hours from all forms must total 4,000.

APPLICANT INFORMATION

To be completed by the applicant.

Full Legal Name: ______________________________
First *Middle* *Last*

Mailing Address: ______________________________
Street/PO Box *City* *State/Zip*

EMPLOYMENT INFORMATION

To be completed by the Supervisor.

Name of Establishment: ______________________________

Name of Supervisor: ____________________ **License Number:** ____________

Establishment Address: ______________________________
Street/PO Box *City* *State/Zip*

Telephone Number: ____________________ **Email:** ____________________

Dates of Employment/Supervision: ____________ to ____________
MM/DD/YYYY *MM/DD/YYYY*

Supervised experience of face-to-face mental health therapy with clients: ____________

Other hours of clinical mental health counseling training: ____________

Hours of direct supervision: ____________

Total hours of clinical mental health counselor training: ____________

Describe the applicant's duties: ______________________________

____

____

Did the applicant and supervisor work in the same place of employment? ☐ Yes ☐ No
If "no", describe how you were able to provide supervision: ______________________________

____

I do hereby certify that the applicant for licensure as a clinical mental health counselor has successfully completed the above hours of post-graduate supervised experience as a W-2 employee of the facility listed. I certify that the experience supervised meets the requirements outlined in R156-60c-302b and 401.

I further certify that the applicant is qualified and competent to practice as a clinical mental health counselor.

Signature of Supervisor: ______________________________ **Date:** ____________

Verification of Active Practice as a CMHC in Another State

For endorsement applicants only.
Each employer must complete a separate form.

APPLICANT INFORMATION

To be completed by the applicant.

Full Legal Name: ______________________________
First *Middle* *Last*

Mailing Address: ______________________________
Street/PO Box *City* *State/Zip*

License Number: ______________ **State of Issue:** ______________

EMPLOYMENT INFORMATION

To be completed by the employer, human resources, supervisor or colleague within the profession.

Name of Establishment: ______________________________

Establishment Address: ______________________________
Street/PO Box *City* *State/Zip*

Telephone Number ______________ **Email:** ______________

Applicant's Dates of Employment as a CMHC: ______________ to ______________
MM/DD/YYYY *MM/DD/YYYY*

How many hours did the applicant work per week? ______________

Number of hours practicing mental health therapy: ______________

Total number of hours practiced as an CMHC: ______________

Describe the applicant's duties: ______________________________

____

____

Is the applicant still employed? ☐ **Yes** ☐ **No**
If no, is the applicant re-hirable? ☐ **Yes** ☐ **No: Please Explain:** ______________________________

____

____

I do hereby certify that the applicant for licensure as a clinical mental health counselor was actively engaged in the lawful practice as a CMHC at the above named establishment for the time frame listed.

I further certify that the applicant is qualified and competent to practice as a clinical mental health counselor.

Signature of Supervisor: ______________________________ **Date:** ______________

Relationship to Applicant: ______________________________

APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience, you do not need to include it with your application.
NOTE: Incomplete applications will be denied.

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

ALL APPLICANTS

All applicants are required to submit the following items to complete the application:

- ☐ $120.00 non-refundable application processing fee, made payable to "DOPL".
- ☐ Supporting documentation for any "yes" answers provided on either of the qualifying questionnaires. See pages 2 and 3 of the application for more information.
- ☐ Verification of Post-Graduate Supervised Experience. See page 6 of the application. ***NOTE:*** *You must have each supervisor complete a separate form, and the hours from all forms must total 4,000.*
- ☐ Official score report of passing the NCMHCE

Applicants seeking licensure who do not have an active Utah ACMHC License must also provide documentation of meeting the education requirements for this license. *Submit one of the options below.*

- ☐ Official transcripts documenting completion of a master's or doctorate degree in clinical mental health counseling from a program accredited by CACREP.
- ☐ Official transcripts documenting completion of a master's or doctorate in clinical mental health counseling or a related field from a non-CACREP accredited program. Complete pages 4 and 5 of this application outlining required coursework. It is recommended applicants from fields related to clinical mental health counseling submit a course description or syllabus for each course from the year it was completed.

LICENSURE BY ENDORSEMENT

If you are currently licensed as the equivalent of clinical mental health counselor in another state, and have been engaged in lawful practice for at least 4,000 hours, of which at least 1,000 hours providing mental health therapy, you may apply for *Licensure by Endorsement*. In addition to the items required by all applicants, you must submit the following:

- ☐ Official verification of license from one or more states in which you are currently licensed. Verifications must cover the time period used to qualify for endorsement outlined above.
- ☐ Verification of Active Practice as a CMHC in Another State Form. See page 7 of the application. **NOTE:** Each employer complete a separate form and the hours from all forms must total 4,000.

Submit the above items with your completed application to:

In person or via express delivery:
Division of Occupational and Professional Licensing
Heber M Wells Building, 1st Floor Lobby
160 E 300 S
Salt Lake City, UT 84111

US Postal Service:
Division of Occupational and Professional Licensing
PO BOX 146741
Salt Lake City, UT 84114-6741

If you have questions, please contact the Division via our direct email address, doplbureau3@utah.gov , or via the phone or fax listed below.