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 lawful presence 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

Do not leave any question blank.

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, resigned, or surrendered while under investigation, or otherwise **disciplined in any way**?

2. ☐ Yes ☐ No Do you CURRENTLY have **any criminal action active or pending**?

3. ☐ Yes ☐ No WITHIN THE PAST 10 YEARS, have you pled **guilty** to, **no contest** to, entered into a **plea in abeyance,** or been **convicted** of **a misdemeanor** in any jurisdiction?

4. ☐ Yes ☐ No Have you EVER pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a **felony** in any jurisdiction?

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 2,3, or 4 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.

NOTE:

- **DISCLOSE** charges that were later held in abeyance, diverted, reduced, or dismissed.
- **DISCLOSE** motor vehicle offenses such as driving while impaired or intoxicated. But you do not need to disclose minor traffic offenses such as parking or speeding violations.
- You do **not need to disclose** juvenile offenses, unless you were tried as an adult.
- **DISCLOSE** if you are restricted from possession, purchase, transfer, or ownership of a firearm or ammunition (even if your restriction is based on a non-reportable juvenile conviction).
- You do **not need to disclose** legally expunged or sealed criminal history incidents.

For more information, see DOPL's criminal history FAQs.

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.

EDUCATIONAL COURSE REQUIREMENTS

To be completed by applicants who have not graduated from a CACREP accredited mental health counseling program. Graduates from CACREP accredited programs or those who hold a Utah ACMHC license are not required to complete this section.

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

Professional Orientation and Ethical Practice

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Social and Cultural Diversity

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Group Work

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Human Growth and Development

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Career Development:

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Counseling and Helping Relationships

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Substance-Related and Addictive Disorder

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Assessment and Testing

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Mental Status Examination and the appraisal of DSM Maladaptive and Psychopathological Behavior

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Research and Evaluation

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Continued on next page.

EDUCATIONAL COURSE REQUIREMENTS (continued)

To be completed by applicants who have not graduated from a CACREP accredited mental health counseling program. Graduates from CACREP accredited programs or those who hold a Utah ACMHC license are not required to complete this section.

Internship and/or Practicum:

Note: Must include 700 documented hours of supervised clinical training from at least one practicum or internship, of which 240 hours consist of providing therapy directly to clients

Course Title: _____ Course #_____ University:_____

Course Title: _____ Course #_____ University:_____

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

Placement Site: _____ Total number of hours: _____

Description of services provided: _____

_____

_____

Placement Site: _____ Total number of hours: _____

Description of services provided: _____

_____

_____

Placement Site: _____ Total number of hours: _____

Description of services provided: _____

_____

_____

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 Utah Administrative Code R156-60c-302 and R156-60-302.

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 certifying individual: _____

Relationship to Applicant: _____ Date: _____

License Number *(if applicable)*: _____ State of Licensure: _____

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.

INITIAL LICENSURE

If applying for **Initial Licensure**, *in addition* to the items required for all applicants, you must submit:

- ☐ Verification of Post-Graduate Supervised Experience. See page 6 of this 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, please see the exam section of our website for additional information.
- ☐ Official score report of passing the NCE, please see the exam section of our website for additional information.
- ☐ Documentation of a two-hour suicide prevention training course.
- ☐ Documentation of meeting the education requirements, which included one of the following:
  - Official transcripts documenting completion of a master's or doctorate degree in clinical mental health counseling, clinical rehabilitation counseling, or counselor education accredited by CACREP; or
  - Official transcripts documenting completion of a master's or doctorate degree in an equivalent field from a program accredited by an institution that is recognized by the Council for Higher Education Accreditation. Transcripts must include the coursework identified on the required "Education Course Requirement" forms included with this application.

  NOTE: If you hold a *current Utah ACMHC license,* you *do not* need to submit the education documentation.

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 not less than 4,000 hours, of which at least 1,000 hours are in 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 this application. ***NOTE:*** *You must have 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, b3@utah.gov , or via the phone or fax listed below.