

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

- Associate Clinical Mental Health Counselor  
 Associate Clinical Mental Health Counselor Extern

**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.

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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?

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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
- court record(s)
- police report(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.

## 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:

- \$85.00 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.
- Documentation of meeting the education requirement (*submit one of the options below*):

### **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.*
- 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 or counselor education accredited by CACREP;
  - Official transcripts documenting completion of a master's or doctorate degree in rehabilitation counseling accredited by CACREP *and* a passing score on *both* the NCE and NCMHCE; 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.

### **EXTERN APPLICANTS**

If you have a degree in mental health counseling or an equivalent field but are deficient in course work, you may apply for an externship license. An extern license expires upon the issuance of the associate license or 3 years from the date of issuance, *whichever comes first*. The extern license requires you submit all the items listed under "All Applicants", with the exception of the deficiencies in your coursework. Please identify any deficiencies clearly on the required "Education Course Requirement" forms included with this application.

Once you have remedied the deficiencies in coursework, you must submit a new application for your ACMHC. If your ACMHCE license expires prior to the issuance of your ACMHC, you must cease practice until your license is issued.

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, 1<sup>st</sup> 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](mailto:b3@utah.gov), or via the phone or fax listed below.