Clear Form

UTAH DEPARTMENT OF COMMERCE

Division of 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*

Phone: _____ **Email:** _____
Note: All Division notices and communication will be sent to this 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 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.

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

Social and Cultural Diversity (3 semester or 4 quarter credit hours)

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Group Counseling and Group Work (3 semester or 4 quarter credit hours)

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Human Growth and Development (3 semester or 4 quarter credit hours)

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Career Development: (3 semester or 4 quarter credit hours)

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Counseling and Helping Relationships (3 semester or 4 quarter credit hours)

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Substance-Related and Addictive Disorder (3 semester or 4 quarter credit hours)

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Assessment and Testing (3 semester or 4 quarter credit hours)

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Mental Status Examination and the appraisal of DSM Maladaptive and Psychopathological Behavior
(3 semester or 4 quarter credit hours)

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Research and Evaluation (3 semester or 4 quarter credit hours)

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.

Professional Counseling Orientation and Ethical Practice (3 semester or 4 quarter credit hours)

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

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.*

Supervisor Verification

A supervisee may not count any post-graduate supervised training towards their supervision requirements until the division notifies the supervisor listed below of receipt of this form.

SUPERVISEE INFORMATION

To be completed by the supervisee.

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

Mailing Address: _____
Street / PO Box / Apt or Suite *City* *State / Zip*

Email Address: _____
*Note: **REQUIRED** All Division notices and communication regarding supervision will be sent to this email.*

CSW License Number if Issued: _____

SUPERVISOR INFORMATION

To be completed by the Supervisor.

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

Mailing Address: _____
Street / PO Box / Apt or Suite *City* *State / Zip*

Email Address: _____
*Note: **REQUIRED** All Division notices and communication regarding supervision will be sent to this email.*

License Number: _____ **License Type:** _____

Proposed supervisors must have been actively engaged in licensed practice for at least 2 years before supervising post-graduate hours.

☐ **Yes** ☐ **No** Supervisee is a W-2 employee of a public or private mental health agency.

☐ **Yes** ☐ **No** Written supervision contract meets the requirements outlined in R156-60-302.

☐ **Yes** ☐ **No** Supervisor and Supervisee have both signed a written supervision contract.

Date Written Supervision Contract Was Signed: _____

I certify I have read Utah Admin. Code R156-60-302. Supervised Training Requirements-Supervision Contract-Duties and Responsibilities of Supervisor and Supervisee. I understand that hours MUST be documented using the Division-provided Supervision Record of Post-Graduate Mental Health Practice Hours form.

Signature of Supervisor: _____ **Date:** _____

Signature of Supervisee: _____ **Date:** _____

EMAIL THIS COMPLETED FORM TO B8@UTAH.GOV

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.
- ☐ "Verification of Supervision for Post-Graduate Mental Health Practice Hours", found in this application.
  Note: This form is not required to obtain a license, but you cannot begin your post-graduate hours until it is on file and approved by the Division.
- ☐ 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 Professional Licensing
Heber M Wells Building, 1st Floor Lobby
160 E 300 S
Salt Lake City, UT 84111

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

If you have questions, please contact the Division via our direct email address, B8@utah.gov, or via the phone or fax number listed below. **Do not send applications or payments to this email**.