UTAH DEPARTMENT OF COMMERCE
Division of Professional Licensing

Clinical Mental Health Counselor

☐ Initial Licensure Application ☐ Endorsement Application Clear Form

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 with 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.

I declare under criminal penalty under the law of Utah that this application is true and correct.

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: _____

If you identified a clinical mental health counselor license above, please answer the following:

☐ Yes ☐ No After obtaining the license(s) above, have you engaged in at least one year of experience in the state, district, or territory of the United States where the license was issued?

Note: If you answer yes to the question above, please see the checklist at the end of this application or our website for instructions on applying by endorsement.

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.

NATIONAL PROVIDER IDENTIFIER (NPI)

Your NPI:_____

EXAMINATION REQUIREMENTS

☐ I have passed the NCE for Utah
☐ I have passed the NCE in another state. State: _____ Exam Date: _____

☐ I have passed the NCMHCE for Utah
☐ I have passed the NCMHCE in another state. State: _____ Exam Date: _____

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: _____

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: _____

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

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

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

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

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

INTERNSHIP AND/OR PRACTICUM REQUIREMENTS

To be completed by applicants who have NOT graduated from a CACREP accredited mental health counseling program.

Internship and/or Practicum *(use additional sheets if necessary)*:

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: _____

Course Title: _____ Course #_____ University: _____

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 courses listed above.*

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RECORD OF POST-GRADUATE SUPERVISED MENTAL HEALTH PRACTICE HOURS

Use this form to report your supervision after obtaining licensure as an Associate Clinical Mental Health Counselor. Each Supervisor must complete a separate form. The hours from all forms must total 3,000.

APPLICANT INFORMATION (TO BE COMPLETED BY THE APPLICANT)

Full Legal Name: _____ _____ _____
First Middle Last

License Number: _____ License Type: _____

SUPERVISOR INFORMATION (TO BE COMPLETED BY THE SUPERVISOR)

Name of Establishment: _____

Supervisor Name: _____ _____ _____
First Middle Last

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

License Type: _____ License Number: _____ State of Issue: _____

Dates of Supervision as a W-2 Employee: _____ to _____
Note: Intern / Practicum hours cannot be counted MM/DD/YYYY MM/DD/YYYY

_____ Hours of clinical mental health therapy directly with clients (1,000 hour minimum)
As defined in Utah Administrative Code § R156-60a-102(7) and Utah Code § 58-60-405(1)(e)

_____ Hours of clinical mental health therapy under direct supervision (75-hour minimum)
As defined in Utah Administrative Code R156-60a-102(1)(e) and Utah Code § 58-60-305(1)(e), 58-60-405(1)(e), & 58-60-502(3)

_____ Hours of clinical mental health therapy experience.

0 **TOTAL OF ALL HOURS** performed under this supervisor
As defined in Utah Code § 58-60-405(1)(e)

☐ Yes ☐ No Did the supervisee meet the expectations of supervision outlined in the written plan, with regard to the quality of work performed? If no, submit a written statement, regarding the performance, to the Division at B8@utah.gov

☐ Yes ☐ No Did the supervisor and supervisee work at the same place of employment? If no, submit a written statement, describing how you were able to perform supervision, to the Division at B8@utah.gov

ATTESTATION:

I certify that the applicant for licensure as a clinical mental health counselor (CMHC) has successfully completed the above hours of post-graduate supervised experience as a W-2 employee of the facility listed above and that the experience meets the requirements outlined in Utah Admin. Code R156-60a-302c. I further certify that the applicant is qualified and competent to practice as a clinical mental health counselor.

Signature of Supervisor: _____ Date: _____

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Verification of Active Practice as a CMHC in Another State

*For endorsement applicants applying by via **Option 2**. See checklist for additional information*
Applicants using **Option 1** *do not need to complete this form.*
Each employer must complete a separate form.

APPLICANT INFORMATION (TO BE COMPLETED BY THE APPLICANT)

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

Address: _____ City: _____ State: _____ Zip: _____

License Number: _____ State of Issue: _____

EMPLOYMENT INFORMATION:
(TO BE COMPLETED BY THE EMPLOYER, HUMAN RESOURCES, SUPERVISOR OR A PROFESSIONAL COLLEAGUE)

Name of Establishment: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ –_____ Email: _____

Dates of Employment as a CMHC: _____ to _____

How many hours did the applicant work per week? _____

Number of hours practicing mental health therapy: _____

Total number of hours practiced as a CMHC: _____

Describe the applicant's duties: *(attach additional sheet if needed)*

Is the applicant still employed? ☐ Yes ☐ No

The applicant is/was a ☐ W-2 Employee ☐ Contracted Labor.

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

If Not re-hirable, Please explain *(attach additional sheet if needed)*:

ATTESTATION:

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.

I declare under criminal penalty under the law of Utah that this application is true and correct.

Signature of certifying individual: _____ 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 that is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other laws.

ALL APPLICANTS

The following items are required to complete your 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.

INITIAL LICENSURE

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

- ☐ Record of Post-Graduate Supervised Experience. NOTE: Each supervisor must complete the form for the hours they supervised and the hours from all supervisors must total 3,000.
- ☐ 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 applying licensure by endorsement, there are two options. In addition to the items required for all applicants, you must complete one of the following options:

Option 1: One Year of Active Licensure from a Jurisdiction Deemed Equivalent.

- ☐ Official verification, showing active licensure in good standing for at least one year, from a jurisdiction designated by the Division as equivalent to Utah.
- ☐ If required, official transcripts and/or exam scores to demonstrate equivalency.

Please see our website for additional information regarding approved jurisdictions, and any additional documentation that may be necessary.

Option 2: 3,000 Hours of Active Licensure from any U.S. Jurisdiction.

- ☐ 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.
- ☐ Verification of Active Practice as a CMHC in Another State form found in this application. NOTE: You must have each employer complete a separate form, and the hours from all forms must total 3,000.

Submit completed application to the Division:

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

By in-person or express delivery:
Division of Professional Licensing
Heber M Wells Building, 1st Floor
160 E 300 S
Salt Lake City, UT 84111

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.