FOR OFFICE USE ONLY
Mental Health Couns. Checklist
☐ Endorsement ☐ Examination
☐ App. & Fee
☐ Date:_____ Check_____
☐ Transcript
☐ Statements of Supervised Practice
☐ Supervisor's Resume(s)
☐ Verification of Supervisor's OOS Lic.
☐ Score/Certification from NBCC
☐ License Verif. from Other State(s)

FOR OFFICE USE ONLY
Application Approved:
License Number:
Issue Date:
Signature of Board Administrator
ID#:
Receipt #:

Rhode Island
Board of Mental Health Counselors and Marriage & Family Therapists

Room 104
3 Capitol Hill
Providence, RI 02908-5097

License #_____

Name_____

Instructions and Application For

License As A

Mental Health Counselor

by

☐ Examination

Have you already taken the NCMHCE or NCE Exams through the NBCC?

☐ **Yes** ☐ **No**

☐ Endorsement

(From Another State)

MILITARY STATUS ELIGIBILITY *(Documentation Required) see next page for instructions*

Please check ONE of the following criteria for expedited application:

☐ I am in active military duty or a reservist

☐ I am a military veteran with honorable discharge

☐ I am the spouse of someone in active military duty or the spouse of a reservist

Applicant - Print Name

LAST NAME	*FIRST NAME*	*MI*

Phone: (401) 222-2828 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-1272**

LICENSURE REQUIREMENTS

- ☐ Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.
- ☐ Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **$70.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE. Please be advised that this is an application fee and includes the first license **only** up until the next expiration date. All Marriage and Family Therapist licenses expire biennally on July 1st of the even numbered years.
- ☐ Official transcript(s), with registrar's signature and school seal from an accredited College or University (60 credits required). CACREP Accreditation, if applicable **No student copies will be accepted.**
- ☐ Score/Certification NCMHCE sent directly from the NBCC - **Telephone 1-336-547-0607)** (pertains only to applicants who have previously sat for the national exam).
- ☐ Statement(s) of Supervised Practice - These hours are to be accrued after 60 credits are completed. (including supervisor's resume) (Form included in this application to be used for that purpose) If you are applying for the MHC license by endorsement and your original practice supervisor is no longer available to complete the RI Statement of Supervised Practice form, please have your original state of licensure send a copy of your original supervised practice form from your original license or have the state verify your supervision and submit in a sealed envelope.
- ☐ If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that purpose)
- ☐ If applying for expedited military status you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

Examination Information

The exam required for licensure is the National Clinical Mental Health Counselor Exam (NCMHCE). The National Board of Certified Counselors (NBCC) is the national certification agency, which owns/administers this exam. Upon receipt of your completed license application, HEALTH will register you with NBCC for the next scheduled exam. You will receive notification of exam admittance, location, directions, etc. from NBCC approximately ten (10) days prior to the exam date. NBCC sends exam results to HEALTH (not individual applicants) in approximately six (6) weeks. HEALTH will then forward your exam results to you.

For exam information, including exam dates, the preparation guide and other study materials, please refer to the NBCC website:

http://www.nbcc.org

Licensure Information

Please visit the RIDOH website at **http://www.health.ri.gov/licenses** to Verify your license, download Rules and Regualtions/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the ex pense of others.

License Certificates

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of $30.00 made payable to RI General Treasurer.

☐ I would like to receive a license certificate. I have enclosed a separate check in the amount of $30.00

State of Rhode Island

Board of Mental Health Counselors and Family & Marriage Therapists

Application for License as a Mental Health Counselor

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/Permit/Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

3. Gender

☐ Male ☐ Female

4. Date of Birth

Month Day Year

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Home Phone Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone Extension Business Fax

7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address

☐ Please use my **Business Address** as my preferred mailing address

8a. Qualifying Education

Please list the name and information about the school that you attended that qualifies you for this license.

MINIMUM OF 60 CREDITS ARE REQUIRED

Type of School (University, College, Technical School, etc.)

Name of School

Date Graduated: Month Year

Number of Credit Hours

Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)

8b. Supervised Practicum, Internship and Work Experience

Please list:
Supervised Practicum (12 semester or 18 quarter hours)
Supervised Internship (1 calendar year of 20 hours/week)
Supervised Work Experience (minimum 2000 hours Post-Graduate completed in minimum of 2 years)
Approved Supervisor of Work Experience
Include name and address (minimum 100 hours)

Requirement	Location (Name and Address)	Date Began	Date Completed	Hours Completed
Supervised Practicum (12 semester or 18 quarter hours)				
Supervised Internship (1 calendar year of 20 hours/week) Minimum of 600 Hours				
Supervised Work Experience (Minimum 2000 Hours of Post-Graduate Experience completed in minimum of 2 yrs) After 60 Credits				
Approved Supervisor of Work Experience (Minimum of 100 Hrs. Post-Graduate Supervised Casework)				

9. Other State License(s)

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state? Yes ☐ No ☐

If the answer to this question is ***"yes"***, enter all other state licenses in Question 10 (below):

10. Licensure

List all states or countries in which you are now, or ever have been licensed to practice your profession.

State/Country:			State/Country:		
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive

11. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year

12. Disciplinary Questions

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are formal charges pending? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit in any state? ☐ Yes ☐ No

Note: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.

13. Affidavit of Applicant

Complete this section and sign.

Make sure that you have completed all components accurately and completely.

I _____ being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Mental Health Counselor in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Mental Health Counselors and Marriage & Family Therapists of any change in the answers to these questions after this application and this affidavit is signed.

_____ _____

Signature of Applicant Date of Signature (MM/DD/YY)

Substitute forms are not acceptable, copy this form as needed.

RI Board of Mental Health Counselors and Marriage & Family Therapists
Room 104, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2828

STATEMENT OF SUPERVISED PRACTICE

I am applying for a license to practice as a Mental Health Counselor in the State of Rhode Island. The Rhode Island Board of Mental Health Counselors and Marriage & Family Therapists requires that the following section be completed by my supervisor. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board at the above address.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Date of Birth _____

THIS SECTION TO BE COMPLETED BY THE SUPERVISOR

1. What is the educational level of the supervisee? _____

2. Please provide the name and the nature of the setting in which the supervised practice took place.

_____

_____

_____

3. Dates of practice covered in this report: _____ Number of practice hours during this period _____

4. Supervisee's duties _____

_____ Number of one-to-one supervisory hours _____

5. Assessment of supervisee's performance (elaborate): _____

_____

_____

_____

CERTIFICATION: I hereby acknowledge that the above statements are true and I am willing to accept professional responsibility for the work done by the candidate while under my supervision. I will return this completed form directly to the Board at the above address. **I will also attach a copy of my curriculum vitae to this form for review by the Board.**

Signature **Date**

Printed Name **Title**

Address

License Number **State in which granted** **Area of specialization**

Substitute forms are not acceptable, copy this form as needed.

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CORE CURRICULUM COURSEWORK REQUIREMENT FORM

Print/Type Full Name _____ Signature _____ Date _____

ALL APPLICANTS - PLEASE COMPLETE THE FOLLOWING:

In order to qualify for Licensure you must have taken graduate credit courses and graduate work in the following areas. Please list your courses which correspond to the given content areas. Refer to the licensing regulations (Appendix A-1) for clarification of the content areas. Elective courses that do not fit into the particular areas should be noted also. If the title of the course does not clearly reflect course content attach a course description.

Content Area	Date	Course Code	Course Title	Credit Hours
1. Helping Relationships and Counseling Theory *(9 credits minimum)*				
2. Human Growth and Development *(3 credits minimum)*				
3. Social and Cultural Foundations *(3 credits minimum)*				
4. Group Counseling *(3 credits minimum)*				
5. Lifestyle and Career Development *(3 credits minimum)*				
6. Appraisal *(3 credits minimum)*				
7. Research and Program Evaluation *(3 credits minimum)*				
8. Professional Orientation *(3 credits minimum)*				
9. Electives: (*Courses may reflect a specialization area, or add knowledge & skills in interdisciplinary studies).*				

Substitute forms are not acceptable, copy this form as needed.

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INTERSTATE VERIFICATION FORM - OTHER STATE LICENSURE

I am applying for a license to practice as a Mental Health Counselor in the State of Rhode Island. The Rhode Island Board of Mental Health Counselors and Marriage & Family Therapists requires that this form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board at the above address.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE MENTAL HEALTH COUNSELORS BOARD

Counseling/Therapy Degree Completed:	Location:	Graduation Date:

Licensed by Examination?	Applicant has completed and passed the National Certification Exam (LCMHC):
☐ Yes ☐ No	☐ Yes ☐ No

License Status:	Original Date Issued:	Expiration Date:
☐ Active ☐ Inactive ☐ Lapsed		

Questions:

1. Has this licensee ever been investigated by your Board? ☐ Yes ☐ No
2. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

_____

_____

_____

Certification:

Signature _____ Date _____

Type or Print Name _____

Title _____

Full Name of Licensing Board _____

Please Affix
Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.