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

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**

☐ **Endorsement**

Applicant - Print Name (First/MI/Last)

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

Revised 09/05/2006 awp

GENERAL INFORMATION

Enclosures

The following materials and information should be enclosed within this application packet:

Application Process Overview..... 3

Instructions for Completing Application.....4

Application Materials

Application.....5-8
Application Checklist..... 9
Statement of Supervised Practice Form.....10
Core Curriculum Coursework Requirement Form.....11
Interstate Verification Form - Other State License(s).....12
Addendum to License Application (Verification of Social Security Number Form).....13

Licensure Requirements

U.S. Graduates

- Application Fee of **$350.00** (NON-REFUNDABLE).
- Recent passport type photograph (Approximately 2” X 2” head and shoulder view).
- Birth certificate (***original or a copy notarized as being a true copy of the original)***, or if born outside the United States, proof of citizenship or lawful alien status, ***(original or a copy notarized as being a true copy of the original).***
- Official transcript from an accredited College or University (60 credits required).
- Two (2) statements of good moral character.
- Score/Certification of NCMHCE sent directly from the National Board of Certified Counselors (NBCC).
- Statement(s) of Supervised Practice (including supervisor’s resume) (page 10).
- License Verifications from the state(s) in which applicant holds or has held a license (page 12).
- Completed Mandatory Addendum to License Application (“Verification of Social Security Number Form” page 13).

Rules and Regulations/Laws

The Rules and Regulations for licensing “Mental Health Counselors and Marriage and Family Therapists” (R5-63.2-MHC/MFT) may be found at the Board Website:

http://www.health.ri.gov/hsr/professions/mf_counsel.php

APPLICATION PROCESS OVERVIEW

The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Health Professionals Regulation, and the Rhode Island Board of Mental Health Counselors and Marriage & Family Therapists (Board).

Application Process

In addition to the application, you must submit additional information directly to the Board. All items listed on the "checklist" (page 9) must be submitted for an application to be considered complete. All applications are considered valid for 1 year from the day they are received at HEALTH. If you do not complete the application process and obtain a license within 1 year a new application must be submitted.

Please allow a minimum of 4-8 weeks for the entire licensure process to be completed. If you have malpractice criminal or disciplinary history, in Rhode Island or another state, it can take an additional 2 or 3 months for all pertinent documentation to be received, and a decision to be made regarding issuance of your license.

Licenses will be issued within 7-10 working days following approval of the license. Wallet-sized license cards are mailed within 3 weeks from the date of issuance, and are mailed to the address furnished in the application. You are responsible for notifying the Board office, in writing, if your address changes in the interim. The Board may be emailed an address change. The email address is located at the following web site.

http://www.health.ri.gov/hsr/professions/mf_counsel.php

To obtain your license number prior to receiving your license card, please refer to the HEALTH Licensee Lookup web site:

http://www.health.ri.gov/hsr/professions/license.php

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the application. If you have any questions about this application process, or would like to check on the status of your application, please contact the board staff at (401) 222-2828.

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.

The exam is administered four times per year; dates may be found at our website:

http://www.health.ri.gov/hsr/professions/mf_counsel.php

For exam information, including the preparation guide and other study materials, please refer to the NBCC website: **http://www.nbcc.org**

INSTRUCTIONS FOR COMPLETING THE LICENSE APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the application. **Only complete applications with the appropriate fee will be accepted.** Failure to submit all required information and appropriate documentation may result in processing delays.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. HEALTH staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to HEALTH.
5. It is your responsibility to check on the status of your application.

Completing your Application

1. Complete the application (pages 5-8). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the application, such pages **MUST** clearly indicate the section for which such information is being reported.

2. Make a check or money order (preferred), payable to the **"Rhode Island General Treasurer"** in the amount of **$350.00** and staple it to the upper left-hand corner of the first (Top) page of the application. **NOTE:** This application fee is NON-REFUNDABLE .

3. **For those born in US**: An original or notarized copy of birth certificate. **For those born outside US**: An original or notarized copy of citizenship or lawful alien status.

4. Affix a recent **2 X 2 photo** of yourself in the space provided.

5. A completed official transcript **sent directly** from the accredited College or University to the Board of Mental Health Counselors and Marriage & Family Therapists. **No student copies will be accepted.**

6. Scores of NCMHCE **sent directly** from the **NBCC** **(Telephone 1-336-547-0607)** to the Board of Mental Health Counselors and Marriage & Family Therapists (pertains only to applicants who have previously sat for the national exam).

7. Statement(s) of Supervised Practice (including supervisor's resume) submitted to the Board of Mental Health Counselors and Marriage & FamilyTherapists (page 10).

8. **(Endorsement Candidates):** Please send the license verification form on page12 to all states in which **applicant** holds or has held a license. Be sure to sign and complete the identifying information on the form. The Board must receive these verifications **directly** from the licensing authority in each state.

9. Mail the application and documentation to:

Rhode Island Department of Health
Board of Mental Health Counselors and
Marriage & Family Therapists, Room 104
3 Capitol Hill
Providence, RI 02908-5097

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

Please Refer to "Mandatory Addendum to License Application" on the last page of this application

3. Gender

☐ Male ☐ Female

4. Date and Place of Birth

Month Day Year 19

City and State; **OR** Province and Country, etc., if NOT U.S.

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.

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)				
Supervised Work Experience (Minimum 2000 Hours of Post- Graduate Experience completed in minimum of 2 yrs)				
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 in the presence of a notary public.

Make sure that you and the notary public 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 my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the law. I understand that my records are protected under the Federal and State Laws and Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

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)

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

_____ Name of Notary (Print, Type or Stamp)

_____ Signature of Notary

Notary Seal

_____ Notary No/Commission No.

_____ Commission Expiration Date (MM/DD/YY)

14. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.

Affix Photo Here

Write your name on the back of the photograph, and provide the date that the photograph was taken.

_____ Date of Photograph

APPLICATION CHECKLIST

Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

Board Application

- ☐ I have read and understand the "Instructions for Completing the Application".
- ☐ I have completed the Rhode Island Board application as instructed (pages 5-8).
- ☐ I have attached the cover page of the application.
- ☐ I have completed Section 13, **"Affidavit of Applicant"**, and had the form notarized by a notary public.
- ☐ I have attached a photograph to Section 14, **"Recent Photograph"** as instructed. I have verified that it meets the photograph requirements as stated in the application.
- ☐ I have attached a birth certificate (***original or a copy notarized as being a true copy of the original)***, or if born outside the United States, proof of citizenship or lawful alien status, ***(original or a copy notarized as being a true copy of the original)***, and understand that submitted documents will not be returned.
- ☐ I have made a **check** or **money order** (preferred), payable (in U.S. funds only) to the ***"Rhode Island General Treasurer"*** in the amount of **$350.00** (NON-REFUNDABLE) and attached it to the upper left-hand corner of the first (Top) page of the application.
- ☐ I have arranged my Board Application materials in the following order.

  1. Fee (attached as instructed).
  2. Board Application (including cover page) and pages 5-8.
  3. Core Curriculum Coursework Requirement Form (page 11)
  4. Mandatory Addendum to License Application (Verification of Social Security Number Form) (Page 13)
  5. Supporting documentation as required. [**Note:** Pages containing additional information in continuation of the Board application] MUST indicate the section for which the information is being reported.]

- ☐ I have mailed the above application materials directly to the Rhode Island Board of Mental Health Counselors and Marriage & Family Therapists.

Required Forms

- ☐ I have completed and mailed the following forms as instructed.

  1. Statement of Supervised Practice Form (page 10) (With Supervisor's Resume)
     REQUIRED FOR ALL APPLICANTS
  2. Interstate Verification Form(s) - Other State License(s) (page 12) (**Endorsement Candidates ONLY**).

Other Documents

- ☐ I have requested a school transcript and my certification score (NBCC), if applicable, as instructed.

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 19

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.

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

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

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

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

19

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.

Rhode Island Department of Health

3 Capitol Hill, Providence RI, 02908-5097

MANDATORY ADDENDUM TO LICENSE APPLICATION

Tax Payer Status Affidavit / Identity Verification

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

Licensee Declaration

☐ I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.

☐ I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.

☐ I am currently pursuing administrative review of taxes owed to the state.

☐ I am in federal bankruptcy. (Case #)

☐ I am in state receivership. (Case #)

☐ I have been discharged from bankruptcy. (Case #)

Mental Health Counselor

Type of Professional/Business License for which you are applying.

Full Name (Please Print or Type)

Social Security Number (or FEIN for Business)

Signature

Phone Number (including area code if not 401)

Date

This form must be completed, signed and attached to your license application for processing.