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STATE BOARD OF SOCIAL WORKERS, MARRIAGE AND FAMILY THERAPISTS AND PROFESSIONAL COUNSELORS
717-783-1389
FAX: 717-787-7769
Email st-socialwork@state.pa.us
Website www.dos.state.pa.us/social

APPLICATION FOR A LICENSE BY EXAMINATION TO PRACTICE PROFESSIONAL COUNSELING QUALIFICATIONS

1. Application fee- $45.00 and is non-refundable. Check/money order should be made payable to "Commonwealth of PA". A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for nonpayment. "If the application process has not been completed within one year from the date it was received, applicants will be required to submit an updated application (another application processing fee) and supporting documents as necessary."

2. Be of good moral character. Have 2 recommendations completed on page 3.

3. Meet **ONE** of the following education requirements as per Section 7(f) (2) Act 136 – 1998 (on website www.dos.state.pa.us/social - click on Rules and Regulations, Chapter 49 (Licensure of Professional Counselors). Request the school to send an official transcript of your educational degree and other graduate level coursework **DIRECTLY** to the Board.

   a. **By March 2, 2007,** has completed a planned program of 60 semester hours or 90 quarter hours of graduate coursework in counseling or a field closely related to the practice of professional counseling, including a master's degree in counseling or a field determined by the board by regulation to be closely related to the practice of professional counseling, from an accredited educational institution, and has met specific course requirements listed in Section 49.2.

   b. Has successfully completed a planned program of 60 semester hours or 90 quarter hours of graduate coursework in counseling or a field determined by the board by regulation to be closely related to the practice of professional counseling, including a 48-semester-hour or 72-quarter-hour master's degree in counseling or a field determined by the board by regulation to be closely related to the practice of professional counseling, from an accredited educational institution, and has met specific course requirements listed in Section 49.2.

   c. Holds a doctoral degree in counseling from an accredited educational institution or holds a doctoral degree in a field determined by the board by regulation to be closely related to the practice of professional counseling from an accredited educational institution, and has met specific course requirements listed in Section 49.2.

4. Demonstrate proof of supervised clinical experience. **Master's degree**-completion of 3 years or 3600 hours of supervised clinical experience. **Doctoral degree**-completion of 2 years or 2,400 hours of supervised clinical experience. **Experience must meet the criteria established in Section 49.13(a)(4) and 49.13(b) of the regulations.** Have your supervisor complete Pages 4 through 6 certifying your supervised clinical experience and return **DIRECTLY** to you in a sealed envelope. **A total of 3600 hours of supervised clinical experience is required.** As per Section 49.13(b)(2) 1800 hours shall be supervised by a supervisor meeting the qualifications of Section 49.3(1) and (3). Only 1800 hours may be supervised by a supervisor meeting the qualifications of Section 49.3(2). Supervised clinical experience completed prior to January 1, 2006, may be supervised by a supervisor meeting the requirements of Section 49.3(3).

****Please note that the practicum and internship are part of your educational requirements and cannot be counted towards the 3600 hours of supervised clinical experience.**

5. Please provide a curriculum vitae (a list activities of graduation to the present.)

6. Request each state licensing agency where you have ever held a license to practice send letter(s) of good standing **DIRECTLY** the Board office in official sealed agency envelope.

7. Pass one of the following accepted examinations for licensure. Request your licensure examination scores to be sent **DIRECTLY** to the Board from the certification and examination agency.

   a) The National Counselor Examination for Licensure and Certification (NCE) given by the National Board for Certified Counselors, Inc. (NBCC) 3 Terrace Way, Suite D, Greensboro, NC 27403 Phone 336-547-0607. Attached is the registration form, when completed forward to NBCC.

   b) The Certified Rehabilitation Counselor (CRC) Examination given by the Commission on Rehabilitation Counselor Certification (CRCC) 1835 Rohlwing Road, Suite E, Rolling Meadows, IL 60008 Phone 847-394-2104

   c) The Art Therapy Credentials Board (ATCB) Certification Examination given by the Art Therapy Credentialing Board, 3 Terrace Way, Suite B, Greensboro, NC 27403-3660 Phone 877-213-2822

   d) The Board Certification Examination given by the Certification Board for Music Therapists (CBMT) 506 East Lancaster Avenue, Suite 102, Downingtown, PA 19335 Phone 1-800-765-2268

   e) The Practice Examination of Psychological Knowledge given by Northamerican Association of Masters in Psychology (NAMP) P O Box 721270, Norman, OK 73070 Phone 1-800-919-9330

   f) The Advanced Alcohol and Other Drug Abuse Counselor Examination (AAODA) given by the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse Inc. (IC&RC/AODA) 6402 Arlington Boulevard, Suite 1200, Falls Church, VA 22042 Phone 703-294-5827

   g) The Examination for Masters Addictions Counselors (EMAC) given by the National Board for Certified Counselors, Inc (NBCC) 3 Terrace Way, Suite D, Greensboro, NC 27403 Phone 336-547-0607

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STATE BOARD OF SOCIAL WORKERS, MARRIAGE AND FAMILY THERAPISTS AND PROFESSIONAL COUNSELORS

Email: st-socialwork@state.pa.us **Website: www.dos.state.pa.us/social**

Mailing address
P.O. BOX 2649
HARRISBURG, PA 17105-2649

Courier Delivery Address:
2601 North Third Street
Harrisburg, PA 17110

APPLICATION FOR A LICENSE BY EXAMINATION TO PRACTICE PROFESSIONAL COUNSELING

Complete page 1 and 2 and submit to the above address.

Application fee - $45.00 and is non-refundable. Make check/money order payable to "**Commonwealth of PA**". A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for nonpayment.

Name: _____
Last First Middle Maiden

Address: _____
Street

_____
City State Zip

Daytime Telephone Number: (____) _____ Email _____

Social Security Number: _____ Date of Birth: _____ _____ _____
Month Day Year

School _____

Address of School: _____
Street

_____
City State Zip

Date of Graduation: _____ Type of Degree _____
Month Day Year

Name of licensing exam taken_____ Date of examination _____
Month Day Year

The following questions must be answered, please check the appropriate box.		Yes	No
1.	Do you hold or have you held a professional license for any profession in this state or any other state or jurisdiction? If yes, please list all professions and states where you have been licensed and request a letter of good standing be sent from each state board to the Pennsylvania Board. _____		
2.	Has any disciplinary action been taken or are any charges pending, or any investigation occurring, against any professional license in this or any other state or jurisdiction?		
3.	Have you ever withdrawn an application, had an application denied or refused, or agreed not to apply for licensure in another jurisdiction?		
4.	Have you ever been convicted of a felony or any other crime in any state or federal court or the equivalent thereof (or do you have any criminal charges pending or unresolved)?		
5.	Have you ever been found guilty of immoral or unprofessional conduct?		
6.	Have you ever violated standards of professional practice or conduct?		
7.	Are you now, or have you within the past five years, been actively addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? (Note: You may answer "No" if you are currently a participant in or have successfully completed the requirements of the Board's Health Monitoring Program.)		
8.	Do you have any mental or physical condition that would prevent you from practicing counseling with reasonable skill?		

IF YOU HAVE ANSWERED "YES" TO ANY QUESTIONS FROM 2 THROUGH 8, PLEASE ATTACH AN 8 ½ X 11 SHEET OF PAPER GIVING FULL DETAILS. INCLUDE COURTHOUSE CERTIFIED COPIES OF ANY DOCUMENTS EXPLAINING THE SITUATION, IF APPLICABLE.

VERIFICATION

I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way and that the statements in this application are true and correct to the best of my knowledge, information and belief. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 Pa. C.S, Section 4904 (relating to unsworn falsification to authorities) and may result in the suspension or revocation of my license.

_____ _____

APPLICANT'S SIGNATURE DATE

Note that disclosing your social security number on this application is mandatory in order for the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. § 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal Healthcare Integrity and Protection Data Bank. Reports to the HIPDB must include the licensee's social security number.

RECOMMENDATIONS

TO BE COMPLETED BY **TWO** LICENSED PROFESSIONAL COUNSELORS, **OR** OTHER LICENSED HEALTH CARE PROFESSIONALS. **(THE PROFESSIONAL COUNSELORS OR OTHER HEALTH CARE PROFESSIONALS CAN BE LICENSED IN ANY STATE)**

APPLICANT NAME _____

LAST **FIRST** **MIDDLE** **MAIDEN**

I hereby certify that to the best of my knowledge, the applicant is of good moral character and he/she is not currently under the addicting influence of alcohol, a narcotic or other habit-forming drug. I recommend the applicant for a license to practice professional counseling in the Commonwealth of Pennsylvania.

_____

SIGNATURE OF RECOMMENDING PROFESSIONAL **DATE** **STATE WHERE LICENSED**

_____

PRINT OR TYPE NAME **PROFESSION** **LICENSE NUMBER**

_____

ADDRESS **DAYTIME TELEPHONE**

I hereby certify that to the best of my knowledge, the applicant is of good moral character and he/she is not currently under the addicting influence of alcohol, a narcotic or other habit-forming drug. I recommend the applicant for a license to practice professional counseling in the Commonwealth of Pennsylvania.

_____

SIGNATURE OF RECOMMENDING PROFESSIONAL **DATE** **STATE WHERE LICENSED**

_____

PRINT OR TYPE NAME **PROFESSION** **LICENSE NUMBER**

_____

ADDRESS **DAYTIME TELEPHONE**

Return completed form to applicant. The entire form is to be submitted by the applicant with pages 1 & 2 of the application.

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VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE
(Licensure by examination)

MASTER'S DEGREE **- YOUR SUPERVISOR (as defined in the rules and regulations) MUST COMPLETE THE FOLLOWING PAGES (4, 5 and 6) VERIFYING COMPLETION OF 3 YEARS OR 3600 HOURS OF SUPERVISED CLINICAL EXPERIENCE IN PROFESSIONAL COUNSELING WHICH WERE OBTAINED AFTER THE COMPLETION OF 48 SEMESTER HOURS OR 72 QUARTER HOURS OF GRADUATE COURSEWORK AND STATISFIES THE CRITERIA OF SECTION 49.13(b)(9).**

DOCTORAL DEGREE **– YOUR SUPERVISOR (as defined in the rules and regulations) MUST COMPLETE THE FOLLOWING PAGES (4, 5 AND 6) VERIFYING COMPLETION OF 2 YEARS OR 2400 HOURS OF SUPERVISED CLINICAL EXPERIENCE IN PROFESSIONAL COUNSELING. 1 YEAR OR 1200 HOURS OF WHICH WAS OBTAINED SUBSEQUENT TO THE GRANTING OF THE DOCTORAL DEGREE.**

A total of 3600 hours of supervised clinical experience must be completed.

If more than one supervisor, please make a copy of the verification of supervised clinical experience pages and have each supervisor complete a verification.

Applicant's Name: _____
Last First Middle

Supervisor's qualifications: Please check all that apply.

1800 hours of supervised clinical experience must be completed under an individual that meets the requirements of Section 49.3(1) and if the supervised clinical experience was completed prior to January 1, 2006, may be completed under an individual that meets the requirements of Section 49.3(3).

☐ Holds a license as a professional counselor and has 5 years of experience within the last 10 years as a professional counselor (Section 49.3(1)). **Supervisor must hold a current license in the state where the supervised clinical experience has occurred.**

☐ Holds a license and has at least a master's degree in a related field and has 5 years of experience within the last 10 years in that field (Section 49.3(2)). **Only 1800 hours of supervised clinical experience may be completed under a supervisor meeting this qualification. Supervisor must hold a current license in the state where the supervised clinical experience has occurred.**

☐ Practices as a professional counselor. Has 5 years experience within the last 10 years as a professional counselor (Section 49.3(3)). **This qualification is for supervised clinical experience completed prior to January 1, 2006.**

Supervisor's Name: _____
Please print

Supervisor's Address: _____
Street

_____
City State Zip

License Number_____ Profession_____ State_____

(Pages 4, 5 and 6 must all be submitted together)

Location where Supervised Clinical Experience was gained:

Name: _____
Please print

Address: _____
Street

_____
City State Zip

Dates of Supervised Experience: _____ **/** _____ **/** _____ **to** _____ **/** _____ **/** _____
month day year month day year

Total Number of Hours of Supervised Experience Worked: _____
(Verification of all supervised clinical hours worked)

Hours per week Applicant worked: _____

Hours per week Supervisor met with Applicant (individual): _____
(At least 90 hours of face to face individual supervision must be completed.)

Hours per week Supervisor met with Applicant (group): _____
(90 hours of group supervision may be completed.)

As per Section 49.13(b)(5) The supervisor, or one to whom supervisory responsibilities have been delegated, shall meet with the supervisee for a minimum of 2 hours for every 40 hours of supervised clinical experience. At least 1 of the 2 hours shall be with the supervisee individually and in person, and 1 of the 2 hours may be with the supervisee in a group setting and in person.

As per Section 49.13(b)(9) The supervised clinical experience shall be completed in no less than 2 years and no more than 6 years, except that no less than 600 hours and no more than 1,800 hours may be credited in any 12-month period.

_____ _____
Signature of Supervisor Date

Form must be completed by supervisor; any attachments must be signed and dated by supervisor. As per Section 49.13(b) (1) At least one-half of the experience shall consist of providing services in one or more of the following areas:

Please check all that apply

☐ (i) Assessment

☐ (ii) Counseling

☐ (iii) Therapy

☐ (iv) Psychotherapy

☐ (v) Other therapeutic interventions

☐ (vi) Consultation

☐ (vii) Family Therapy

☐ (viii) Group Therapy

For any additional supervised clinical experience completed, please provide a detailed list of duties performed.
A copy of a job description is not acceptable.

I verify that the statements in this verification of Clinical Supervised Experience are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 (relating to unsworn falsification to authorities) and may result in the suspension or revocation of my license. I also verify that I have complied with Section 49.3 and Section 49.13(b) and Section 49.14 of Title 49 Standards for supervisors.

_____ _____

Signature of Supervisor Date

(Pages 4, 5 and 6 must all be submitted together)
RETURN ALL PAGES (4, 5 and 6) TO THE APPLICANT IN SEALED ENVELOPE