State of New Hampshire

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
DIVISION OF LICENSING AND BOARD ADMINISTRATION
Board of Mental Health Practice
7 Eagle Square, Concord, NH 03301-2412
Phone: 603-271-2152

INSTRUCTIONS AND CHECKLIST

APPLICATION INFORMATION FOR LICENSURE AS A CLINICAL MENTAL HEALTH COUNSELOR

Prior to completing the application, it is strongly recommended that all applicants review administrative rules Mhp 100-500 online at www.oplc.nh.gov/board-mental-health-practice and verify that all educational, exam, and supervision requirements are met. It is also recommended that applicants maintain a copy of their application for their records.

All applicants must pass the National Clinical Mental Health Examination (NCMHCE) prior to submitting an application for licensure.

There is a non-refundable application fee which must be in the form of a check or money order payable to the State of New Hampshire. All fees must accompany the completed application. Upon approval of meeting all requirements a letter of notification is mailed to applicants. At that time the license fee ($135.00) will be requested.

Please make sure all of the following information is included when submitting your application packet to the Board office:

1. A completed application booklet, photograph and resume.
2. A completed Summary of Supervised Clinical Experience form.
3. A completed Supervisor's Confirmation of Clinical Experience form(s) in an envelope that has been signed and sealed by the supervisor. At least one supervisor must also complete a professional reference form.
4. A completed License Verification form from another jurisdiction that has been signed and sealed by the state (if applicable).
5. Three Professional Reference forms that have been signed and sealed by each reference. At least one (1) professional reference form shall be from a supervisor.
6. An official undergraduate **and** master's/or doctoral transcript in an envelope that has been sealed by the school.
7. Proof of passing the NCMHCE. If you took the exam in NH, not more than two years ago, it is likely we have it on file. If you took it out of state or more than two years ago include a copy of your score in an envelope that has been sealed by Center for Credentialing and Education (CCE).
8. New Hampshire Criminal Offender Record Report with fingerprints as outlined in RSA 330-A:15-a.
9. A check or money order payable to the State of New Hampshire - Treasurer. Refer to our fees page for amount.

All application materials should be submitted to:

NH Board of Mental Health Practice
7 Eagle Square
Concord, NH 03301

April 23, 2015

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APPLICATION FOR LICENSURE FOR:

CLINICAL MENTAL HEALTH COUNSELOR

(TYPE OR PRINT CLEARLY)

(a) PRINT NAME..... .....
Type or Print Name exactly as it should appear on the license

Your Full Name if different from (a) above..... .....

Street Address.....

Mailing Address..... .....

City.....State.....Zip.....Telephone..... .....
List place of current employment (if any) and address:

Place..... .....

Address..... State.....Zip.....Telephone. .....

Height..... Weight..... Hair Color.....Eye Color.....

Birthplace.....Date of Birth.....

Sex.....Soc Sec No...../...../..... E-mail……

(b) List any other names used (eg.maiden name), and dates used.

(c)List all residences used in the previous five years.

(d)List the name(s), address(es), and degree(s) awarded from all colleges/junior colleges attended at either the undergraduate or graduate level.

College/University Address Degree Dept. Mo/Yr Awarded Major

.....……

.....……

.....……

(e) Indicate, by marking the appropriate space, if you have previously taken the examination required by your profession:

[ ] Mental Health Counselors - National Clinical Mental Health Counselor Exam from NBCC

(f) If you have indicated in section (e) that you have previously taken the exam please include a copy of your exam score in an envelope that has been sealed by the testing company.

(g) Was any part of your graduate study online, telephonic, or other remote learning? Circle one Yes No

(h) Was your graduate program in clinical mental health counseling approved by the Council for Accreditation of Counseling or Related Educational Programs (CACREP)? Circle one Yes No

If yes, please include a one page verification from your program's materials, or a letter from your program that states this status.

(i) Your signature on this document indicates that you have included an original certified copy of both undergraduate and graduate complete academic transcripts showing dates of attendance, courses taken, grades and class hours earned, programs completed and degrees awarded by colleges and universities in an envelope that has been signed and sealed by the school.

(j) If you have ever held a certificate or license to practice, or have been refused a certificate/license in any state/jurisdiction, please complete the CERTIFICATE/LICENSE VERIFICATION form and forward it to the board(s) or jurisdiction(s) applicable. Correspondence from those board(s) or jurisdiction(s)should be sent back to y9ou in a signed sealed envelop to include with your application. List this information below.

Dates held	**State or Jurisdiction**	**Cert/Lic #**	**Status (Reason if no longer held)**
.....	.....	.....	.....
.....	.....	.. ..	.....

(k) If you have ever been convicted of a felony or misdemeanor, then attach a separate sheet, including the name of the court, the details of the offense, the date of conviction, and the sentence imposed.

(l) If you have ever been treated for drug or alcohol addiction or abuse, or have ever been hospitalized for any mental or emotional illness, then attach a separate sheet, including details of the treatment, current treatment, and effects of treatment.

Continued on page 3

(m) Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or have you ever been withdrawn or failed to proceed with an application for any of the following: (if you answer yes to any of these questions please provide full information on a separate sheet):

1. License or certificate to practice in any state or jurisdiction..... yes[ ] no[ ]
2. Academic appointment.....… yes[ ] no[ ]
3. Membership on any hospital medical or allied health provider staff... yes[ ] no[ ]
4. Provider status with any group, health maintenance organization etc. yes[ ] no[ ]
5. Clinical privileges..... ... yes[ ] no[ ]
6. Privileges or rights on any medical or clinical staff..... yes[ ] no[ ]
7. Any other institutional affiliation or status…… yes[ ] no[ ]
8. Professional society or association membership or fellowship..... yes[ ] no[ ]
9. Professional Office..... yes[ ] no[ ]
10. Board Certification..... yes[ ] no[ ]
11. Any other type of professional sanction..... yes[ ] no[ ]
12. Have any judgments or settlements been made against you in professional liability cases or are there any pending law suits?..... yes[ ] no[ ]
13. Have you ever been convicted of a felony or misdemeanor crime?..... yes[ ] no[ ]
14. Have you ever had a charge of felony or misdemeanor criminal conduct which has been filed with the court, but not yet been finally resolved by a dismissal or judgment of "not guilty"?..... yes[ ] no[ ]
15. Have you ever been convicted of a drug or alcohol related offense?..... yes[ ] no[ ]
16. To your knowledge, have you been the subject of an individual focused review required by a Professional Review Organization (PRO) or a similar agency?..... yes[ ] no[ ]
17. Have you been the subject of a malpractice or civil suit involving the practice of your profession or any other health care profession?..... yes[ ] no[ ]
18. Have you ever been charged or convicted of a crime(felony) in any state or country?..... yes[ ] no[ ]
19. Have there been any complaints, charges of violation of any ethical codes, professional misconduct, unprofessional conduct, incompetence or negligence made against you?..... yes[ ] no[ ]
20. Do you have any of the above (#19) pending against you ?..... yes[ ] no[ ]
21. Have you ever been required to surrender any license/certificate?..... yes[ ] no[ ]
22. Have you ever entered into a consent decree regarding a violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country by any licensing board or professional ethics body?..... yes[ ] no[ ]
23. Have you ever been previously licensed with this Board?..... yes[[no[ ]
(If yes, please provide a written description of the type of work you have been doing since your license expired, whether in NH or elsewhere.)

(n) Checks or money order, made out to the TREASURER, STATE OF NEW HAMPSHIRE, must be enclosed with this application (indicate with an "X" the appropriate fee):

[ ] Initial application fee for all applicants $150.00

If your application for licensure is approved you will be issued a license valid for two years. At the time of approval you will be notified to send $135.00 to cover the license fee.

(o) Attach a recent 2 x 2 passport quality photo taken within 90 days of the date on the application.

_____

ALL OF THE ABOVE STATEMENTS, AND ALL STATEMENTS AND INFORMATION CONTAINED IN THIS APPLICATION ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I ACKNOWLEDGE THAT THE PROVISION OF FALSE INFORMATION IN THE APPLICATION IS A BASIS FOR DENIAL OF THE APPLICATION AND DISCIPLINARY ACTION BY THE BOARD.

I SHALL NOTIFY THE BOARD IN WRITING WITHIN 30 DAYS OF ANY CHANGE IN THE INFORMATION CONTAINED IN THIS APPLICATION, EVEN AFTER THE APPLICATION IS GRANTED, AND I CONSENT TO THE BOARD'S USE OF THE MAILING ADDRESS PROVIDED IN THE APPLICATION FOR ALL PURPOSES UNDER RSA 330-A AND MHP 100-500.

I,_____,HEREWITH APPLY FOR LICENSURE AS A/AN

[ ] CLINICAL MENTAL HEALTH COUNSELOR

IN ACCORDANCE WITH RSA 330-A AND MHP 100-500 OF THE NEW HAMPSHIRE BOARD OF MENTAL HEALTH PRACTICE, AND HEREBY CERTIFY THAT I AM THE APPLICANT IDENTIFIED IN THIS APPLICATION AND THAT ALL STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND THAT THE ENCLOSED PHOTOGRAPH IS A TRUE LIKENESS OF MYSELF.

_____ _____

Applicant's signature Date

Attach check here please.

State of New Hampshire

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SUMMARY OF SUPERVISED CLINICAL EXPERIENCE GRID SHEET

ALL APPLICANTS NEED TO COMPLETE THIS FORM AND SUBMIT IT WITH YOUR APPLICATION PACKET. THE HOURS ON THIS FORM SHOULD MATCH THE HOURS VERIFIED ON THE SUPERVISOR'S CONFIRMATION OF CLINICAL EXPERIENCE FORM BY PRESENT AND/OR PAST SUPERVISORS.

APPLICANT'S NAME _____

START AND END DATE OF POST-GRAD SUPERVISION	NAME OF FACILITY	NAME OF SUPERVISOR	TOTAL HOURS OF FACE-TO-FACE SUPERVISION	TOTAL HOURS OF CLINICAL WORK EXPERIENCE*
TOTAL HOURS OF SUPERVISED CLINICAL EXPERIENCE				

*THE TOTAL HOURS OF CLINICAL WORK EXPERIENCE IS DETERMINED BY THE NUMBER OF HOURS WORKED PER WEEK TIMES THE NUMBER OF WEEKS WORKED.

BY SIGNING BELOW, I CERTIFY THAT THE FOREGOING IS CORRECT TO THE BEST OF MY KNOWLEDGE.

APPLICANT'S SIGNATURE_____DATE _____

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Supervisor's Confirmation of Clinical Experience

To be completed by the applicant and forwarded to the supervisor of clinical experience

Request to the Supervisor and Release of Information to the Board

Please send one form to each supervisor and have them **return it to you** in a signed sealed envelope.

I am applying for licensed **CLINICAL MENTAL HEALTH COUNSELOR** in the State of New Hampshire. The Board of Mental Health Practice requires confirmation of post-graduate clinical experience. This is your authority to release any information you have in your files, favorable or otherwise.

Applicant's Name_____

Address_____

City_____State_____Zip_____

Signature_____Date_____

Summary of Post-Masters Supervised Clinical Experience

Name of Facility_____

Address of Facility_____

Applicant's Title at the time of supervision_____

Dates of Supervised Clinical Experience: From: month_____year_____To: month_____year_____

FACE-TO-FACE Individual Supervision: Hours/Week____TOTAL supervised face-to-face hours_____

Total Hours of Paid Post-Master's Supervised Clinical Work Experience*_____
(* # of hours worked per week X # of weeks worked)

If the supervision took place in New Hampshire was an approved Candidate for Licensure/Supervision Agreement on file in the Board office prior to commencement of the supervision? YES NO

CONTINUED ON NEXT PAGE – PLEASE STAPLE TOGETHER

SUPERVISOR'S CONFIRMATION

Supervisor: Please provide (typed and attached to this form)

1) **A description of the supervisory methods and the types of issues dealt with during supervision,**
2) **A description of the type of work performed by the applicant, and**
3) **A description of the quality of work performed by the applicant.**

(Please Print Clearly)

Name_____

Title at the time of Supervision_____

Address_____

Highest degree earned_____

Licensed as a/an_____By (state)_____License#_____

Issue Date_____

Phone Number _____

Signature_____Date_____

Licensure Verification Form

New Hampshire Board of Mental Health Practice

RELEASE OF INFORMATION FROM OTHER LICENSING AUTHORITIES

I am applying for licensed clinical mental health counselor in the State of New Hampshire. The NH Board of Mental Health Practice requires that the following form be completed by each jurisdiction in which I am now or was previously licensed. This constitutes your authority to release any and all information in your files, favorable or otherwise to the NH Board of Mental Health Practice. Please complete the form, put it in a sealed envelope, sign the back of the envelope and **RETURN IT TO THE APPLICANT.**

Biographic Information:

Last Name _____ First Name _____ Middle Name _____ Gen. Suffix _____

Mailing Address _____ City _____ State _____ Zip Code _____

Date of Birth: _____

License Number (if known) _____ Signature _____

The following should be completed by the licensing authority and returned directly to the applicant in a sealed envelope signed across the back.

1. Name of Licensing Authority: _____
2. Full Name of Licensee: _____
3. License Number: _____
4. Is License Current? Yes No Expiration Date: _____
5. Is License Restricted? Yes No
6. Previous Disciplinary Action? Yes No
7. Pending Investigations? Yes No

If the answer is yes to questions 5, 6 or 7, please attach supporting information.

Please affix official Board seal here

_____
Signature/Title

April 23, 2015

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Professional Reference Form

TO BE COMPLETED BY APPLICANT AND FORWARDED TO THE REFERENCE:

I am applying for (check one that applies) [ ] Licensed Independent Clinical Social Worker; [ ] Licensed Clinical Mental Health Counselor; [ ] Licensed Marriage and Family Therapist; [ ] Licensed Pastoral Psychotherapist. The New Hampshire Board of Mental Health Practice requires professional references. THIS IS YOUR AUTHORITY TO RELEASE ANY INFORMATION YOU HAVE IN YOUR FILE FAVORABLE OR OTHERWISE. **RETURN THIS FORM TO THE APPLICANT IN A SIGNED SEALED ENVELOPE.**

(Please print legibly)
Name_____ Address_____

Signature_____ Date _____

TO BE COMPLETED BY REFERENCE:

Professional relation to applicant_____

Length of time you've known applicant: From (Mo/Yr)_____to (Mo/Yr) _____

Please provide a brief description of your knowledge of the applicant's professional and ethical behavior. _____

_____

_____

_____

Title of applicant's position and name of organization he/she was employed at when you worked with them_____

Brief description of applicant's duties & responsibilities: _____

_____

_____

Area of applicant's specialties: _____

Do you attest and certify that the applicant is an individual of good moral character?

[ ] Yes [ ] No

If No, please explain_____

_____

If you are aware that the applicant has been or is the subject of any malpractice or civil suit involving the practice of their profession, or if they have been charged or convicted of a crime in any state or country; the disposition of which was other than acquittal or dismissal; or if there have been or are any complaints or charges of violation of the ethical codes, professional misconduct, unprofessional conduct, incompetence or negligence made or pending against them; or that they have ever been required to surrender their license/certification or have been found guilty of, or have entered into a consent decree regarding a violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country by any licensing board or professional ethics body; please clarify those circumstances and the current status of the applicant below.

_____

_____

_____

Quality and extent of your endorsement:

[ ] Without Reservation [ ] With Reservation [ ] No Recommendation

If you checked "With Reservation," please elaborate_____

_____

_____

THIS FORM IS TO BE RETURNED TO THE APPLICANT IN A SIGNED SEALED ENVELOPE.

Signature of Reference _____ Date _____

(Please Print)

Name_____

Address_____

Phone Number_____Title_____Degree_____

Licensed/Certified (Specialty)_____State_____

License Number _____

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Do you attest and certify that the applicant is an individual of good moral character?

[ ] Yes [ ] No

If No, please explain_____

_____

If you are aware that the applicant has been or is the subject of any malpractice or civil suit involving the practice of their profession, or if they have been charged or convicted of a crime in any state or country; the disposition of which was other than acquittal or dismissal; or if there have been or are any complaints or charges of violation of the ethical codes, professional misconduct, unprofessional conduct, incompetence or negligence made or pending against them; or that they have ever been required to surrender their license/certification or have been found guilty of, or have entered into a consent decree regarding a violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country by any licensing board or professional ethics body; please clarify those circumstances and the current status of the applicant below.

_____

_____

_____

Quality and extent of your endorsement:

[ ] Without Reservation [ ] With Reservation [ ] No Recommendation

If you checked "With Reservation," please elaborate_____

_____

_____

THIS FORM IS TO BE RETURNED TO THE APPLICANT IN A SIGNED SEALED ENVELOPE.

Signature of Reference _____ Date _____

(Please Print)

Name_____

Address_____

Phone Number_____Title_____Degree_____

Licensed/Certified (Specialty)_____State_____

License Number _____

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Signature_____ Date _____

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_____

_____

_____

Title of applicant's position and name of organization he/she was employed at when you worked with them_____

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Do you attest and certify that the applicant is an individual of good moral character?

[ ] Yes [ ] No

If No, please explain_____

_____

If you are aware that the applicant has been or is the subject of any malpractice or civil suit involving the practice of their profession, or if they have been charged or convicted of a crime in any state or country; the disposition of which was other than acquittal or dismissal; or if there have been or are any complaints or charges of violation of the ethical codes, professional misconduct, unprofessional conduct, incompetence or negligence made or pending against them; or that they have ever been required to surrender their license/certification or have been found guilty of, or have entered into a consent decree regarding a violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country by any licensing board or professional ethics body; please clarify those circumstances and the current status of the applicant below.

_____

_____

_____

Quality and extent of your endorsement:

[ ] Without Reservation [ ] With Reservation [ ] No Recommendation

If you checked "With Reservation," please elaborate_____

_____

_____

THIS FORM IS TO BE RETURNED TO THE APPLICANT IN A SIGNED SEALED ENVELOPE.

Signature of Reference _____ Date _____

(Please Print)

Name_____

Address_____

Phone Number_____Title_____Degree_____

Licensed/Certified (Specialty)_____State_____

License Number _____