NH BOARD OF MENTAL HEALTH PRACTICE
121 SOUTH FRUIT STREET
CONCORD NH 03301

PHONE - 603-271-2702
FAX – 603-271-6702

REQUEST TO SIT FOR ASWB CLINICAL EXAM

This form must be completed and filed with the Board before you will be allowed to register for the exam with ASWB. This process generally takes 3-5 days once it is received at the Board office.

Name: _____
(Print clearly) This name must match the one on the photo ID you will present at the test site.

Address:_____

_____

Phone Number: _____

Social Security Number:_____

Date of Birth:_____

Email address:_____

You must have an approved Candidate for Licensure: Agreement on file with the Board to sit for the ASWB Clinical Exam.

I have an approved Candidate for Licensure: Agreement on file with the NH Board of Mental Health Practice: (circle one) YES NO

Signature_____ Date:_____

The Board will notify you by email with details on how to register for the exam once you are approved.

6/10/2014