



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

REINSTATEMENT APPLICATION

(Use this application if your license has been expired less than six months)

PLEASE PRINT OR TYPE

Name _____

Business Address _____

Home Address _____

Business Phone # _____ Home Phone # _____

Email Address _____

License # before expiration of license _____

I was licensed as a: LPP LICSW LCMHC LMFT (Please circle one)

Your mailing address is available to the public. Please designate at which address you prefer your mail: Circle one: Home **or** Business

Please answer the following questions:

1) Have you practiced mental health while your license was expired? YES _____ NO _____

2) Have any malpractice claims been made against you since you last renewed your NH license? YES _____ NO _____

3) Have you been denied a psychology, pastoral psychotherapist, social work, mental health counselor or marriage and family therapist license, certificate or registration anywhere for any reason since you last renewed your NH license? YES _____ NO _____

4) Do you have any formal disciplinary charges pending in any other state or jurisdiction?
YES _____ NO _____

5) Do you have any complaints pending in another jurisdiction? YES _____ NO _____

6) Have you been found civilly liable for professional misconduct, guilty of any criminal offense, or found to have committed an ethical violation by a state or national professional association or any other state's regulatory Board since you last renewed your NH license? YES _____ NO _____

7) Have you entered into a Settlement Agreement with any state outside of New Hampshire since you last renewed your NH license? YES _____ NO _____

8) Do you have an emotional disturbance, mental illness, organic illness, or additive disorder which would impair you to practice mental health counseling, and if so, a description of the treatment received and the outcome of such treatment?
YES _____ NO _____

If you answered yes to any of the above questions please attach a written explanation.

Be sure to attach all CEU certificates and a statement as to how you fulfilled the collaboration requirement. Be sure to include at least two names of licensed professionals you have collaborated with and a short description of the kinds of issues discussed.

By signing this application I acknowledge that the provision of false information in the application is a basis for disciplinary action by the board.

Signature

Date

**Be sure to enclose your check made payable to: State of New Hampshire
Reinstatement fee for two-year license - \$300.00**

Mail this Reinstatement Application and your check to:

**NH Board of Mental Health Practice
7 Eagle Square
Concord, NH 03301
603-271-2152**