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: PP SW MHC MFT (Please circle one)

PLEASE SEND MY MAIL TO MY HOME or BUSINESS (Please circle one)

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.

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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
121 South Fruit Street
Concord, NH 03301
603-271-6762