



**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**