Application for Licensure as a Clinical Social Worker, Marriage & Family Therapist or Mental Health Counselor by Examination

Board *of* Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: FloridasMentalHealthProfessions.gov
Email: MQA.491@FLHealth.gov
Phone: (850) 245-4292
Fax: (850) 413-6982

DH-MQA 1174, Revised 5/2025, Rule 64B4-3.001, F.A.C.

Are you an active-duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at http://www.FLHealthSource.gov/valor.

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Do Not Write in this Space
For Revenue Receipting Only

Select profession:

Clinical Social Work (5201)	**$180.00**
Marriage & Family Therapy (5202)	**$180.00**
Mental Health Counseling (5203)	**$180.00**

Total fee of $180.00 includes the following:

Application Fee	$100.00
Initial Licensure Fee	$75.00
Unlicensed Activity Fee	$5.00

Are you a registered intern in Florida? Yes No

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to an $80.00 (Initial Licensure Fee and Unlicensed Activity Fee) refund. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone

Practice Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)

_____ _____ _____
Street Suite No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone

EQUAL OPPORTUNITY DATA:
We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: Male Female

Race: Native Hawaiian or Pacific Islander; American Indian or Alaska Native; Two or More Races; Hispanic or Latino; Black or African American; White; Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

U.S. Social Security Number: _____

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

B. Do you hold, or have you ever held a license to practice any counseling-related profession or any other health-related license(s)? Yes No

C. List all health-related licenses (active, inactive, or lapsed).

License Type	License #	State / Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

Staff will attempt to complete verifications online. If unavailable online or if the online verification lacks sufficient detail, you will be required to request an official verification from your state. License verifications must be received directly from the licensing authority. A copy of your license will not be accepted in lieu of official verification from the licensing agency.

D. Do you have any applications for licensure in a counseling-related profession currently pending in any state (including Florida), U.S. territory, or foreign country? Yes No

E. List all pending applications for licensure in a counseling-related profession.

License Type	State / Country

4. AVAILABILITY FOR DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? Yes No

If you respond "Yes," your name will be added to a listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

Name: _____

5. EDUCATION HISTORY

Complete the appropriate education worksheet for your profession, found at the back of the application. Education worksheets are not required for Florida-registered interns. **The completed worksheet must be included with your application.**

A. List all schools where you completed coursework in specific content areas to receive a master's or doctoral degree in the profession for which you are applying. All schools listed below must be consistent with the schools provided on the education worksheet for your profession.

School Name	Major	Degree Conferred Date (MM/DD/YYYY)	Degree Awarded (if applicable)

Applicants must request an official transcript from the accredited institution(s) from which you received your degree or have taken coursework. **Transcripts must be sent directly to the board office from the registrar's office of the institution and include a degree conferred date or they will not be considered official.** Transcripts may be sent via email if the institution can send official digital transcripts using a secure transcript clearinghouse or parchment service. The transcript download link can be sent directly to MQA.491@FLHealth.gov. **Transcripts are not required for Florida-registered interns whose education has been certified complete.**

If the course title on the transcript does not clearly identify the content of the coursework, a course description or syllabus will be required.

The following documentation is <u>required</u> for proof of Practicum, Internship, or Field Experience:

An official of the school (Dean, Department Chair) that awarded your graduate degree must provide a letter on university letterhead verifying that the supervised practicum, internship, or field experience was completed. Specific requirements for each profession can be found on the appropriate education worksheet.

B. **For clinical social work applicants <u>only</u>:** Were you an advanced standing student? Yes No

If "Yes," you must provide a letter on university letterhead from an official of the school which awarded your master's degree in social work, verifying the specific courses and number of semester hours completed at the baccalaureate level which were used to waive or exempt completion of similar courses at the graduate level.

Applicants educated outside the United States or Canada:

Any document in a language other than English must be translated into English by a board-approved translation/education evaluation service. Accepted evaluators can be found at https://FloridasMentalHealthProfessions.gov/forms/Foreign-Credential-Evaluators.pdf.

Clinical Social Work- If you received your master's degree in social work from a program outside the U.S. or Canada, documentation must be received that the program was determined to be equivalent to programs approved by the Foreign Equivalency Determination Service of the Council on Social Work Education (CSWE). To contact the CSWE, visit http://www.cswe.org or call (703) 683-8080.

Marriage and Family Therapy / Mental Health Counseling - For the board to consider education completed outside the U.S. or Canada, documentation must be received which verifies the institution at which the education was completed was equivalent to a U.S. institution accredited by an institutional accrediting body recognized by the Council for Higher Education Accreditation or its successor organization during enrollment and up to the time of graduation, and the coursework met the content and credit hour requirements for graduate level coursework in the U.S. It is the applicant's responsibility to obtain an evaluation from a recognized foreign equivalency determination service that documents the acceptability of the coursework. The board office must receive an original evaluation mailed directly from the educational evaluation service.

Name: _____

The following continuing education courses are required for licensure:

A. Have you completed the required 8-hour Florida Laws and Rules course? Yes No

Florida Laws and Rules Course Title	Provider Name	Date Completed (MM/DD/YYYY)

B. Have you completed the required 3-hour HIV/AIDS course? Yes No

HIV/AIDS Course Title	Provider Name	Date Completed (MM/DD/YYYY)

If you have not completed the 3-hour HIV/AIDS course, you may submit the HIV/AIDS Affidavit found at the back of this application, attesting you will complete the course within six months.

Board-approved providers and courses can be found at www.cebroker.com.

Documentation must be sent to the board office at MQA.491@FLHealth.gov, or by mail to:

Board *of* Clinical Social Work, Marriage & Family Therapy
and Mental Health Counseling
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

6. CLINICAL EXPERIENCE

List in chronological order all professional and supervised experience in the profession for which you are applying.

Dates of Experience (From-To) MM/DD/YYYY	Place of Employment	Hours Worked per Week	Supervisor Name
to			
to			
to			
to			
to			
to			

Applicants must complete the "Verification of Clinical Experience" form documenting two years of post-master's supervised clinical experience**.** Either you or your supervisor(s) may send the completed form(s) to the board office.

Out-of-State Supervised Experience - Supervisors not licensed in Florida must submit additional information with the "Verification of Clinical Experience" form:

Licensed supervisors: Submit proof of licensure with the original date of issuance and the expiration date. Most states list this information on their website (print and submit the page) or request a written verification.

Unlicensed supervisors: Submit proof they meet all educational requirements with copies of graduate level transcripts.

Two years of Supervised Clinical Experience is equal to:

Experience
At least 1,500 hours of psychotherapy provided face-to-face with clients, accrued in no less than 100 weeks.

Supervision
At least 100 hours of supervision in no less than 100 weeks, at least 1,500 hours of psychotherapy provided face-to-face with clients, and at least one hour of supervision every two weeks.

7. EXAMINATION HISTORY

For information regarding application deadlines, examination approval, and examination dates, visit FloridasMentalHealthProfessions.gov/resources/exam-schedule/.

Have you passed the national clinical examination for the profession in which you are applying? Yes No

If "Yes," provide the following:

Exam Name: _____ Date passed: _____
MM/DD/YYYY

If you have passed the national clinical examination for your profession and did not take the examination as a Florida-registered intern, you must request an official score report to be sent directly to the board office. Scores are only accepted from other state boards and the following:

Licensed Clinical Social Worker scores accepted from the Association of Social Work Boards (ASWB).

Licensed Marriage and Family Therapist scores accepted from the Association of Marital and Family Therapy Regulatory Boards (AMFTRB).

Licensed Mental Health Counselor scores accepted from the National Board of Certified Counselors (NBCC).

Applicants requiring Special Testing Accommodations:

Licensed Clinical Social Work candidates requiring special accommodations must contact the Association of Social Work Boards (ASWB) directly to arrange testing accommodations. Contact ASWB at 800-225-6880 extension 3250 or at http://www.aswb.org.

Licensed Marriage and Family Therapy candidates requiring special accommodations must submit an application for special testing accommodations to the Professional Testing Corporation (PTC) **no later than 60 days prior** to sitting for the examination. Candidates must submit their request using the "Request for Test Accommodations Form" found online at https://ptcny.com/candidate-corner/request-accommdations/. Contact the PTC by phone at 212-356-0660.

Licensed Mental Health Counseling candidates requiring special accommodations must submit a request form to the National Board for Certified Counselors (NBCC). A Computer-Based Testing Special Accommodations Request form is located in the NCMHCE Candidate Handbook, which can be downloaded at the NBCC website at www.nbcc.org.

This information is exempt from public records disclosure.

8. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? Yes No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? Yes No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? Yes No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? Yes No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? Yes No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

A letter from a Licensed Health Care Practitioner, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

A written self-explanation, identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

9. DISCIPLINE HISTORY

A. Have you ever been denied a psychotherapy or counseling-related license or the renewal thereof in any state? Yes No

B. Have you ever been denied the right to take a psychotherapy or counseling-related licensure examination? Yes No

C. Have you ever had a license to practice any profession revoked, suspended, or otherwise acted against in a disciplinary proceeding in any state? Yes No

D. Is there currently pending, in any jurisdiction, a complaint or investigation against your professional conduct or competency? Yes No

E. Have you ever been involved in, reprimanded for, or disciplined by an employer or educational institution for misconduct including fraud, misrepresentation, academic misconduct, theft, or sexual harassment? Yes No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y N
				Y N
				Y N
				Y N

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint** and **Final Order**.

10. CRIMINAL HISTORY

*For the question below, you **must include** all misdemeanors and felonies, even if adjudication was withheld. Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are **not** minor traffic offenses for purposes of this question.*

*Pursuant to s. 943.0585(6)(b), Florida Statutes, and s. 943.059(6)(b), Florida Statutes, an applicant seeking to be licensed by the Department of Health **must disclose** expunged and sealed criminal history records.*

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? Yes No

If you responded "Yes," complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				Y N
				Y N
				Y N

If you responded "Yes" in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding each offense; including dates, city and state, charges, and final results.

Final Dispositions and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

Completion of Sentence Documents. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

11. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), Florida Statutes.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? Yes No

If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), Florida Statutes)? Yes No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? Yes No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Yes No

If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? Yes No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, Florida Statutes? Yes No

If you responded "No" to the question above, skip to question 4.

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? Yes No

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes No

If you responded "No" to the question above, skip to question 5.

   a. Have you been in good standing with a state Medicaid program for the most recent five years? Yes No

   b. Did termination occur at least 20 years before the date of this application? Yes No

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? Yes No

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? Yes No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? Yes No

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

Supporting documentation including court dispositions or agency orders where applicable.

Documentation for sections 8 and 9 must be sent to the board office via email at MQA.491@FLHealth.gov, or mailed to:

Board *of* Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

Documentation for sections 10 and 11 must be sent to the Background Screening Unit at MQA.BackgroundScreen@FLHealth.gov or mailed to:

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

12. LIVESCAN PRIVACY STATEMENT

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation (found in the forms following this application).

The board will not receive your Livescan results if you do not confirm the above statement by checking the box.

Electronic Fingerprinting: (Required for ALL applicants)

All applicants, including out-of-state applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan service providers that are approved by the Florida Department of Law Enforcement. For a list of approved vendors, visit our website at: http://www.FLHealthSource.gov/background-screening/.

Typically background results submitted by Livescan are received by the board within 24-72 hours of being processed. The board's ORI number is **EDOH4550Z**. The board cannot accept hard fingerprint cards or results. All results must be submitted electronically by the Livescan service provider.

The Florida Department of Health retains fingerprints on any applicant in the Care Provider Clearinghouse. One of the requirements for your Livescan to be retained in the Care Provider Clearinghouse is a photograph must be taken by the Livescan service provider at the time of fingerprinting. Your background screening results will be retained for five years. Licensees will be notified when their retention date is approaching and will be provided instructions on how to retain their fingerprints to avoid having to submit a new background screening.

Name: _____

13. APPLICANT SIGNATURE

I, the undersigned, state that I am the person identified in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, Florida Statutes.

I understand that Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

I hereby acknowledge that I have read the regulations in ch. 491, Florida Statutes, and related rules. I understand that I am under a continuing obligation to keep informed of any changes to ch. 491, Florida Statutes, and related rules. I further state that I will comply with all requirements for licensure renewal, including continuing education credits.

Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____

You may print this application and sign it or sign digitally. MM/DD/YYYY

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR ALL APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORDS RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record to be employed, licensed, work under contract, or serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Person with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of your record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, Florida Statutes, and Rule 11C-8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice
Federal Bureau of Investigation
Criminal Justice Information Services Division

PRIVACY STATEMENT

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub. L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN): Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosure to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional information: The requesting agency and/or the agency conducting the application investigation will provide additional information to the specific circumstances of this application, which may include identification of other authorities, purposes, uses and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

Board *of* Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling

Electronic Fingerprinting

Take this form with you to the Livescan service provider. Check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting a fingerprint scan using the Livescan method.
- You can find Livescan service providers at: http://www.FLHealthSource.gov/background-screening/.
- Failure to submit background screening will delay your application.
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department.
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider, the board office will not receive your background screening results.
- The ORI number for the Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling is **EDOH4550Z**.
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, **including your Social Security number (SSN)**.
- Typically background screening results submitted through a Livescan service provider are received by the board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: _____ SSN#: _____
Last First Middle

Aliases: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ ZIP: _____

Date of Birth: _____ Place of Birth: _____
MM/DD/YYYY

Weight: _____ Height: _____ Eye Color: _____ Hair Color: _____

Race: _____
(W-White/Latino(a); B-Black; A- Asian; NA-Native American; U-Unknown)

Sex: _____
(M= Male; F=Female)

Citizenship: _____

Transaction Control Number (TCN#): _____
(This will be provided to you by the Livescan service provider.)

Keep this form for your records.

Complete verifications must be mailed directly from the licensing agency to:

Board *of* Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

Board *of* Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling
License / Certification Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board seal
* Signature and title of state board official

The following information must be included in all verifications:

* Licensee name
* License number
* State or jurisdiction of licensure
* Licensure status
* Is license in good standing?
* Date of issuance and expiration
* Licensure method (examination, grandfathering, reciprocity/endorsement) If exam provide exam name, exam level, exam date, and score achieved.
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.

Board *of* Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling

CLINICAL SOCIAL WORK
EDUCATION WORKSHEET FOR EXAMINATION

Name: _____

1. GENERAL INFORMATION

You are required to complete 24 semester hours or 32 quarter hours of graduate level coursework in theory of human behavior, and practice methods as courses in clinically oriented services within an accredited school of social work program. (Only one research course may be counted towards the coursework requirement). Do **not** list fieldwork.

Course numbers and titles should be listed as they appear on your official transcripts. **You must submit a course description photocopied from a school catalog or a course syllabus for all courses listed below.**

If you were admitted to an advanced standing program, an official of the school which awarded your master's degree in social work must provide a letter on university letterhead, verifying the specific courses completed at the baccalaureate level which were used to waive or exempt completion of similar courses at the graduate level.

School Name	Course Number	Course Title	Credit Hours

2. PSYCHOPATHOLOGY

List the graduate level psychopathology course you completed within an accredited school of social work program. You must submit a course description photocopied from a school catalog or a course syllabus for the course listed.

School Name	Course Number	Course Title	Credit Hours

3. ADVANCED SUPERVISED FIELD PLACEMENT

You are required to complete a supervised field placement which was part of your advanced concentration in direct practice, during which you provided clinical services directly to clients. An official of the school (Dean, Department Chair) which awarded your graduate degree must provide a letter on university letterhead verifying:

1) That the supervised field placement was completed during the master's or doctorate program; and

2) The setting in which you provided clinical services directly to clients.

School Name	Course Number	Advanced Supervised Field Placement Course Title	Field Placement Dates: From-To (MM/DD/YYYY)
			to

Submit worksheet with your application.

MARRIAGE & FAMILY THERAPY EDUCATION WORKSHEET FOR EXAMINATION

Name: _____

If you graduated from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), check the box verifying your degree. You will not be required to verify your coursework.

☐ I graduated from a COAMFTE accredited program.

If you graduated with a master's degree with a major emphasis in marriage and family therapy or a closely related field from a university program accredited by the Council for Accreditation of Counseling and Related Education Programs (CACREP), your graduate courses must be approved by the board. Complete the coursework information below.

If you graduated with a degree with an emphasis in marriage and family therapy or a closely related field, with a degree conferred before September 1, 2027, from an institutionally accredited college or university, complete the coursework information below.

1. COURSEWORK VERIFICATION

You must indicate the graduate level course(s) you completed that satisfy the educational requirement in the content areas listed. Course numbers and titles should be listed as they appear on your official transcripts. If the course title on your transcript does not clearly identify the content of the coursework, a course description or syllabus may be required.

Each of the following content areas must have a minimum of three semester hours or four quarter hours in graduate level coursework.

Content Area	School Name	Course Number	Course Title	Credit Hours
Dynamics of Marriage and Family Systems	1.			
	2.			
Marriage Therapy and Counseling Theory and Techniques	1.			
	2.			
Family Therapy and Counseling Theory and Techniques	1.			
	2.			
Individual Human Development Theories Throughout the Life Cycle	1.			
	2.			
Psychopathology	1.			
	2.			
Human Sexuality Theory and Counseling Techniques	1.			
	2.			
Psychosocial Theory	1.			
	2.			
Substance Abuse Theory and Counseling Techniques	1.			
	2.			

MARRIAGE & FAMILY THERAPY
EDUCATION WORKSHEET FOR EXAMINATION

Name: _____

The following courses must be a minimum of one graduate-level course of three semester hours or four quarter hours.

Content Area	School Name	Course Number	Course Title	Credit Hours
Legal, Ethical, Professional Standards Issues in the Practice of Marriage & Family Therapy				
Diagnosis, Appraisal, Assessment, and Testing for Individual or Interpersonal Disorder or Dysfunction				
Behavioral Research (Course must focus on the interpretation and application of research data as it applies to clinical practice)				

Submit worksheet with your application.

Board *of* Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling

MENTAL HEALTH COUNSELING EDUCATION WORKSHEET FOR EXAMINATION

Name: _____

If the program you graduated from was not accredited by the Council for Accreditation of Counseling and Related Education Programs (CACREP) **or** if the program you graduated from was a CACREP accredited program that was not mental health counseling, then **sections 1, 2, and 3 apply to you.** (There are CACREP accredited programs in community counseling; marital, couple, and family counseling; and school counseling, for example.) If you graduated from a CACREP **clinical mental health counseling/mental health counseling program,** then **only section 4** applies to you.

Beginning July 1, 2025, an applicant must have a master's degree from a program that is accredited by the Council for Accreditation of Counseling and Related Educational Programs, the Master's in Psychology and Counseling Accreditation Counsel, or an equivalent accrediting body which consists of at least 60 semester hours or 80 quarter hours to apply for licensure as a mental health counselor.

1. GENERAL INFORMATION

Your overall degree program must be a minimum of 60 semester hours or 80 quarter hours. Within the degree program, you will be required to complete three semester hours or four quarter hours of individualized graduate level coursework at an accredited institution in each of the content areas listed below. Course numbers and titles should be listed as they appear on your official transcripts. **If the course title on your transcript does not clearly identify the content of the coursework, a course description or syllabus will be required.**

2. COURSEWORK VERIFICATION

You must indicate below the graduate level course you completed that satisfies the education requirement in the specific content area. You must have a **minimum of three semester hours or four quarter hours** to satisfy each content area.

Content Area	School Name	Course Number	Course Title	Credit Hours
Counseling Theories and Practice				
Human Growth and Development				
Diagnosis and Treatment of Psychopathology				
Human Sexuality				
Group Theories and Practice				
Individual Evaluation and Assessment				
Career and Lifestyle Assessment				
Research and Program Evaluation				
Social and Cultural Foundations				
Substance Abuse				
Legal, Ethical, and Professional Standards				

MENTAL HEALTH COUNSELING EDUCATION WORKSHEET FOR EXAMINATION

Name: _____

3. UNIVERSITY-SPONSORED SUPERVISED CLINICAL PRACTICUM, INTERNSHIP OR FIELD EXPERIENCE

You must complete at least 700 hours of university-sponsored supervised clinical practicum, internship, or field experience that includes at least 280 hours of direct clinical services as required in the accrediting standards of CACREP for mental health counseling programs.

The accrediting standards of CACREP for these hours are:

- At least 280 of these hours must be in direct service with actual clients that contributes to the development of counseling skills, including experience leading groups
- An average of one hour per week of individual and/or triadic supervision
- The opportunity for the applicant to become familiar with a variety of professional activities and resources in addition to direct service (e.g., record keeping, assessment instruments, supervision, information and referral, in-service and staff meetings)
- The opportunity for the applicant to develop program-appropriate audio/video recordings for use in supervision or to receive live supervision of the applicant's interactions with clients
- Evaluation of the applicant's counseling performance throughout the practicum/internship, including a formal evaluation after the completion of the practicum/internship hours

An official of the school (Dean, Department Chair) which awarded your graduate degree must provide a letter **on university letterhead** verifying that the supervised practicum/internship was completed in accordance with CACREP standards. **The practicum letter should also include the following:**

a. Course Title(s) of Practicum/Internship/Field Experience
b. Course Number(s)
c. School or Site Where Experience was Completed
d. Dates of Practicum/Internship or Field Experience
e. Total Number of Clock Hours Completed
f. Total Number of Direct Client Service Hours Completed

This requirement may be met by supervised practice experience which took place outside the academic arena that met the CACREP standards and was under the supervision of a qualified supervisor or the equivalent.

4. GRADUATE OF A CACREP MENTAL HEALTH COUNSELING PROGRAM

If you graduated from a **mental health counseling program** accredited by CACREP**,** your overall degree program must be a minimum of 60 semester hours or 80 quarter hours, including a course in human sexuality and a course in substance abuse.

Indicate below the graduate level course you completed that satisfies the two specific content areas. You must have a minimum of three semester hours or four quarter hours in each content area.

Content Area	School Name	Course Number	Course Title	Credit Hours
Human Sexuality				
Substance Abuse				

Submit worksheet with your application.

Board *of* Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling

HIV/AIDS AFFIDAVIT

Pursuant to s. 491.0065, Florida Statutes, and Rule 64B4-8.002, Florida Administrative Code, all initial licensure applicants are required to complete an approved education course on human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). The course must provide a minimum of three hours of HIV/AIDS education, including education on protocols and procedures applicable to HIV counseling, testing, reporting and partner notification.

An applicant who has not taken the course at the time of licensure shall, upon submission of an affidavit showing good cause, be allowed six months to complete this requirement. If you have already completed this course, send proof with the application. If you have not yet completed the course, fill out this affidavit, have it notarized, and return it with your application.

Applications are incomplete without this affidavit or proof of completion of the HIV/AIDS course.

APPLICANT STATEMENT

I, _____, am of legal age and have personal knowledge of the matters stated in
(Applicant Full Name)
this affidavit. I will complete an approved course which provides a minimum of three hours of HIV/AIDS education within the first six months of my licensure by the Department of Health.

Applicant Signature _____ Date _____
MM/DD/YYYY

NOTARY SIGNATURE

Before me, the undersigned authority, personally appeared _____ who
(Applicant Full Name)
deposes and affirms the above statement is true and correct.

State of _____ County of _____

Sworn to and/or subscribed before me this _____ day of _____, 20_____

By _____ whose identity is known to me by _____

Notary Signature _____ Printed Name of Notary _____

[NOTARY SEAL]

Submit form with application, email to MQA.491@FLHealth.gov, or mail to:

Board *of* Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

Verification of Clinical Experience

Form must be completed by the supervisor.

Applicant Name: _____

Florida Intern Registration Number/Other State License Number: _____

Select profession: Clinical Social Work Marriage & Family Therapy Mental Health Counseling

1. SUPERVISOR INFORMATION

Supervisor Name: _____

Email Address: _____

License Type	State	License Number

Supervisors licensed outside of Florida must provide a license verification.

2. SUPERVISED CLINICAL EXPERIENCE

I have read and understand Rule 64B4-2, Florida Administrative Code (F.A.C.), which states, in part:

An intern shall be credited for the time of supervision required by s. 491.005, Florida Statutes, if the intern:

a) Received at least 100 hours of supervision in no less than 100 weeks; and
b) Provided at least 1,500 hours of face-to-face psychotherapy with clients; and
c) Received at least one hour of supervision every two weeks

A. Dates of supervision: Start Date: _____ (MM/DD/YYYY) End Date: _____ *Provide specific date* - MM/DD/YYYY

B. The applicant received _____ hours of supervision, with at least one hour of supervision every two weeks.

C. The applicant provided psychotherapy face-to-face with clients for a total of _____ hours.

Select one of the following:

I intend to provide supervision until the registered intern is fully licensed pursuant to s. 491.0045(3), Florida Statutes. If this changes, I will notify the board office of the date supervision ended.

I am no longer providing this registered intern with supervision as of: _____ MM/DD/YYYY

3. SUPERVISOR STATEMENT

As the qualified supervisor of this intern, I affirmatively state that I have complied with all the duties of a qualified supervisor as established in Rule 64B4-2.0025, F.A.C., during the course of the supervision of this applicant.

Supervisor Signature: _____ Date: _____ MM/DD/YYYY