



# Application for Registration as a Registered Intern for Clinical Social Work, Marriage & Family Therapy, or Mental Health Counseling

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

P.O. Box 6330

Tallahassee, FL 32314-6330

Website: [floridasmentalhealthprofessions.gov](http://floridasmentalhealthprofessions.gov)

Email: [MQA.491@flhealth.gov](mailto:MQA.491@flhealth.gov)

Phone: (850) 245-4292

Fax: (850) 413-6982



# Application for Registration as a Registered Intern for Clinical Social Work, Marriage & Family Therapy, or Mental Health Counseling

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

P.O. Box 6330

Tallahassee, FL 32314-6330

Fax: (850) 413-6982

Email: [MQA.491@flhealth.gov](mailto:MQA.491@flhealth.gov)

Do Not Write in this Space  
For Revenue Receipting Only

Upon receipt of your application, you will be provided a file number that identifies your application. **This is not a license number and may not be used to practice in a counseling-related field.**

## Select profession:

Clinical Social Work (5207)	<b>\$150.00</b>
Marriage and Family Therapy (5208)	<b>\$150.00</b>
Mental Health Counseling (5209)	<b>\$150.00</b>

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. The \$150.00 application fee is non-refundable.

## 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 Apt. 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	Race:	Native Hawaiian or Pacific Islander	Hispanic or Latino	White
	Female		American Indian or Alaska Native	Black or African American	Asian
			Two or More Races		

**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](http://www.ssa.gov) or by calling 1-800-772-1213.

Name: \_\_\_\_\_

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 currently hold, or have you previously held a license to practice in any counseling-related profession or any other health-related field, in any state, apart from the license(s) you are applying for?  
Yes       No

C. If “Yes,” list all licenses you hold or have held:

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

**Submit a License Verification** form to **ALL** state(s) of licensure. License verifications must be received directly from the licensing authority regardless of the status of the license. **A copy of your license will not be accepted** in lieu of official verification from the licensing agency.

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. 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 educational institution(s) from which you received your degree or have taken coursework. **The transcript must be sent directly to the board office from the registrar’s office of the institution and include a degree conferred date or it 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](mailto:MQA.491@flhealth.gov).

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

- B. For clinical social work applicants only: 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.

The following documentation is required 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 your profession can be found on the appropriate education worksheet for your profession.

Documentation must be sent to the board office at [MQA.491@flhealth.gov](mailto:MQA.491@flhealth.gov), or by mail to:

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

Name: \_\_\_\_\_

**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 social work degree 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 Council on Social Work Education by the International Social Work Degree Recognition and Evaluation Service provided by the Office of Social Work Accreditation (OSWA). To contact the OSWA, visit [www.cswe.org](http://www.cswe.org) or call (703) 683-8080.

**Marriage and Family / 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 an accredited U.S. institution and the coursework met the content and credit hour requirement 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.

**6. SUPERVISOR INFORMATION**

List all qualified supervisor(s) who will be providing individual and/or group supervision. Attach additional sheets if necessary.

Supervisor Name	License Title	Florida License Number	Year Licensed (YYYY)

**Each** supervisor listed must submit written correspondence that states that the supervisor has agreed to provide you with supervision while you are a registered intern. Correspondence must come **directly** from the supervisor, and may be sent by fax to 850-413-6982, or by email to [MQA.491@flhealth.gov](mailto:MQA.491@flhealth.gov).

**Applications will not be deemed complete until all supervisor(s) have provided correspondence confirming their agreement to supervise you as an intern. Experience obtained under the supervision of a qualified supervisor will not count toward completion of the experience requirement until the registered intern has received board approval of the qualified supervisor.**

Name: \_\_\_\_\_

**This information is exempt from public records disclosure.**

## 7. 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: \_\_\_\_\_

8. 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**.

9. 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: \_\_\_\_\_

**10. 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 (if “Yes,” provide supporting documentation)? 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

Name: \_\_\_\_\_

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 7, 8, 9 and 10 must be sent to the board office at [MQA.491@flhealth.gov](mailto:MQA.491@flhealth.gov), or by mail to:**

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

## 11. APPLICANT SIGNATURE

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

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

I acknowledge 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 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.

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

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

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

4052 Bald Cypress Way Bin C-08

Tallahassee, FL 32399-3258



## 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
- \* Licensure status
- \* 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.
- \* License number
- \* Is license in good standing?
- \* State or jurisdiction of licensure

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

## CLINICAL SOCIAL WORK EDUCATION WORKSHEET FOR INTERN



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
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.**



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

MARRIAGE AND FAMILY THERAPY  
EDUCATION WORKSHEET FOR INTERN

Page 1 of 2



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 from a counseling program accredited by the Council for Accreditation of Counseling and Related Education Programs (CACREP), or have 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. List course numbers and titles 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
<i>Dynamics of Marriage and Family Systems</i>	1.			
	2.			
<i>Marriage Therapy and Counseling Theory and Techniques</i>	1.			
	2.			
<i>Family Therapy and Counseling Theory and Techniques</i>	1.			
	2.			
<i>Individual Human Development Theories Throughout the Life Cycle</i>	1.			
	2.			
<i>Psychopathology</i>	1.			
	2.			
<i>Human Sexuality Theory and Counseling Techniques</i>	1.			
	2.			
<i>Psychosocial Theory</i>	1.			
	2.			
<i>Substance Abuse Theory and Counseling Techniques</i>	1.			
	2.			

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

MARRIAGE AND FAMILY THERAPY  
EDUCATION WORKSHEET FOR INTERN

Page 2 of 2



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 and 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 and Family Therapy, and Mental Health Counseling

## MENTAL HEALTH COUNSELING EDUCATION WORKSHEET FOR INTERN

Page 1 of 2



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.

### 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 educational institution in each of the content areas listed below. List course numbers and titles 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

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. To qualify for mental health counseling intern registration, you must have completed a **minimum of seven** of the required course content areas below, one of which must be a course in psychopathology or abnormal psychology. Refer to section 491.005(4), Florida Statutes, for more information.

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

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

## MENTAL HEALTH COUNSELING EDUCATION WORKSHEET FOR INTERN

Page 2 of 2



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.

If you completed **fewer** than 700 practicum/internship hours in your master's program, this requirement may be met outside the university setting by completing supervised practice experience that meets the CACREP standards below and is under the supervision of a qualified supervisor or equivalent.

Document non-university experience on the "Graduate-Level Practicum, Internship, or Field Experience Verification Form" for Mental Health Counseling found at <https://floridasmmentalhealthprofessions.gov/forms/mhc-graduate-practicum-form.pdf>. You **cannot** begin your post-master's supervision experience until you meet the 700 hours of practicum/internship requirement. The CACREP accrediting standards 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 to become familiar with a variety of professional activities and resources in addition to direct service (e.g., record keeping, assessment instruments, supervision, referral, staff meetings, etc.).
- The opportunity 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 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

### 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.**