



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

**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



**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 Receiving Only

Applicants must hold a valid, current license in another state in the specific profession identified for licensure and have actively practiced in that profession for at least three of the past five years. If you do not meet both the licensure and practice requirements you are ineligible to apply by endorsement and must apply by examination.

### Select profession:

Clinical Social Work (5201)	<b>\$180.00</b>
Marriage & Family Therapy (5202)	<b>\$180.00</b>
Mental Health Counseling (5203)	<b>\$180.00</b>

### Total fee of \$180.00 includes the following:

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

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	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 hold a valid, current license in another state in the profession for which you are applying, and actively practiced in such capacity for at least three of the past five years?      Yes      No

If "No," you are ineligible to apply by endorsement.

C. List the **active license in the profession for which you are applying** from the state(s) in which you have actively practiced for three of the past five years.

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

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

E. List all health-related licenses (active, inactive, or lapsed), **other than the license(s) listed above**.

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.

F. 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

G. 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**

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

HIV/AIDS Course Title	Provider Name	Date Completed (MM/DD/YYYY)
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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.cebroke.com](http://www.cebroke.com).**

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

**6. EXAMINATION HISTORY**

For information regarding application deadlines, examination approval, and examination dates, visit [floridasmantalhealthprofessions.gov/resources/exam-schedule/](http://floridasmantalhealthprofessions.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 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 1-800-225-6880 or <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 Special Needs Accommodations Form found online at [http://www.ptcny.com/PDF/PTC\\_SpecialAccommodationRequestForm.pdf](http://www.ptcny.com/PDF/PTC_SpecialAccommodationRequestForm.pdf). 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](http://www.nbcc.org).

**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

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? You must include all misdemeanors and felonies, even if adjudication was withheld. 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.

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.      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.



## 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 to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 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



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
- \* 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 and Family Therapy,  
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**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 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]