



DEPARTMENT OF HEALTH

**BOARD OF CLINICAL SOCIAL WORK,
MARRIAGE AND FAMILY THERAPY AND
MENTAL HEALTH COUNSELING**

APPLICATION FOR LIMITED LICENSURE and Instructions

Department of Health
Florida Board of CSW/MFT/MHC
4052 Bald Cypress Way, C-08
Tallahassee, FL 32399-3258
Telephone: (850) 245-4474
www.floridasmentalhealthprofessions.gov
Email: MQA.491@flhealth.gov

APPLICATION FOR LIMITED LICENSURE INSTRUCTIONS

You must read the laws and rules in order to determine your eligibility prior to applying. The laws and rules may be accessed through our website at <http://floridasmmentalhealthprofessions.gov> and click on "Resources". The requirements for limited licensure are in Section 456.015, Florida Statutes, and Rule 64B4-3.009, Florida Administrative Code.

COMPLETING THE FORMS: Application for Limited Licensure [6 pages]

Complete all forms by printing neatly in ballpoint pen or typing the information on the forms. It is your responsibility to notify this office in writing if the answer to any application question changes.

1. Applicant Profile Data:

List your legal name as it should appear on your license. Your mailing address is used whenever you are sent documents, renewals, licenses, etc. from the Department of Health. When you become a licensee, your name, license number and practice location address will be shown on our Internet License Verification. If you do not want your mailing address on the website, fill in the "practice location address" on the Application for Limited Licensure as you want it to appear on the website. If you only provide one address, it will be used for both the mailing address and the practice location address. Please note that the practice location address must be a street address.

2. Licensure Data:

List all counseling related professional licenses, including inactive or expired licenses issued from any state, U.S. territory, or foreign country.

3. Applicant History – Professional:

If you answer "yes" to any question in this section, you must provide complete details. A "yes" answer does not mean the application will be denied, however, failure to provide the correct information may result in licensure denial.

4. Applicant History – Pursuant to Section 456.0635, Florida Statutes:

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

5. Applicant History – General:

If you answer "yes", you must provide complete details and certified copies of court records/dispositions.

6. Certification:

Your signature is required. By signing you are attesting that you have provided true and correct information on the application and supporting documents, as well as having read the laws and rules.

7. Social Security Number: Your social security number is required.

8. Applicant History – Health:

The Board reviews each applicant's history to determine that the applicant is able to practice the profession with reasonable skill or competence. If you answer "YES" to any of the questions in this section, you must submit a current mental health status report from a licensed mental health professional, wherein this professional practitioner opines that you are able to practice with reasonable skill and safety to patients or clients.

The report should include: a description and summary of the diagnosis, onset, course of treatment, medications, inpatient treatments, outpatient treatments, group settings, factors which have triggered setbacks, compliance with treatment, prognosis, and recommendations for continued treatment.

Submit the completed application, affidavit for limited license applicant, and either the \$25.00 fee or the limited license fee waiver form to the Board of CSW, MFT, MHC, 4052 Bald Cypress Way, Bin C08, Tallahassee, FL 32399-3258. You may pay with a credit or debit card, if you submit your application online at www.flhealthsource.com and click on "Apply for a License".

DEPARTMENT OF HEALTH	Board of Clinical Social Work Marriage and Family Therapy & Mental Health Counseling
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APPLICATION FOR LIMITED LICENSURE

1. APPLICANT PROFILE DATA *(PLEASE TYPE OR PRINT IN BLACK INK)*

Name	Last	First	Middle
Mailing Address	Street and No.		Apt. No.
	City	State	Zip
Practice Location Address*	Street and No.		Apt. No.
	City	State	Zip

DO NOT WRITE IN THIS SPACE
FOR OFFICE USE ONLY

Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name? YES NO
If "YES", list names and dates of changes.

(Check One)

- Clinical Social Work (5201)
- Marriage & Family Therapy (5202)
- Mental Health Counseling (5203)

Primary Telephone: area code ()	Business Telephone: area code ()
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E-Mail Address (Optional. Will be public record if provided.):	Date of birth: ____/____/____
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Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR 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.

SEX: Male Female U.S. Citizen: Yes No RACE: White Black Asian/Pacific Hispanic Other

*** Your Practice Location Address Will Show On The Internet License Verification**

Our Internet license verification provides the public with information on licensed health care practitioners in the State of Florida, including an "address of record". The "location address" from the licensure database will show as the "address of record" on the Internet.

Please check the box applicable to your proposed practice setting:

Paid Employee **MUST REMIT \$25.00**

Volunteer – not paid for services **Must remit Fee Waiver Affidavit.**

APPLICANT NAME _____

2. LICENSURE DATA		
<p>A. Do you hold or have you ever held a license to practice any counseling-related professions in any state, U.S. territory, or foreign country? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, list <u>all</u> licenses and the issuing state, territory, or foreign country, regardless of status.</p>		
Type of License/Certificate	Issuing State, Territory, Foreign Country	
<p>B. Do you have any applications for licensure or certification in a counseling-related profession currently pending in any state (including Florida), U.S. territory, or foreign country? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, list <u>all</u> pending applications and the issuing state, territory, or foreign country:</p>		
<p>List Place of Practice in Florida, if known. Section 456.035, Florida Statutes, requires that each licensee notify the department in writing of the licensee's current mailing address and place of practice.</p>		
Place of Employment	Location Address (street, city, state, zip)	Employment Setting <input type="checkbox"/> State Mental Institution <input type="checkbox"/> State Institution for the Mentally Retarded <input type="checkbox"/> Department of Corrections <input type="checkbox"/> Health Manpower Shortage Area established by the U.S. Dept. of Health & Human Services
3. APPLICANT HISTORY - PROFESSIONAL		
A. Have you ever been denied a license to practice any counseling-related profession or any other health care profession, or the renewal thereof by any state, U.S. Territory or foreign country?		<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature, including, but not limited to, a charge of violation of a practice act, unprofessional or unethical conduct?		<input type="checkbox"/> Yes <input type="checkbox"/> 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, U.S. territory or foreign country?		<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Is there currently pending, in any jurisdiction, a complaint against your professional conduct or competency in any profession?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>If you answered "YES" to any question in Section 3 you must provide complete details.</p>		

<p>4. APPLICANT HISTORY - Pursuant to Section 456.0635(2), Florida Statutes, IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide 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 includes court dispositions or agency orders where applicable.</p>	
1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded "no", skip to # 2.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
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 or conviction, and completion of any sentence or subsequent period of probation?	<input type="checkbox"/> YES <input type="checkbox"/> 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 any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).	<input type="checkbox"/> YES <input type="checkbox"/> NO
c. If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?	<input type="checkbox"/> YES <input type="checkbox"/> 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", please provide supporting documentation).	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, 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)? (If "No", do not answer 2a.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 3a.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If "No", do not answer 4a or 4b.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
a. Have you been in good standing with a state Medicaid program for the most recent five years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. Did the termination occur at least 20 years before the date of this application?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	<input type="checkbox"/> YES <input type="checkbox"/> NO

APPLICANT NAME _____

5. APPLICANT HISTORY - GENERAL

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record or conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. Yes No

If you answered "Yes" to the question above you are required to send the following items:

- 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.

6. CERTIFICATION

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all government agencies and instrumentalities (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals, and groups listed above any information which is material to my application.

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for examination or licensure. Such supplement is required by Sections 456.072, F.S. and 456.013(1)(2), F.S. Failure to do so may result in disciplinary action by the Board or denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind. I declare that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to s. 456.067, F.S., or criminal penalties pursuant to s. 775.082, s. 775.083, or s. 775.084, F.S. Should I furnish any false information on this application, I hereby acknowledge that such act may constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida.

I hereby acknowledge that I have read the regulations in Chapter 491, F.S., and related rules. I understand that I am under a continuing obligation to keep informed of any changes to Chapter 491, F.S., and related rules.

I understand that pursuant to Section 456.013(1)(a), F.S., an incomplete application shall expire one (1) year after initial filing.

I further state that I will comply with all requirements for licensure renewal, including continuing education credits.

Applicant's Signature

Date

CONFIDENTIAL AND EXEMPT FROM
PUBLIC RECORDS DISCLOSURE

DEPARTMENT OF HEALTH

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

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 USCA § 666 (a)(13); and Sections 456.013, 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 assure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L 193, Section 317.

Name: _____
Last First Middle

7. Social Security Number: _____

8. APPLICANT HISTORY – HEALTH	
A. Do you have any condition that currently impairs your ability to practice your profession with reasonable skill and safety?	<input type="checkbox"/> YES <input type="checkbox"/> NO
B. Are you using medications, other drugs, narcotics, or intoxicating chemicals that impair your ability to practice your profession with reasonable skill and safety?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If you answered "yes" to either of the above questions, please provide a letter from a licensed health care practitioner, who is qualified by skill and training to address your condition, which explains the impact your condition may have on your ability to practice your profession with reasonable skill and safety, and stating either that you are safe to practice your profession without restriction or indicating what restrictions are necessary. If necessary, you may attach additional sheets. Documentation must be current within the last year. If you fail to disclose the information requested in this section, your application may be denied.	

AFFIDAVIT FOR LIMITED LICENSE APPLICANT

Pursuant to s. 456.015, F.S., any person desiring to obtain a limited license shall submit an affidavit stating that he or she has been licensed to practice in any jurisdiction in the United States for at least 10 years in the profession for which he or she seeks a limited license.

The affidavit shall also state that he or she has retired or intends to retire from the practice of that profession and intends to practice only pursuant to the restrictions of the limited license granted. Your application is incomplete without this affidavit.

Before me, the undersigned authority, personally appeared _____
Print Applicant's Full Name
who deposes and says that the following statements are true and correct:

1. I _____ am of legal age and have personal
Print Applicant's Full Name
knowledge of the matters stated in this affidavit.
2. I affirm that I have practiced _____ as a licensed
Print Name of Profession
_____ for at least 10 years in the United States.
Print Title of License
3. I affirm that I retired OR I intend to retire on _____ from the
Month/Day/Year
practice of _____
Print Name of Profession
4. I affirm that I will only practice as specified in Rule 64B4-3.009, Florida Administrative Code, if granted a limited license in Florida.

Signature of Applicant

Sworn to and subscribed before this _____ day of _____,
Year Day Month

Signature of Notary Public

(Print or Stamp Commissioned Name of Notary Public)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

**LIMITED LICENSE FEE WAIVER FORM
TO BE COMPLETED BY EMPLOYER**

Pursuant to section 456.015, Florida Statutes, and Rule 64B4-3.009, Florida Administrative Code, if a person applying for a limited license submits a notarized statement from the employing agency or institution stating that he/she will not receive monetary compensation for any services involving the practice of clinical social work, marriage and family therapy, and mental health counseling, the licensure fees shall be waived.

AFFIDAVIT

I, _____, being first duly sworn, state that the following clinical social worker, marriage and family therapist, or mental health counselor:

Type or print the licensee's name

will NOT receive monetary compensation for any service involving the practice of clinical social work, marriage and family therapy, or mental health counseling from:

Agency/Institution: _____

Address: _____

City/State/Zip: _____

Signed: _____

Name: (Type or Print) _____

Title: _____

STATE OF FLORIDA
COUNTY OF: _____

The above person is personally known to me or has produced _____ as identification.

SWORN AND SUBSCRIBED BEFORE ME THIS _____ DAY OF _____, 20____

My Commission expires on: _____ (Notary stamp or seal)

Notary Signature