Application for Licensure as a Certified Master Social Worker

Department of Health
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: floridasmentalhealthprofessions.gov
Email: info@floridasmentalhealthprofessions.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

Application for Licensure as a Certified Master Social Worker

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: info@floridasmentalhealthprofessions.gov

Do Not Write in this Space
For Revenue Receipting Only

You must read the laws and rules to determine your eligibility prior to applying. The laws and rules are available at floridasmentalhealthprofessions.gov/resources. The requirements for master social worker certification are in section (s.) 491.0145, Florida Statutes (F.S.), and Florida Administrative Code Rule 64B25-28.

Certified Master Social Worker **$205.00**

Total fee of $205.00 includes the following:

Application Fee	$50.00
Initial Certification Fee	$150.00
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 a $155.00 (Certification 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 (Input without dashes)

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 (Input without dashes)

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 U.S.C. § 666(a)(13), the Department of Health is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, s. 456.013(1)(a), F.S., authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: ____

First Name: ____

Middle Name: ____

Social Security Number: ______________________________________
(Input without dashes)

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 U.S.C., § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. 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.

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, or have you ever held a license to practice any counseling-related professions 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

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.

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. 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

Name: ____

5. EDUCATION HISTORY

All applicants must complete the education worksheet 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 social work. All schools listed below must be consistent with the schools provided on the education worksheet.

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

Applicants must request an official transcript from the regionally 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 info@floridasmentalhealthprofessions.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. Were you an advanced standing student? Yes No

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

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 can be found on the education worksheet.

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-cred-evaluators.pdf.

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 or call (703) 683-8080.

Documentation must be sent to the board office at info@floridasmentalhealthprofessions.gov, or by mail to:

Department of Health
Certified Master Social Worker
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

Name: ____

6. PROFESSIONAL EXPERIENCE

You are required to have three years of experience in clinical services or administrative activities, two years of which **must** be at the post-master's level under the supervision of a certified master social worker or licensed clinical social worker. The board will count no more than one year of pre-master's experience toward the required three years.

Beginning with your current employment, list all supervised **clinical social work** experience. All employment listed below must be consistent with all experience verification forms/documentation submitted. A resumé will **not** be accepted in lieu of completion of the table below. Attach additional sheets if necessary.

A brief explanation must be attached if you had more than one supervisor during the same time period.

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

Verification of Pre-Master's Experience: All applicants must submit the **"Pre-Master's Experience form,"** found at the back of the application.

Verification of Post-Master's Experience: Applicants may submit the **"Post-Master's Supervised Experience"** form found at the back of the application, **or** documentation verifying membership in the Academy of Certified Social Workers (ACSW).

It is the applicant's responsibility to provide each supervisor with a copy of s. 491.0145, F.S., and Florida Administrative Code Rule 64B25-28 regarding supervised experience, specifically:

- 64B25-28.013(1), (2) Definition of Experience
- 64B25-28.012(2) Application Requirements
- 64B25-28.012(2)(e) Qualified Supervisors
- 64B25-28.013(4), (6) Definition of Supervision
- 64B25-28.013(5) Supervision Requirements
- 64B25-28.013(7) Verification of Supervised Experience

Name: ____

7. EXAMINATION HISTORY

Have you passed the National Association of Social Work Board (ASWB) Advanced Generalist Examination?
Yes No

If you have already passed the ASWB Advanced Generalist Examination, you must request to have your scores transferred to Florida. Scores must be received **directly** from the testing center or from the state in which you took the exam.

If you have **not** passed the ASWB Advanced Generalist Examination, you must submit the application, all required fees, and supporting documentation to the board to become eligible to sit for the exam. The board will send approved candidates an exam approval letter with appropriate registration materials.

The national examination is offered in a worldwide computer-based format weekly, Monday through Saturday, by individual appointment. There are no completion deadlines. **Approved candidates schedule and pay for the national examination directly through ASWB.** The exam may be re-taken every 90 days.

A study prep guide may be purchased from the ASWB at 1-800-225-6880 or online at www.aswb.org. You must request the Advanced Generalist Examination Study Guide.

Applicants requiring Special Testing Accommodations:

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.

Name: ______________________________

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

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. Reckless driving, driving while license suspended or revoked (DWSLR), 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" in this section, **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 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 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 time frames as established in s. 456.0635(2), F.S.

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, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (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 ten 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), F.S.)? Yes No

c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., 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, F.S.?
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

Name: ____

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 that includes court dispositions or agency orders where applicable.

Documentation for sections 8, 9, 10 and 11 must be submitted to info@floridasmentalhealthprofessions.gov, or mailed to:

Department of Health
Certified Master Social Worker
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

12. 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, F.S.

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, F.S., and related rules. I understand that I am under a continuing obligation to keep informed of any changes to ch. 491, F.S., 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), F.S., provides that an incomplete application shall expire one year after the initial filing with the Department of Health.

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:

Department of Health
Certified Master Social Worker
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 Department of Health.

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.

CERTIFIED MASTER SOCIAL WORKER
EDUCATION WORKSHEET

Worksheet must be submitted with your application.

Name: ____

You are required to have a master's or doctoral degree in social work with a major emphasis or specialty in clinical practice or administration and complete graduate level coursework in the following areas: agency administration and supervision, program planning and evaluation, staff development, research, community organization, community services, social planning and human service advocacy.

Indicate below the graduate or doctorate level course you completed that satisfied the education requirement in the specific content area.

Content Area	School Name	Course Number	Course Title	Credit Hours
Agency Administration and Supervision				
Program Planning and Evaluation				
Staff Development				
Research				
Community Organization				
Community Services				
Social Planning				
Human Services Advocacy				

Submit form with application, email to info@floridasmentalhealthprofessions.gov, or mail to:

Department of Health
Certified Master Social Worker
4052 Bald Cypress Way Bin C-08
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Pre-Master's Experience Form
CERTIFIED MASTER SOCIAL WORKER

Form must be completed by the individual verifying the experience.

Applicant Name: ______________________________

1. VERIFYING PARTY INFORMATION

Name of individual verifying the experience: ______________________________

Address: ______________________________
Street City State ZIP

Telephone: ______________________________

Office or agency where experience took place: ______________________________

Relationship to applicant: ☐ Employer ☐ Co-worker ☐ Supervisor ☐ Personnel Representative

2. EXPERIENCE HOURS

A. Dates of applicant's experience: From: ____________ (MM/DD/YYYY) To: ____________ (MM/DD/YYYY)

B.

____________ × ____________ = ____________

Number of **weeks** applicant worked × Average number of **hours** applicant worked **per week** = **Total** number of hours applicant worked

C. Average number of hours **per week** applicant provided psychotherapy face-to-face directly to clients: ____________

D. Average number of hours **per week** applicant worked in administration or supervision related to social work programs: ____________

3. VERIFYING PARTY SIGNATURE

I certify that the above information is true and correct to the best of my knowledge.

Verifying Party Signature: ______________________________ Date: ____________
MM/DD/YYYY

Submit form with application, email to info@floridasmentalhealthprofessions.gov, or mail to:

Department of Health
Certified Master Social Worker
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

Post-Master's Experience Form

CERTIFIED MASTER SOCIAL WORKER

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This form must be completed by the supervisor.

Applicant Name: ____

1. SUPERVISOR INFORMATION

Supervisor Name: ____ Telephone: _______________________

Address: ____
Street City State ZIP

2. SUPERVISOR EDUCATION

School Name	Graduate Degree Title	Degree Conferred Date (MM/DD/YYYY)	Degree Awarded

3. SUPERVISOR LICENSURE

Are you licensed, certified, or credentialed? ☐ Yes ☐ No

If "No," you must attach **both** a:

1. Photocopy of your graduate level transcript; and
2. Professional resume.

If "Yes," complete the following:

License Title	State	Year Received (YYYY)	License Number

Certification/Credential Title	Organization/State	Year Received (YYYY)	Certification/Credential Number

If you are credentialed or certified by a national organization, attach a copy of your certificate.

Applicant Name: ____

4. APPLICANT EXPERIENCE HOURS

A. Dates of applicant's experience: From: ____________________ To: _____________________
MM/DD/YYYY MM/DD/YYYY

B.

________________________ × ________________________ = ________________________

Number of **weeks** applicant worked × Average number of **hours** applicant worked **per week** = **Total** number of hours applicant worked

C. Average number of hours **per week** applicant provided psychotherapy face-to-face directly to clients: _________________________

D. Average number of hours **per week** applicant worked in administration of supervision related to social work programs: ________________________

E.

________________________ + ________________________ = ________________________

Number of hours **per month** you provided the applicant individual face-to-face supervision + Number of hours **per month** you provided the applicant group supervision = Total hours **per month** you provided the applicant supervision

5. SUPERVISOR SIGNATURE

I confirm that I have read and understand ch. 491, F.S. and that I am qualified to supervise as specified in the Florida Administrative Code. I further attest that supervision included: a focus on raw data from the applicant's clinical work, which was made directly available through such means as written clinical materials, direct observation, and video and audio recordings; face-to-face contact between the applicant and myself during which the applicant apprised me of the diagnosis and treatment of each client; discussion of the clients' cases; oversight and guidance in diagnosing, treating, and dealing with clients; and evaluation of the applicant's performance.

I certify that the above information is true and correct to the best of my knowledge.

Supervisor Signature: ____ Date: __________________
MM/DD/YYYY