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STATE BOARD OF SOCIAL WORKERS, MARRIAGE AND FAMILY THERAPISTS AND PROFESSIONAL COUNSELORS
717-783-1389
FAX: 717-787-7769

Email st-socialwork@pa.gov
Website www.dos.pa.gov/social

APPLICATION FOR A LICENSE BY EXAMINATION TO PRACTICE PROFESSIONAL COUNSELING
QUALIFICATIONS

1. Application fee- $45.00 and is non-refundable. Check/money order should be made payable to "Commonwealth of PA". A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for nonpayment. If the application process has not been completed within one year from the date it was received, applicants will be required to submit an updated application (another application processing fee) and supporting documents as necessary.

2. Meet **ONE** of the following education requirements as per Section 7(f) (2) Act 136 – 1998. Request the school to send an official transcript of your educational degree and other graduate level coursework **DIRECTLY** to the Board in an official sealed school envelope.

   i. Has successfully completed a planned program of 60 semester hours or 90 quarter hours of graduate coursework in counseling or a field determined by the board by regulation to be closely related to the practice of professional counseling, including a master's degree granted on or before June 30, 2009, in counseling or a field determined by the board by regulation to be closely related to the practice of professional counseling, from an accredited educational institution, and has met specific course requirements listed in Section 49.2.

   ii. Has successfully completed a planned program of 60 semester hours or 90 quarter hours of graduate coursework in counseling or a field determined by the board by regulation to be closely related to the practice of professional counseling, including a 48-semester-hour or 72-quarter-hour master's degree in counseling or a field determined by the board by regulation to be closely related to the practice of professional counseling, from an accredited educational institution, and has met specific course requirements listed in Section 49.2.

   iii. Holds a doctoral degree in counseling from an accredited educational institution or holds a doctoral degree in a field determined by the board by regulation to be closely related to the practice of professional counseling from an accredited educational institution, and has met specific course requirements listed in Section 49.2.

3. Demonstrate proof of supervised clinical experience. **Master's degree**-completion of 3000 hours of supervised clinical experience. **Doctoral degree**-completion of 2,400 hours of supervised clinical experience. **Experience must meet the criteria established in Section 49.13(a)(4) and 49.13(b) of the regulations.** Have your supervisor complete Pages 3 through 5 certifying your supervised clinical experience and return **DIRECTLY** to you in a sealed envelope. As per Section 49.13(b)(2) 1500 hours shall be supervised by a supervisor meeting the qualifications of Section 49.3(1) and (3). No more than 1500 hours may be supervised by a supervisor meeting the qualifications of Section 49.3(2). Supervised clinical experience completed prior to January 1, 2006, may be supervised by a supervisor meeting the requirements of Section 49.3(3).

   ****Please note that the practicum and internship are part of your educational requirements and cannot be counted towards the 3000 hours of supervised clinical experience.**

4. Please provide a curriculum vitae (a list activities from graduation to the present).

5. Request each state licensing agency where you have ever held a license to practice send letter(s) of good standing **DIRECTLY** the Board office in official sealed agency envelope.

6. Pass one of the following accepted examinations for licensure. Request your licensure examination scores to be sent **DIRECTLY** to the Board from the certification and examination agency.

   a) The National Counselor Examination for Licensure and Certification (NCE) given by the National Board for Certified Counselors, Inc. (NBCC).

   b) The Certified Rehabilitation Counselor (CRC) Examination given by the Commission on Rehabilitation Counselor Certification (CRCC).

   c) The Art Therapy Credentials Board (ATCB) Certification Examination given by the Art Therapy Credentialing Board.

   d) The Board Certification Examination given by the Certification Board for Music Therapists (CBMT).

   e) The Practice Examination of Psychological Knowledge given by Northamerican Association of Masters in Psychology (NAMP).

   f) The Advanced Alcohol and Other Drug Abuse Counselor Examination (AAODA) given by the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse Inc. (IC&RC/AODA).

   g) The Examination for Masters Addictions Counselors (EMAC) given by the National Board for Certified Counselors, Inc (NBCC).

7. If documents will be submitted to the Board under a name different from your present name, submit a copy of legal document showing the name change (marriage certificate, divorce decree, court order, etc..).

8. All persons applying for issuance of an initial license shall be required to complete 3 hours of DHS-approved training in child abuse recognition and reporting requirements as a condition of licensure. Please review the Board website for further information on approved CE providers. Once you have completed a course, the approved provider will electronically submit your name, date of attendance, etc., to the Board.

9. Provide a Self-Query from the National Practitioner Data Bank which is valid for 6 months from the date of issuance. A Self-Query can be requested online at https://www.npdb.hrsa.gov/. When you receive the "Self-Query Response" from the National Practitioner Data Bank, forward it to the Board office. (Verify that "Self-Query Response" is sent to the Board and not a discrepancy notice.)

10. Provide an official Criminal History Record Check (CHRC) from the state agency for every state in which you have resided for the past 5 years. The report(s) is valid for 90 days from the date of issuance. This report can be sent to you and forwarded to the Board with your application. For Pennsylvania CHRC, this can be done online at http://epatch.state.pa.us. **For states that do not provide CHRC for employment or licensing purposes (CA & AZ)**, we will accept an FBI background check. You may visit https://www.fbi.gov/about-us/cjis/identity-history-summary-checks to obtain your Federal Bureau of Investigation (FBI) Identity History Summary Check.

PLEASE NOTE:
If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee.

In order to complete the application process, many of the supporting documents associated with the application cannot be more than six months from the date of issuance. All background check documents cannot be older than 90 days from the date of issuance.

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STATE BOARD OF SOCIAL WORKERS, MARRIAGE AND FAMILY THERAPISTS AND PROFESSIONAL COUNSELORS

Email: st-socialwork@pa.gov **Website: www.dos.pa.gov/social**

Mailing address
P.O. BOX 2649
HARRISBURG, PA 17105-2649

Courier Delivery Address:
2601 North Third Street
Harrisburg, PA 17110

APPLICATION FOR A LICENSE BY EXAMINATION TO PRACTICE
PROFESSIONAL COUNSELING

Complete page 1 and 2 and submit to the above address.

Application fee - $45.00 and is non-refundable. Make check/money order payable to "**Commonwealth of PA**". A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for nonpayment.

Name: _____
Last First Middle Maiden

Address: _____
Street

_____
City State Zip

Daytime Telephone Number:_(_____)_____ Email: _____

Social Security Number: _____ Date of Birth: _____ _____ _____
Month Day Year

Will any documentation submitted in connection with this application be received in a name other than the name under which you are applying? Yes [ ] No [ ]

If Yes, please list the other name or names below (Submit a copy of the legal document evidencing the name change (i.e., marriage certificate, divorce decree or court order) ;

_____

Please list all states in which you have lived in the past five years: _____

School _____

Address of School:_____
Street

_____
City State Zip

Date of Graduation: _____ Type of Degree_____
Month Day Year

Name of licensing exam taken_____ Date of examination_____
Month/Day/Year

The following questions must be answered, please check the appropriate box.		Yes	No
1.	Do you hold or have you ever held, a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction? If yes, please list all professions and states where you have been licensed and request a letter of good standing be sent from each state board to the Pennsylvania Board.		
2.	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		
3.	Do you currently have any disciplinary charges pending against your professional or occupational license certificate, permit or registration in any state or jurisdiction?		
4.	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
5.	Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		
6.	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		
7.	Have you ever been found guilty of immoral or unprofessional conduct?		
8.	Have you ever violated standards or professional practice or conduct?		
9.	Do you currently engage in or have you ever engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?		
10.	Have you ever had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
11.	Have you ever had practice privileges denied revoked, suspended or restricted by a hospital or any health care facility?		
12.	Have you ever been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		

IF YOU HAVE ANSWERED "YES" TO ANY QUESTIONS FROM 2 THROUGH 12, PLEASE ATTACH AN 8 ½ X 11 SHEET OF PAPER GIVING FULL DETAILS. INCLUDE COURTHOUSE CERTIFIED COPIES OF ANY DOCUMENTS EXPLAINING THE SITUATION, IF APPLICABLE.

VERIFICATION

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties form tampering with public records or information under 18 Pa.C.S .§ 49.11. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

_____ _____

APPLICANT'S SIGNATURE DATE

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa.C.S. § 4304.1(a). At the request of the Department of Human Services (DHS), the licensing boards must provide to DHS information prescribed by DHS about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

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VERIFICATION OF SUPERVISED CLINICAL EXPERIENCE

Regular address:
State Board of Social Workers, Marriage and Family Therapists and Professional Counselors
PO Box 2649
Harrisburg, PA 17105-2649

Courier Delivery:
State Board of Social Workers, Marriage and Family Therapists and Professional Counselors
2601 North Third Street
Harrisburg, PA 17110

The information on these forms must be provided by the applicant's supervisor that provided the supervision for the supervised clinical experience hours completed towards meeting the 3000 hours of supervised clinical experience defined in Section 49.13(b) and Section 49.14 of the regulations. **This verification of supervised clinical experience form should be photocopied then completed by each supervisor that provided supervision towards the 3000 hours of supervised clinical experience. If there are gaps in dates greater than 1 month during the supervised clinical experience being completed, separate forms must be completed after each gap in dates.**

MASTER'S DEGREE **- YOUR SUPERVISOR (as defined in the rules and regulations) MUST COMPLETE THE FOLLOWING PAGES (3, 4 and 5) VERIFYING COMPLETION OF 3000 HOURS OF SUPERVISED CLINICAL EXPERIENCE IN PROFESSIONAL COUNSELING WHICH WERE OBTAINED AFTER THE COMPLETION OF 48 SEMESTER HOURS OR 72 QUARTER HOURS OF GRADUATE COURSEWORK AND STATISFIES THE CRITERIA OF SECTION 49.13(b)(9).**

DOCTORAL DEGREE **– YOUR SUPERVISOR (as defined in the rules and regulations) MUST COMPLETE THE FOLLOWING PAGES (3, 4 AND 5) VERIFYING COMPLETION OF 2400 HOURS OF SUPERVISED CLINICAL EXPERIENCE IN PROFESSIONAL COUNSELING. 1200 HOURS OF WHICH WAS OBTAINED SUBSEQUENT TO THE GRANTING OF THE DOCTORAL DEGREE.**

Applicant's Name: _____
Last First Middle

Supervisor's qualifications: Please check all that apply.

1500 hours of supervised clinical experience must be completed under an individual that meets the requirements of Section 49.3(1) and if the supervised clinical experience was completed prior to January 1, 2006, may be completed under an individual that meets the requirements of Section 49.3(3).

☐ Holds a license as a professional counselor and has 5 years of experience within the last 10 years as a professional counselor (Section 49.3(1)).

☐ Holds a license and has at least a master's degree in a related field and has 5 years of experience within the last 10 years in that field (Section 49.3(2)). **Only 1500 hours of supervised clinical experience may be completed under a supervisor meeting this qualification.**

☐ Practices as a professional counselor. Has 5 years experience within the last 10 years as a professional counselor (Section 49.3(3)). **This qualification is for supervised clinical experience completed prior to January 1, 2006.**

Supervisor's Name: _____
Please print

Supervisor's Address: _____
Street

_____
City State Zip

License Number_____ Profession_____ State_____

(Pages 3, 4 and 5 must all be placed in a sealed envelope by the supervisor and the supervisor's shall sign their name over the flap of the envelope and the sealed, signed envelope shall be given to the applicant to submit.)

Where did the Clinical Experience occur:

Site: _____
Please print

Address:_____
Street

_____
City State Zip

Dates of Supervised Experience: _____ **/** _____ **/** _____ **to** _____ **/** _____ **/** _____
month day year month day year

Number of weeks worked in which clinical experience was accrued between the dates listed above: _____

Total Number of Hours of Supervised Clinical Experience Worked with this Supervisor between the dates listed above: _____
(Do not include vacation days, sick days, etc..)

The total number of hours of face-to-face direct client contact hours completed: _____

Average Hours per week Applicant worked: _____

Dates of Individual supervised clinical experience: _____ / _____ / _____ to _____ / _____ / _____
month day year month day year

I provided _____ hour(s) of individual supervision for every 40 hours worked.

Dates of Group supervised clinical experience: _____ / _____ / _____ to _____ / _____ / _____
month day year month day year

I provided _____ hour(s) of group supervision for every 40 hours worked.

As per Section 49.13(b) (1) At least one-half of the experience shall consist of providing services in one or more of the following areas:

Please check all that apply

☐ (i) Assessment

☐ (ii) Counseling

☐ (iii) Therapy

☐ (iv) Psychotherapy

☐ (v) Other therapeutic interventions

☐ (vi) Consultation

☐ (vii) Family Therapy

☐ (viii) Group Therapy

(Pages 3, 4 and 5 must all be placed in a sealed envelope by the supervisor and the supervisor's shall sign their name over the flap of the envelope and the sealed, signed envelope shall be given to the applicant to submit.)

As per Section 49.13(b)(5), the supervisor, or one to whom supervisory responsibilities have been delegated, shall meet with the supervisee for a minimum of 2 hours for every 40 hours of supervised clinical experience. At least 1 of the 2 hours shall be with the supervisee individually and in person, and 1 of the 2 hours may be with the supervisee in a group setting and in person.

As per Section 49.13(b)(9), the supervised clinical experience shall be completed in no less than 2 years and no more than 6 years, except that no less than 500 hours and no more than 1,800 hours may be credited in any 12-month period.

I verify that _____ has met the requirements of Sections 49.13(b)(5) and 49.13(b)(9) of the regulations.

I verify that I have reviewed and understand Sections 49.13(b) and 49.14 of the regulations. I further verify that the supervised clinical experience documentation completed on these forms was completed based on my records and will provide the records upon request by the Board.

I verify that the statements in this verification of Clinical Supervised Experience are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 (relating to unsworn falsification to authorities) and may result in the suspension or revocation of my license. I also verify that I have complied with Section 49.14 of Title 49 Standards for supervisors.

_____ _____

Signature of Supervisor Date

(Pages 3, 4 and 5 must all be placed in a sealed envelope by the supervisor and the supervisor's shall sign their name over the flap of the envelope and the sealed, signed envelope shall be given to the applicant to submit.)