CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR LICENSED ASSOCIATE COUNSELOR OF MENTAL HEALTH
INSTRUCTION SHEET

Before completing the application for licensure as an Associate Counselor of Mental Health (LACMH), both you, as the applicant, and your supervisor(s) should carefully read this entire instruction sheet–including the counseling experience and supervision requirements explained below. The hours of experience and supervision that you will be completing are documented on the **WRITTEN PLAN FOR PROFESSIONAL COUNSELING EXPERIENCE AND SUPERVISION** section of the application. To assure that both you and your supervisor(s) understand the plan, both must sign off on it.

Associate Counselor of Mental Health
POST-MASTERS MENTAL HEALTH COUNSELING EXPERIENCE REQUIREMENTS

When applying for Licensed Associate Counselor of Mental Health (LACMH), you must arrange for the Board office to receive verification that you will be acquiring the required hours of post-masters professional mental health clinical counseling experience.

Definitions to Understand

- Professional mental health clinical counseling experience means hours spent providing face-to-face professional mental health clinical counseling services with clients and other matters directly related to the treatment of clients in a setting that is clearly designated to provide professional and mental health clinical counseling services and is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPPA).
- Direct supervision means face-to-face consultation, on a regularly scheduled basis between a LACMH and a Licensed Professional Counselor of Mental Health (LPCMH) as required by the nature of the work of the LACMH. The supervising LPCMH is responsible for insuring that the extent, kind and quality of the services rendered by the LACMH are consistent with the person's education, training and experience.
- An approved clinical supervisor must be a Delaware-licensed LPCMH with the exceptions listed below. If your proposed supervisor is in one of the categories listed below, the Board must ***pre-approve*** the supervisor.
    - If a Delaware-licensed LPCMH is not available, you may request approval from the Board for supervision by another professional licensed by the Board of Professional Counselors of Mental Health and Chemical Dependency Professionals. You must document a compelling reason, and the proposed supervisor must demonstrate sufficient competence to supervise a LACMH.
    - If a supervisor licensed by the Board is not available, you may request approval from the Board for supervision by a professional counselor of mental health licensed in another state. The proposed supervisor must have held a license in good standing for at least five years in that state and must be certified by the National Board of Certified Counselors.
    - Only if none of the above professionals is available, you may request approval from the Board for supervision by an individual who holds any of the following licenses in any state ***and*** who is trained in professional mental health counseling supervision: clinical social worker, psychologist practicing in the clinical realm, or physician specializing in psychiatry.

  Any proposed supervisor who is not licensed by the Delaware Board of Professional Counselors of Mental Health and Chemical Dependency Professionals must attest that he/she has read and is familiar with Delaware's licensure requirements, including the applicable statutes, rules and regulations. He/she must also attest to having at least five years of good standing, post-licensure experience and that he/she is trained to provide clinical supervision.

  Certified school counselors and certified school psychologists are not approved clinical supervisors.

Associate Counselor of Mental Health
POST-MASTERS MENTAL HEALTH COUNSELING EXPERIENCE REQUIREMENTS
(continued)

Breakdown of Hours of Counseling Experience Under Direct Supervision

You will be required to provide verification that you have completed a total of ***at least 1600 hours*** of ***post-Masters mental health counseling*** while under the ***direct supervision*** of one or more ***approved clinical supervisors***.

- At least 1500 of the 1600 hours must be actual face-to-face direct mental health counseling services. Of the 1500 hours, at least 750 hours must be individual face-to-face client sessions and must involve providing direct mental health counseling services. The other 750 hours may be individual, group, couple or family counseling services or some combination of those services.
- At least 100 of the 1600 hours must be face-to-face professional direct supervision with your supervisor. When totaled, at least 60 of the 100 hours of direct supervision under all approved clinical supervisors must be face-to-face one-on-one – that is, you and your supervisor. The remaining 40 may be in a group setting – that is, you, your supervisor, and up to six other LACMH supervisees.
- ***All*** **of the required hours, whether or not directly supervised—must be completed in a period of not less than two but no more than four years.**

Counseling Experience *Not* Under Direct Supervision

Whether any further documentation of hours of post-Masters experience is required depends on whether you have completed 30 post-Masters credit hours in the field of counseling.

IF you have…	THEN…
completed 30 post-Masters credit hours in the counseling field	no further documentation of post-Masters experience is required other than an official transcript, sent directly from the school(s), showing that you have completed the credit hours.
not completed 30 post-Masters credit hours in the counseling field	your clinical or administrative supervisor(s) must verify that you have provided additional hours of post-Masters mental health counseling. These hours, when added to the 1600 or more hours of direct supervision verified by your clinical supervisor(s), must total at least 3200 hours.

For more information about the experience requirements, refer to Sections 2.1.3 and 2.1.4 of the Board's Rules and Regulations available at www.dpr.delaware.gov.

Requirements for *All* Applications

Both you and your supervisor(s) should carefully follow the instructions for completing the forms. *Incomplete or incorrectly completed forms delay processing of the application*. The Board will not accept a resume in lieu of or in addition to the forms.

☐ Submit completed, signed and notarized *Application for Licensed Associate Counselor of Mental Health*.
- Applications that are incomplete, unsigned or not notarized will be rejected.

☐ Enclose the processing fee by check or money order made payable to the "State of Delaware."
- Applications not accompanied by the required fee will be rejected.

☐ Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the form to arrange to be fingerprinted.

☐ Arrange for the Board office to receive verification of your examination scores as follows:
- If you have passed the NCE (National Counselor Exam) available through the NBCC, follow the instructions for requesting score verifications on the NBCC website at www.nbcc.org.
- If you have passed an exam other than the NCE, arrange for the Board office to receive a *National Certifying Organization Certification Form* sent *directly* from the certifying organization to the Board office and verification of your exam scores. Follow the instructions on the form. Note that the organization must be acceptable to the Board. For more information on certifying organizations, see Section 2.1.1.1 of the Board's Rules and Regulations.

☐ Arrange for the Board office to receive a verification of licensure from each jurisdiction (state, U.S. territory, District of Columbia) where you now hold, or have *ever* held, a license to practice as a mental health professional.
- You may use the *Verification of Licensure* form enclosed with this packet to request the verification.

☐ Arrange for the Board office to receive an official transcript showing your completed graduate degree, sent *directly* from the college/university to the Board office.

☐ If you have 30 post-Masters credit hours in the field of counseling, arrange for the Board office to receive an official transcript showing these graduate credits, sent *directly* from the school(s) to the Board office.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.
- *The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants:* Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

☐ Arrange for your *approved clinical supervisor(s)* under whose supervision you will complete the required hours to complete the box entitled **PLANNED DIRECT SUPERVISION**.

☐ If you do not have 30 post-Master credit hours, arrange for the box entitled **PLANNED PROFESSIONAL COUNSELING Experience** to be completed and signed to verify the experience that you plan to finish while not under your approved clinical supervisor's direct supervision.
- For experience you plan to complete while employed, your *clinical or administrative supervisor(s)* must complete and sign the boxes.
- For experience you plan to complete while self-employed, a *professional colleague, supervisor or other individual who will have personal knowledge of your professional practice while self-employed* must complete and sign the boxes. The person who attests to your experience while self-employed cannot be related to you as a spouse, former spouse, parent, step-parent, grand-parent, child, step-child, sibling, aunt, uncle, cousin or in-law.

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APPLICATION FOR LICENSED ASSOCIATE COUNSELOR OF MENTAL HEALTH

IDENTIFYING AND CONTACT INFORMATION

1. Full Name: _____ _____ _____
   Last First Middle

2. Other Names Used: _____ _____ _____
   (Include maiden, prior married, alternate spellings)

3. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

4. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ If yes, enter your SSN: _____
   If no, you must file a *Request for Exemption from Social Security Number Requirement*.

5. Mailing Address: _____

   _____ _____ _____
   City State Zip

6. Phone: _____ _____ Email: _____
   Home Work

EXAMINATION INFORMATION

7. Have you passed the National Counselor Exam (NCE) or a standardized examination which is substantially similar to NCE? Yes ☐ No ☐ Exam Type: _____ Date of Exam: _____

   Arrange for the Board office to receive verification of your examination scores sent *directly* from the organization. If you are certified by another national mental health organization (other than the NBCC), arrange for the Board office to receive a *National Certifying Organization Certification Form* sent *directly* from the certifying organization to the Board office.

LICENSURE HISTORY

8. Have you ever held a license to practice as a mental health professional in any jurisdiction other than Delaware? Yes ☐ No ☐ If yes, enter the following information about *each* mental health license that you have *ever* held.

JURISDICTION	TYPE OF LICENSE HELD	LICENSE NUMBER	LICENSURE DATES	
			From	To

Arrange for the Board office to receive a verification of licensure from *each* jurisdiction where you have *ever* held a mental health professional license.

9. Have you ever been denied licensure in any other jurisdiction? Yes ☐ No ☐ If yes, explain fully: _____

   _____

DISCLOSURES

10. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon? Yes ☐ No ☐ **If yes, attach a detailed explanation of the charges.**

    Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks.

11. Are any criminal charges pending against you? Yes ☐ No ☐ **If yes, enclose a detailed explanation along with any documentation of the charges.**

12. Have you received any administrative penalties regarding your actions as a licensed, registered or certified mental health provider, including but not limited to fines, formal reprimands, license suspensions or revocation (except for license revocations for nonpayment of license renewal fees), probationary limitations, and/or have you entered into any "consent agreement" which contains conditions placed by a Board on your professional conduct, including any voluntary surrender of a license? Yes ☐ No ☐ **If yes, enclose a detailed explanation of all such penalties.**

13. Are any disciplinary actions pending against you? Yes ☐ No ☐ **If yes, enclose a detailed explanation of any pending actions.**

14. Have you done any of the following grounds for discipline:
    - committed or knowingly cooperated in a fraud or material deception in order to acquire a license? Yes ☐ No ☐
    - impersonated another person holding a license? Yes ☐ No ☐
    - allowed another person to use your license? Yes ☐ No ☐
    - aided or abetted an unlicensed person to represent himself or herself as a licensee? Yes ☐ No ☐

    If yes to *any*, enclose a detailed explanation of the violations.

15. Do you currently excessively use or abuse drugs or have you done so in the past 3 years? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**

16. Have you engaged in an act which involved consumer fraud or deception, restraint of competition, or price fixing? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**

17. Do you have any impairment related to drugs or alcohol or a finding of mental incompetence by a physician that would limit your ability to act as a professional counselor of mental health or associate counselor of mental health in a manner consistent with the safety of the public? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**

18. Have you been penalized for any willful violation of the code of ethics adopted by the Board, the NBCC code of ethics or other similar professional mental health counseling standard? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**

19. Are you presently in violation of any Rule and Regulation set forth by the Delaware Board of Mental Health and Chemical Dependency Professionals? Yes ☐ No ☐ **If yes, enclose a detailed explanation of all such violations.**

DUTY TO REPORT

20. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** duty to report, in writing, within 30 days of becoming aware of information that you reasonably believe indicates that ***any healthcare provider*** including (but not limited to) any practitioner certified and registered to practice medicine in Delaware or licensed by the Board of Mental Health and Chemical Dependency Professionals
    - has engaged, or is engaging, in conduct that would constitute grounds of discipline under their licensing laws, or
    - may be unable to practice with reasonable skill and safety to the public by reason of mental illness or mental incompetence, physical illness (including deterioration through the aging process or loss of motor skill), or excessive abuse of drugs (including alcohol).

    I certify that I have read and understand 24 *Del. C.* §3018, 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and that I understand my *duty to report* to the Division of Professional Regulation. Yes ☐ No ☐

21. To obtain a Delaware license, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

22. To obtain a Delaware license, you must certify that you understand that you have a ***mandatory*** duty to **self report** when your license to practice in another jurisdiction has been disciplined, surrendered, suspended or revoked.

    I certify that I have read and understand 24 *Del. C.* §3009 (a)(7) and that I understand my *duty to self report*.
    Yes ☐ No ☐

GRADUATE EDUCATION

23. Have you earned a Master's or higher post-graduate degree in a counseling or behavioral science field?
    Yes ☐ No ☐ If yes, enter this information about the program from which you received the highest degree.

    Highest Degree Received: _____ Degree Date: _____

    Institution Name: _____

    Address: _____ _____ _____ _____
    Street City State Zip

    Arrange for the Board office to receive an official transcript sent *directly* from the school to the Board office.

24. Do you have 30 post-Masters credit hours in the counseling field? Yes ☐ No ☐ If yes, complete the following information about your post-Masters credit hours:

    Educational Institution: _____

    Dates: _____ _____ Number of Credits Earned: _____
    From To

    Arrange for the Board office to receive an official transcript showing these graduate credits, sent *directly* from the school(s) to the Board office.

WRITTEN PLAN FOR PROFESSIONAL COUNSELING EXPERIENCE AND SUPERVISION

25. Is your clinical supervisor a Delaware-licensed Professional Counselor of Mental Health? Yes ☐ No ☐ **If no, explain *in detail* (1) the additional steps you took to secure a LPCMH to supervise you and (2) why you are proposing another professional as your supervisor.**

    _____
    _____
    _____
    _____
    _____
    _____
    _____
    _____
    _____
    _____

26. On the next pages, provide the requested information about the direct supervision and professional counseling experience that you will be completing as follows:

    - Arrange for your *clinical* supervisor to complete and sign the box entitled **PLANNED DIRECT SUPERVISION** to verify the hours of direct supervision that you will receive. If you will receive direct supervision in more than one period under different supervisors, have the approved clinical supervisor for each period complete a box for the period during which he or she will supervise you.
    - If you do ***not*** have 30 post-Masters credit hours in the counseling field, arrange for an administrative supervisor to complete the box entitled **PLANNED PROFESSIONAL COUNSELING EXPERIENCE** to verify the hours of post-Master's professional clinical counseling experience that you will receive while ***not*** under the direct supervision of an approved clinical supervisor. If you will have more than one period of experience, arrange for a separate box to be completed for each period of experience.

    Make sure that the supervisors completing the boxes follow the instructions carefully.

PLANNED DIRECT SUPERVISION – To be completed by *Clinical* Supervisor only

INSTRUCTIONS

The proposed clinical supervisor completes this PLANNED DIRECT SUPERVISION form to document hours that he or she will be directly supervising a LACMH. According to the LACMH regulations…

- *Direct supervision is overseeing the LACMH's application of clinical counseling principles, methods, or procedures to assist individuals achieve more effective personal and social adjustment. Individual supervision is one to one, face-to-face, meetings between the Supervisor and LACMH. Group supervision is face-to-face meetings between supervisor, LACMH, and up to six other supervisees.*
- The applicant is required to complete a total of ***at least 1600 hours*** of ***post-Masters direct mental health counseling experience*** while under the ***direct supervision*** of one or more ***approved clinical supervisors***.
  - At least 1500 of the 1600 hours must be actual face-to-face direct mental health counseling services. Of the 1500 hours, at least 750 hours must be individual face-to-face client sessions and must include actually providing direct mental health counseling services. The other 750 hours may be individual, group, couple or family counseling services or some combination of those services.
  - At least 100 of the 1600 hours must be face-to-face professional direct supervision with the applicant's supervisor. When totaled, at least 60 of the 100 hours of direct supervision under all approved clinical supervisors must be face-to-face one-on-one – that is, the applicant and applicant's supervisor. The remaining 40 may be in a group setting – that is, the applicant, the supervisor, and up to six other LACMH supervisees.
- ***All* of the required hours, whether or not directly supervised, must be completed by the LACMH in a period of not less than two but no more than four years**.

INFORMATION ABOUT CLINICAL SUPERVISOR

1. Supervisor Name: _____ _____ _____
   Last First Middle

2. Provide the following information about your professional licensure:

✓	LICENSES HELD (check all that apply)	JURISDICTION	LICENSE #	ISSUE DATE
☐	Professional Counselor of Mental Health			
☐	Clinical Social Worker			
☐	Marriage and Family Therapist			
☐	Clinical Psychologist			
☐	Psychiatrist			

3. Are you a Delaware-licensed LPCMH? Yes ☐ No ☐ If yes, enter your license number: PC - _____
   If no, describe your supervisory experience and credentials:
   _____
   _____
   _____

4. Supervisor's Practice Name (if applicable): _____

5. Practice Address: _____
   _____ _____ _____
   City State Zip

6. Phone: _____ Email: _____

DIRECT SUPERVISION HOURS

7. Enter the dates of planned post-Master's clinical experience that the applicant will provide under your direct supervision: From _____ To _____
   Month/Year Month/Year

   This period must not span more than four years.

8. During the period entered above, how many total hours of face-to-face professional direct supervision will you provide to the applicant? _____ Of this total, enter the breakout:

   Individual supervision hours: _____ Group supervision hours: _____

PLANNED DIRECT SUPERVISION, continued

9. During this period, how many hours of individual face-to-face direct client contact will the applicant provide under your direct supervision? _____ (***At least 750 of the 1500 hours of direct mental health counseling experience must be individual face-to-face client sessions.)***

10. During this period, how many hours of group, couple, or family face-to-face direct client contact will the applicant provide under your direct supervision? _____ ***(Must not exceed 750 hours)***

11. Describe the clinical activities in which the applicant will participate. (Examples include clinical assessments, crisis interventions, and individual/group counseling.) _____

_____

_____

12. I attest that I have discussed the following with the applicant before completing this form. Answer each question***. If you answer 'NO' or 'N/A' to any question, enclose a written statement explaining why.***

I have explained to the applicant that I have the training, credentials, and competence to provide supervision in Delaware.	Yes ☐ No ☐ N/A ☐
I have discussed my role and responsibilities with the applicant. These include:	
• Evaluating the applicant's clinical competence and preparedness to practice independently	Yes ☐ No ☐ N/A ☐
• Ensuring that the applicant practices within the professional and ethical standards of the field	Yes ☐ No ☐ N/A ☐
• Ensuring that the applicant is aware of the rules and regulations for practicing independently in Delaware	Yes ☐ No ☐ N/A ☐
I have discussed a contingency plan for dealing with emergencies and crises.	Yes ☐ No ☐ N/A ☐
I have explained my model and style of supervision to the applicant.	Yes ☐ No ☐ N/A ☐
I have reviewed the supervisory feedback process, including performance appraisal, evaluation feedback, documentation, and feedback intervals.	Yes ☐ No ☐ N/A ☐
I have explained how I will assess the applicant's comprehension of ethical, legal, and professional requirements.	Yes ☐ No ☐ N/A ☐
I have ensured that the appropriate liability coverage is in place for the applicant and for myself.	Yes ☐ No ☐ N/A ☐
I have developed a process to address any issues or concerns regarding the applicant's performance, including the utilization of a third-party to remediate any performance issues, consultation for additional assistance, or options to address concerns.	Yes ☐ No ☐ N/A ☐
I have explained my role in endorsing the applicant for licensure or employment based on the applicant's demonstrated competence and qualifications and that I will not endorse an applicant whom I believe to be impaired in any way that would interfere with the performance of the duties associated with the endorsement.	Yes ☐ No ☐ N/A ☐
I have explained to the applicant that I have the training, credentials, and competence to provide supervision to a LACMH/LAMFT pursuant to the regulations of Delaware Board of Mental Health and Chemical Dependency Professionals.	Yes ☐ No ☐ N/A ☐
I have explained how I will assess the applicant's comprehension of ethical, legal, and professional requirements pursuant to the regulations of Delaware Board of Mental Health and Chemical Dependency Professionals.	Yes ☐ No ☐ N/A ☐
I have the ethical and legal authority to access confidential client information of the LACMH/LAMFT. Note: For supervisors who are not employees of the clinical setting where LAMHC/LAMFT is seeing clients a written agreement between the supervisor and agency should be executed.	Yes ☐ No ☐ N/A ☐

CERTIFICATION

I certify that I have personally completed this information and that the information provided herein is accurate and complete to the best of my knowledge.

***Clinical Supervisor Signature*: _____ Date: _____**

PLANNED PROFESSIONAL COUNSELING EXPERIENCE – To be completed by Administrative Supervisor only

INSTRUCTIONS

If the applicant does not have 30 post-Masters credit hours in the counseling field, an administrative supervisor completes the **PLANNED PROFESSIONAL COUNSELING EXPERIENCE** form to document estimated additional hours of professional counseling experience that the applicant will accrue while ***not*** under the direct supervision of an approved clinical supervisor. Remember that these additional hours, when added to the 1600 or more hours of direct supervision verified by the approved clinical supervisor(s), must total at least 3200 hours.

INFORMATION ABOUT PERSON VERIFYING EXPERIENCE

1. Name: _____ _____ _____
   Last First Middle
2. Practice Name Where Experience Will Occur: _____
3. Describe Practice: _____

   _____
   Examples include group practice, community mental health agency.
4. Practice Address: _____

   _____ _____ _____
   City State Zip
5. Phone: _____ Email: _____

EXPERIENCE HOURS

6. Enter the period when you will supervise the LACMH: From _____ To _____
   Month/Year Month/Year

This period must not span more than four years.

7. Calculate and enter the total number of hours of professional counseling experience that the applicant will engage in during this period while not under direct supervision of an approved clinical supervisor: _____

Answers such as "40 hours/week" will not be accepted.

CERTIFICATION

I certify that I have personally completed this information and that the information provided herein is accurate and complete to the best of my knowledge.

***Administrative Supervisor Signature*: _____ Date: _____**

To assure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within one year of filing may be considered abandoned and discarded. When your application is complete, please allow 4-8 weeks to receive your license.

AFFIDAVIT

The undersigned applicant for Licensed Associate Counselor of Mental Health, being sworn, deposes and affirms that he or she is the person who executed this application; that the statements contained on this application are true in every respect; that he or she has not suppressed or withheld information that might affect this application; that he or she will abide by the laws and the ethical standards of this profession; and that he or she has read and understands this statement.

The applicant further affirms that he or she has read and understands the Written Plan for Professional Counseling and Supervision contained in the application and that he or she will promptly report any change in the plan to the Board office.

The applicant authorizes all jurisdictions to release any and all information regarding his/her disciplinary history and current status to the Delaware Board of Mental Health and Chemical Dependency Professionals.

Signature of Applicant: _____ Date: _____

State of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____2_____.

Signature of Notary: _____

SEAL

My commission expires: _____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

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VERIFICATION OF LICENSE

Send a separate form to *each* jurisdiction other than Delaware where you have ever held a license to practice as a mental health professional. Before sending this form to the jurisdiction, it is advisable to find out if the jurisdiction requires a fee to provide a license verification. You may duplicate this form.

This section to be completed by applicant.

Last Name:_____ First:_____ Middle: _____

SSN:_____ Date of Birth:_____

Other Name(s) Used: _____

Jurisdiction Where Licensed: _____

License/Registration Number(s) in Jurisdiction Named Above: _____

I am applying for Delaware licensure as a(n):

☐ Professional Counselor of Mental Health ☐ Associate Counselor of Mental Health
☐ Chemical Dependency Professional
☐ Marriage and Family Therapist ☐ Associate Marriage and Family Therapist

Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Board of Mental Health and Chemical Dependency Professionals.

Applicant Signature: _____ Date: _____

This section to be completed by Licensing Authority.

Our records indicate that the applicant named above was licensed in the State/Province/Jurisdiction of:

_____ as a (type of license) _____

Registration/License Number: _____

Issue Date (month/day/year): _____ Expiration Date (month/day/year): _____

Has the licensee ever been subject to any disciplinary action or had his/her license revoked or suspended?

Yes ☐ No ☐ **If yes, please enclose a certified copy of the board's final order with this license verification.**

Are any disciplinary proceedings or unresolved complaints pending against the licensee? Yes ☐ No ☐

AFFIX OFFICIAL SEAL HERE

I certify that the statements contained herein are true and correct.

Printed Name of Official: _____

Signature of Official: _____ Date: _____

Title:_____

Phone: _____ Fax: _____ Email:_____

Return completed, signed and sealed form *directly* to the Board office at the address above.

Revised 10/2014

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CERTIFYING ORGANIZATION CERTIFICATION FORM

INSTRUCTIONS

The applicant below has applied for Delaware licensure as a mental health professional. This form elicits information about the applicant's certification issued by a national mental health specialty *other than* the National Board for Certified Counselors or the Academy of Clinical Mental Health Counselors.

- **The applicant completes the APPLICANT INFORMATION section and sends the form to the certifying organization.**
- **An official of certifying organization completes the INFORMATION ABOUT CERTIFYING ORGANIZATION section, signs the form and mails it *directly* to the Board office at the address above.**

INFORMATION ABOUT APPLICANT

1. Full Name: _____ _____ _____
   Last First Middle
2. Mailing Address: _____

   _____ _____ _____
   City State Zip
3. Enter the following information about your certification:

   Certifying Organization Name: _____

   Certified as: _____ Certification No. _____

   Date Certified: _____ Expiration Date: _____

I authorize the certifying agency named above to release information regarding my certification to the Delaware Board of Mental Health and Chemical Dependency Professionals.

Applicant Signature: _____ Date:_____

INFORMATION ABOUT CERTIFYING ORGANIZATION

1. Name of Certifying Organization: _____
2. Address: _____

   _____ _____ _____
   City State Zip
3. Is the applicant *currently* certified as represented above? Yes ☐ No ☐
4. Is the applicant currently in good standing? Yes ☐ No ☐ If no, explain: _____

   _____
5. To enable the Delaware Board to evaluate the applicant's certification, please enclose the following documents:

   ☐ Statement of Mission and Scope of Membership
   ☐ Description of Membership Examination
   ☐ Membership Requirements
   ☐ Code of Ethics for Members

Signature of Official: _____ Date: _____

Printed Name of Official: _____ Title: _____

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 9 am – 7 pm, Tue - Fri 9 am – 3 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(Between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Delaware State Police Troop Four
South DuPont Hwy & Shortley Rd.
Georgetown DE 19947
(Across from DelDOT & the State Service Ctr.)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants Residing in Delaware

1. If you are using the New Castle or Sussex Counties locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $69.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. *Personal checks are not accepted in any county.* As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Out-of-State Applicants

1. You can be fingerprinted by your local police agency. All types of fingerprint cards are accepted. If your local police agency cannot provide a fingerprint card, call **(302) 739-2134** to request a fingerprint card.

2. Your *Authorization for Release of Information* form and fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, sex, etc.), your form will be returned.

3. ***Mail*** the *Authorization* form, fingerprint card, and certified check or money order (*personal checks are not accepted*) for $69.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

⇨***ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.***

DO NOT SEND THE FORM OR FEE TO THE BOARD OFFICE

Revised 10/2014

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

AUTHORIZATION FOR RELEASE OF INFORMATION

Please print or type all information in black ink.

Check the type of license for which you are applying:

- ☐ Adult Entertainment
- ☐ Charitable Gaming Vendor
- ☐ Chiropractic
- ☐ Dental
- ☐ Massage
- ☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)
- ☐ Nursing (RN, LPN, APN)
- ☐ Nursing Home Administrator
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
- ☐ Physical Therapy/Athletic Trainer
- ☐ Podiatry
- ☐ Psychology
- ☐ Real Estate Appraiser (includes Appraisal Management Company)
- ☐ Speech/Hearing
- ☐ Social Work
- ☐ Texas Hold'em Individual
- ☐ Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers)

Print your current full name:

Last Name	First Name	Middle Initial	Suffix (e.g., Jr., Sr.)
_____	_____	_____	_____

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ Date: _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.