State of Tennessee
Department of Health
Health Related Boards
665 Mainstream Drive
Nashville, TN 37243

(Local) **(615) 741-5735** or (Toll Free) **(800) 778-4123**
http://tn.gov/health/topic/applied-behavior-analyst

Licensed Behavior Analyst / Licensed Assistant Behavior Analyst Application

Dear Applicant:

This packet contains information relative to achieving licensure as a Licensed Behavior Analyst ("LBA") or a Licensed Assistant Behavior Analyst ("LABA"). The requirements for application are detailed in the Licensed Applied Behavior Analyst Rules and Tennessee licensure statute (Title 63, Chapter 11, Part 3). Please read instructions, statute and rules carefully to ensure that your application is complete.

The Committee's administrative staff members are dedicated to the professional management of all applicant files. Typically, application materials are in the applicant's file within two (2) weeks of the postmarked date. Your application will be reviewed for completeness, and you will be notified when the review is finished. Please be aware that the review for completeness of your file does not indicate whether you are accepted as a candidate for licensure. All documents submitted to the Committee become part of your file and are not returnable or transferable. If you would like to personally review your file, please call the Committee administrator and make an appointment.

The Committee meets quarterly throughout the year. During these meetings, the Committee considers applications and support materials for the purpose of licensure. The Division of Health Related Boards is empowered to issue licenses to those applicants deemed qualified by the Applied Behavior Analyst Licensing Committee. Licenses are generally issued within thirty days of the Committee meeting.

Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred. The Committee asks that you please give the Committee office every consideration in this matter.

Please understand that applicants and licensees have the responsibility to notify the committee administrator whenever a change of name or mailing address occurs. Notifications need to be in writing, and notifications shall be received in the Committee's administrative office no later than thirty (30) days after the change is effective. Please reference your profession, license or certificate number, and *Applied Behavior Analyst Licensing Committee* in your correspondence. Additionally, a change of name request must be accompanied by the document that changed your name (marriage certificate, divorce decree, etc.).

If necessary documentation has not been received when your application is received by the Committee office, an initial deficiency letter will be sent to you by U.S. postal mail or via email (only if an email address is provided). The supporting documentation requested in the letter or email must be received in the Committee office within sixty (60) days from the date of the initial deficiency letter or email notification. **(Files not completed within sixty (60) days will be closed.)**

Absent any complicating factors, the average application processing time is six (6) to eight (8) weeks. Once the application is completed, your file will be reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.

To ensure timely receipt of materials, all information is to be addressed as follows:

Applied Behavior Analyst Licensing Committee
665 Mainstream Drive
Nashville, Tennessee 37243

Checklist

You send	You request others to send
___ Check or money order for all applicable fees ___ Signed application ___ Certified Birth Certificate or Notarized Copy of Birth Certificate ___ Declaration of Citizenship form (must be notarized) http://tn.gov/assets/entities/health/attachments/PH-4183.pdf ___ 1 signed recent passport type photograph (2x2)	____ 2 Recommendation Letters from Applied Behavior Analyst Professionals or Professionals of a related field (unless applying by reciprocity) **Must be on letterhead.** ____ Verification of Licensure, if licensed in other Jurisdiction regardless of the status of the license (i.e., inactive) ____ DIDD Applicant - Temporary Attestation Certificate (DIDD certified prior to July 12, 2012. Not needed if you hold a BACB credential) ____ Criminal Background Check http://tn.gov/health/article/CBC-instructions ____ Supervisor Affidavit (LABA Applicants) • **The Tennessee Committee will request proof of certification directly from the BACB. You do not need to send a request.**

- DIDD Applicants certified prior to July 12, 2012 should email **bruce.davis@tn.gov** or telephone (615) 532-1610 to request a Verification of *Temporary Attestation Certificate* be emailed to the Applied Behavior Analyst Licensing Committee to Lisa.Williams@tn.gov or Teddy.Wilkins@tn.gov. Only those certified before this date need a verification.

- Licensed Assistant Behavior Analyst applicants must provide **proof of ongoing supervision by a licensed behavior analyst who is currently certified as a BCBA or BCBA-D with the National Board** and currently licensed by the Tennessee Applied Behavior Analyst Licensing Committee

- You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §36-5-1301(a), as authorized by 42 U.S.C. §405 (c) (2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

PLEASE AFFIX PASSPORT STYLE PHOTO

LBA & DIDD Applicants	
5110	$350.00
5110	10.00
Total	$360.00

LABA Applicants	
5120	$250.00
5120	10.00
Total	$260.00

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

(Local) (615) 741-5735 or (Toll Free) (800) 778-4123 ext. 741-5735
http://www.tn.gov/health/

Licensed Behavior Analyst / Assistant Behavior Analyst Application

License applied for: ___ Licensed Behavior Analyst ___ Licensed Assistant Behavior Analyst

Applying by(check 1):___ National Certification (BACB) ___ DIDD Certified (ONLY Prior to July 12, 2012) ___ Reciprocity

Name: _____
Last First Middle Maiden (if not used as your middle name)

Current Home Mailing Address:

_____

_____

_____

Current Practice Name & Address:*

_____

_____

_____

***If you have no practice address, notify the Board of your practice address within 30 days of obtaining a practice address. If you have multiple practice address, please attach an additional page listing all practice addresses.**

Home Phone (____)_____ **Work Phone** (____)_____

E-Mail Address:_____
Do you wish to receive notifications, including renewal notification, from the Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. **Yes** _____ **No** _____

Social Security No. _____-_____-_____ **Birth Date:** _____/_____/_____

Race:_____ **Gender:** Female _____ Male _____ **U.S. Citizen**: Yes_____ No_____
All applicants must complete the Declaration of Citizenship form.

Entitled to Live and Work in the U.S. Yes ___ No___ (Must check box)

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.) Yes ____ No _____

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.) Yes ____ No _____

Have you ever been known by any other names besides what is listed above? Yes ____ No _____
If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known: _____

_____

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space.

From: Mo./Yr.	To: Mo./Yr.	Educational Institution	City, State	Degree Earned	Year Graduated

Have you ever been employed in a healthcare field? ____ **Yes** ____ **No**

If "yes" please complete your entire healthcare employment history starting with the most current position first. Use the back of this page, if you need additional space. Dates of employment must be included.

Company/ Employer:	Address: (City, and State)	Position:	Duties:	From: Mo./Yr.	To: Mo./Yr.

	YES	NO
Are you or have you ever been licensed in this profession in another state?	____	____
Are you or have you ever been licensed in any other profession in Tennessee or another state?	____	____

CERTIFICATION INFORMATION

BCBA ____ BCaBA _____ Certification number: _____ Date issued: _____

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED in this or any other healthcare profession**. Additional pages may be added if necessary. Request that verification of licensure be submitted directly to the Board's Office from each state.

STATE	PROFESSION	LICENSE NUMBER	CURRENT STATUS

Previous Behavior Analyst Related Employment (if applicable):

Employer's name _____

Type of facility _____

Facility address _____

_____

Your job title _____

Dates of employment _____(month/year) to _____(month/year)

Describe types of clients served and services delivered.

_____

_____

_____

Supervisor's name & position _____

Supervisor's licensure status _____

Previous Behavior Analyst Related Employment

Employer's name _____

Type of facility _____

Facility address _____

_____

Your job title _____

Dates of employment _____(month/year) to _____(month/year)

Describe types of clients served and services delivered.

_____

_____

_____

Supervisor's name & position _____

Supervisor's licensure status _____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made.
For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:

a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;

b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3. **"Minor Traffic Offense"** generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. **"Illegal use of illicit or controlled substances"** means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS

		YES	**NO**
(1)	Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated because of ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice?	_____	_____
(2)	Do you currently use any chemical substances with in any way impair of limit your ability practice your profession with reasonable skill and safety?	_____	_____

If so, please list:
_____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.]

(3)	At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	_____	_____

		Yes	No
(4)	Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?	_____	_____
(5)	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	_____	_____
(6)	Have ever held or applied for a license or certificate to practice professional counseling in any state, country, or province, that had been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
(7)	Have you ever held staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, or otherwise disciplined or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
(8)	Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, otherwise disciplined, or voluntarily under threat of investigation or disciplinary action?	_____	_____
(9)	Have you ever been convicted (including a "nolo contendere" plea or guilty plea) of a felony or a misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended??	_____	_____
(10)	Have you ever been rejected or censured by a professional association?	_____	_____
(11)	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered <u>against</u> you;	_____	_____
	b. Have you ever had settlement of any legal action rendered <u>against</u> you; or	_____	_____
	c. Are there any legal actions pending <u>against</u> you or to which you are a party?	_____	_____
(12)	Have ever held a license or certificate in any health care profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
(13)	My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state.	_____	_____

APPLICANT: FILL OUT THE FOLLOWING RELASE AND SIGN (MUST BE NOTARIZED)

RELEASE

I, _____, **of** _____
(Applicant's Name) *(City)* *(State)*

being duly sworn and identified as the person referred to in this application, solemnly swear or affirm that the statements on this application are true and correct. In signing this affidavit, I am aware that Chapter 9, Public Acts of 1947, provides that a person filing a forged affidavit of identification is subject to punishment prescribed by law for the crime of forgery. I further swear or affirm, that I have read the Professional and Ethical Compliance Code for the Behavior Analyst Certification Board (http://bacb.com/ethics-code/) and acknowledge that this is the ethical code in which Licensed Behavior Analysts and Licensed Assistant Behavior Analysts in the State of Tennessee are governed by.

I hereby attest that I have read Title 63, Professions Of The Healing Arts, Chapter 11 Psychologists, Part 3 Applied Behavior Analyst Licensing Committee, Tenn. Code Ann. § 63-11-301 through Tenn. Code Ann. § 63-11-311 (http://www.lexisnexis.com/hottopics/tncode/) and the General Rules & Regulations Governing the Practice of Licensed Behavior Analysts and Licensed Assistant Behavior Analysts, Rule 1180-05-.01 through 1180-05-.18 (http://publications.tnsosfiles.com/rules/1180/1180.htm).

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Committee may find necessary, which may include a full Committee interview.

RELEASE to the Committee, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a Licensed Behavior Analyst or Licensed Assistant Behavior Analyst in the State of Tennessee.

AUTHORIZE the committee, its staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications.

RELEASE from liability the Committee, its staff and all their representatives and any and all organizations that provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications and for resolving any doubts about such qualifications.

AUTHORIZE release, use of disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
Signature of Applicant Date

Sworn to before me this _____ day of _____, _____.

_____
Notary Public

My commission expires: _____

Seal

State of Tennessee
Department of Health
Board of Examiners in Psychology

Licensed Assistant Behavior Analyst Application
Supervisor Affidavit

The Assistant Behavior Analyst license will allow the applicant to perform the functions specified in T.C.A. § 63-11-302 only under qualified supervision and detailed in section 1180-05-.02. Statutory requirements for a Licensed Assistant Behavior Analyst supervisor can be found in T.C.A. § 63-11-308.

_____ has applied for an Assistant Behavior Analyst license. I will have the responsibility for direct supervision of applied behavior analyst services delivered by the above named applicant during the tenure of his/her license in accordance with standards of supervision in the current Board rules.

The applicant will provide assistant behavior analyst services at the following location(s):

_____

_____

Describe the types of clients that will be seen and services that will be provided.

_____

_____

_____

_____
Signature of Supervisor

_____
Print Name of Supervisor

Date _____

_____
Tennessee License Number

_____
National Board Certification Number

NOTE: No Assistant Behavior Analyst License will be issued until this form is completed and received in the Committee's office. Should the applicant's supervisor change, the supervisor and the applicant should notify the Committee within ten (10) days. A new form must be submitted designating the new supervisor.