State of Tennessee

Department of Health

Tennessee Board for Professional Counselors, Marital and Family Therapists and Clinical Pastoral Therapists

665 Mainstream Drive
Nashville, TN 37243

(615) 741-5735
1-800-778-4123 ext. 741-5735
https://www.tn.gov/health/health-program-areas/health-professional-boards/pcmft-board.html

Application and Procedures for

Upgrade to
Licensed Professional Counselor with
Mental Health Services Provider Designation

UNDERSTANDING THE APPLICATION PROCESS

1. **All application fees are non-refundable.**

2. All documents and fees required to be submitted by you or those that must be requested from the appropriate institutions in this application process, must be mailed directly to:

   Tennessee Board For Professional Counselors, Marital And Family Therapists
   And Clinical Pastoral Therapists
   665 Mainstream Drive
   Nashville, TN 37243 (37228 for overnight delivery only)

3. **Allow at least 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 reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred. (The Board asks that you please give the Board office every consideration in this matter.)

4. Please refrain from telephoning the Board office for updates on your application. We will contact you if there is information missing. Thank you for your cooperation.

5. If necessary documentation has not been received when your application is received by the Board office, an initial deficiency letter will be sent to you either by email or postal mail. The supporting documentation requested in the letter must be received in the Board office no later than sixty (60) days from the date of the initial deficiency letter. **(Files not completed within sixty (60) days will be closed.)**

6. You must put your social security number on this application 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 Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

7. Absent any complicating factors, the average application processing time is four to six (4-6) 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.

8. It is the applicant's responsibility to keep the board notified whenever a change of name or mailing address occurs. Such notification must be in writing and you must reference your profession and the board in your correspondence. Supporting documentation and written request for a name change must state the reason for the change, i.e., marriage, divorce, etc.

9. It is recommended that you do not make arrangements to accept employment as a Professional Counselor in Tennessee until you are granted a license number by the Board for Professional Counselors, Marital and Family Therapists and Clinical Pastoral Therapists.

UPGRADE FROM LICENSED PROFESSIONAL COUNSELOR TO MHSP LICENSE

Upgrade from the LPC license to a MHSP license, the applicant shall:

- Notify the Board in writing of intention to seek licensure, by using this form provided by the Board.

- Present proof of the following:

    1. Completion of the required Post Master's supervised experience in a clinical setting which meets the requirements of Rule 0450-01-.10; and
    2. Passage of the National Clinical Mental Health Counseling Examination and the Tennessee Jurisprudence Examination.

- Upon receipt of the materials specified in Parts 1 and 2 the Board shall consider the previously submitted licensure application appropriately supplemented and grant or deny the regular license application, based on satisfactory completion of all requirements for licensure.

- Pay the upgrade fee.

Upgrade from Certified Professional Counselor (CPC) Status to Licensed Professional Counselor Status:

- Individuals certified on July 1, 1991, as professional counselors may upgrade from certification to licensure by any of the following methods:

    1. Providing a copy of his current CPC renewal certificate and verification to the board's satisfaction, that he/she has had five (5) year's work experience, pursuant to Rule 0450-01-.14, as a certified professional counselor.
    2. Providing a copy of his current CPC renewal certificate and evidence that he has been certified by the National Board of Certified Counselors.
    3. Providing a copy of his current CPC renewal certificate and complying with the requirements pursuant to Rule 0450-01-.04(1).
    4. Pay the upgrade fee.

- Upgrading from Certified Associate Professional Counselor Status to Licensed Professional Counselor Status

    1. Any person certified as an Associate Counselor on July 1, 1991, shall be deemed to be a Certified Professional Counselor, but only for the purpose of upgrading to Licensed Professional Counselor.
    2. For the purpose of upgrading to Licensed Professional Counselor from Certified Associate Counselor, the board will accept a passing score on the Professional Exam Service examination, which was previously required for Associate Professional Counselors, as fulfilling the requirement of Rule 0450-01-.08.
    3. Pay the upgrade fee.

3166-001 $ 75.00
3166-006 $ 10.00

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
BOARD FOR PROFESSIONAL COUNSELORS, MARITAL & FAMILY THERAPISTS
AND CLINICAL PASTORAL THERAPISTS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243
http://tennessee.gov/health/topic/pcmft-board
(800) 778-4123, ext. 741-5735
(615) 741-5735

UPGRADE APPLICATION FOR LICENSE AS A PROFESSIONAL COUNSELOR WITH MENTAL HEALTH SERVICE PROVIDER DESIGNATION (LPC/MHSP)

Please select one:

___ Upgrade from LPC to MHSP ____ Upgrade from CPC to LPC

Name _____
First Middle and/or Maiden Last

Current Home Mailing Address:

_____
_____
_____

Current Practice Name and 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___

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 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 _____

Have you ever been known by any other names other than what is listed above? Yes _____ No _____

Please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known:
_____

_____

EDUCATIONAL 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. Request that an official transcript be submitted directly from the educational institution where you completed your master's degree directly to the board's administrative office.

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

EMPLOYMENT INFORMATION

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:	Dates From: Mo./Yr.	Dates To: Mo./Yr.

(This area left blank intentionally)

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "Yes" to any question, attach an explanation on a separate sheet. 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.

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 judgments, to learn and keep abreast of medical developments;
   b. The ability to communicate those judgments and medical information to clients 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 required tasks and procedures, 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 or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, 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 controlled substances"** means the use of controlled 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: Please respond to ALL questions. If you answer "Yes" to any question please attach a written explanation.	**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 or 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?	_____	_____
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. _____ _____

(This area left blank intentionally)

AFFIDAVIT AND RELEASE

I, _____, of _____, being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a licensed professional counselor in the State of Tennessee.

I HEREBY:

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

RELEASE to the Board, 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 professional counselor or licensed professional counselor with mental health service provider designation.

AUTHORIZE the Board, 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 Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith without malice concerning my competence, ethics, character, and/or other qualifications, for certification.

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

AUTHORIZE release, use and 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 **DATE**

VERIFICATION OF SUPERVISED POST-MASTERS EXPERIENCE

(If you have had more than one supervisor, please have **each** supervisor complete a separate form)

SUPERVISOR: PLEASE COMPLETE THIS FORM AND RETURN IT TO THE ADDRESS AT THE END OF THE FORM. **TYPE OR PRINT LEGIBLY.**

THE SUPERVISOR MUST COMPLY WITH THE FOLLOWING:

1. **Been licensed as an LPC, LPC-MHSP, LMFT, licensed psychologist, psychiatrist or LCSW for at least five (5) years; for MHSP status one may not be supervised by an LPC and one half of the hours MUST be supervised by an LPC/MSHP**
2. **Comply with Section F of the current code of ethics adopted by the American Counseling Association, except to the extent that it conflicts with the laws of the State of Tennessee or the Rules of the Board.**
3. **Complete twelve hours (12) training in supervision as defined by the Rule 0450-01-.10(1)(d) and submit verification of the hours with this form. Please include the most recent CE in supervision (three hours required each renewal cycle) OR submit proof of approval by board as approved supervisor.**
4. **Provide supervision based on the definition of supervision as defined by Rule 0450-01-.10(2).**

Name Of Applicant: _____

Supervisor's Name: _____

Supervisor's Address _____

_____

Supervisor's Email address: _____ Telephone Number: _____

Supervisor's License Number_____ State _____ Type Of License _____

If License is M.D. Or D.O., are you certified by The American Board Of Psychiatry And Neurology? _____Yes _____No

Date of initial license: _____ Expiration date of license: _____

Is your license in good standing? _____ Have you ever had any disciplinary action taken against you or your license? ____ Yes ____No

If Yes, Please Explain: _____

_____

What was the job title of applicant during the time of your supervision: _____

Dates Of Supervision: From _____ To _____

What activities did/does your clinical supervision include:

- ❑ sign off on charts
- ❑ discuss individual cases briefly
- ❑ discuss individual cases in depth
- ❑ member of treatment team
- ❑ other (describe) _____
- ❑ treatment planning (for MHSP)
- ❑ DSM/diagnosis (for MHSP)

Location Where Clinical Experience Took Place: _____

_____

Description of Clinical Experience: _____

_____

_____

_____ Total Individual Supervision Hours
_____ Total Group Supervision Hours
_____ Total ALL Supervision Hours
_____ Total Clinical Hours (Individual, Group, Family)
_____ Total Other Hours (Paperwork, Training, Etc.)
_____ Total All Hours

I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT.

Supervisor's Signature	License No.	Date

Send to:

Board for LPC/MFT/CPT
665 Mainstream Drive
Nashville, TN 37243

This Form May Be Duplicated