| | |
|---|---|
| 3166-001 | $75 |
| 3166-006 | 10 |
| Total | $85 |

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS

BOARD FOR PROFESSIONAL COUNSELORS, MARITAL & FAMILY THERAPISTS,
AND CLINICAL PASTORAL THERAPISTS
665 Mainstream Drive
NASHVILLE, TENNESSEE 37243
http://www.tn.gov/health/
(800) 778-4123, ext. 741-5735
(615) 741-5735

**APPLICATION FOR MENTAL HEALTH SERVICE PROVIDER DESIGNATION**

**INSTRUCTIONS**

1. Complete this application, have it notarized, and mail it to the above address. **Type or print legibly.**
2. Enclose a non-refundable check for $85, payable to the Board for Professional Counselors, Marital & Family Therapists, and Clinical Pastoral Therapists.
3. Attach a recent (within the last twelve (12) months) "passport" style photograph to the front of this application.
4. Enclose a course catalog or class syllabi regarding the required nine (9) graduate semester hours of coursework related to diagnosis, treatment, appraisal and assessment of mental disorders.
5. Applicants for initial licensure in Tennessee must obtain a criminal background check. Click http://www.tn.gov/health/topic/CBC-check.
6. Complete the attached Declaration of Citizenship form and have it notarized.

**NAME** _____
**First** **Middle and/or Maiden** **Last**

**DATE OF BIRTH** _____ **SOCIAL SECURITY #** _____

***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 Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.***

**CURRENT HOME MAILING ADDRESS:**

_____
_____
_____

**CURRENT PRACTICE ADDRESS:**

_____
_____
_____

**HOME PHONE #** _____ **WORK PHONE #** _____

Professional Counselor License Number: _____

## VERIFICATION OF EDUCATION

Nine (9) semester graduate hours in coursework specifically related to diagnosis, treatment, appraisal, and assessment of mental disorders are required. Courses should include diagnosis, treatment, and treatment planning, appraisal and assessment of mental disorders, psychopathology, and the use of the DSM. These subjects must have been the focus of the entire course or a substantial portion of a course.

In the space provided below, list the courses that meet the above requirement. If you have completed these courses since you last filed a transcript with the Board, you must have a transcript sent directly from the College or University to the Board's administrative office.

# COMPETENCY INFORMATION

**PLEASE ANSWER THE FOLLOWING QUESTIONS.** If any answers to questions in this part are in the affirmative, 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 professional counseling"** is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate diagnosis or evaluation, and exercise reasoned judgment, and to learn, and keep abreast of professional counseling developments;

   b. The ability to communicate those judgments and 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. **"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.

4. **"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.

5. **"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:** | **YES** | **NO** |
|---|---|---|
| 1. Do you currently have a medical condition which in any way impairs or limits your ability to practice professional counseling with reasonable skill and safety? | _____ | _____ |
| a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? | _____ | _____ |
| b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? | _____ | _____ |

[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.]

| **QUESTIONS:** | **YES** | **NO** |
|---|---|---|
| 2. Do you currently use chemical substances? | _____ | _____ |
| a. If yes, do they in any way impair or limit your ability to practice professional counseling with reasonable skill and safety? | _____ | _____ |
| 3. Are you currently engaged in the illegal use of controlled substances? | _____ | _____ |
| a. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances? | _____ | _____ |
| 4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? | _____ | _____ |

## COMPETENCY INFORMATION CONTINUED

| QUESTIONS: | | YES | NO |
|---|---|---|---|
| 5. | If you have ever held or applied for a license or certificate to practice professional counseling in any state, country, or province, has it or was it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? | | |
| 6. | If you have ever held staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, or otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action? | | |
| 7. | Have you ever applied for and been denied a state or federal controlled substance certificate? | | |
| | a. If you have possessed such a certificate has it ever been revoked, suspended, restricted, otherwise disciplined, or voluntarily under threat of investigation or disciplinary action? | | |
| 8. | Have you ever been convicted of a felony or a misdemeanor other than a minor traffic offense? | | |
| 9. | Have you ever been rejected or censured by a professional association? | | |
| 10. | In relation to the performance of your professional services in any profession: | | |
| | a. Have you ever had a final judgment rendered against you; or | | |
| | b. Have you ever had settlement of any legal action rendered against you; | | |
| | c. Are there any legal actions pending against you or to which you are a party? | | |
| 11. | If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? | | |

**APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC**

**AFFIDAVIT AND RELEASE**

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

**being duly sworn and identified as the person referred to in this application and signed photos attests to the truth of each statement made in said application. I further swear that I have read and understand the statute and the Rules and Regulations, which were enclosed in the application packet, and agree to abide by them in the practice of Professional Counseling 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 professional counseling.

**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 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.

**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**

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

_____ Affix Seal Here
**NOTARY PUBLIC**

My Commission expires _____

**VERIFICATION OF SUPERVISED POST-MASTERS EXPERIENCE**

**TO BE COMPLETED BY THE APPLICANT'S SUPERVISOR**

PLEASE COMPLETE THIS FORM AND RETURN IT TO THE ADDRESS BELOW. **Type or print legibly.**

If the applicant is requesting Mental Health Service Provider designation, then on your letterhead stationery please describe the nature of the applicant's client contact and indicate the Mental Health Services which the applicant delivered during the supervised experience. The experience should have included significant opportunity to appraise and assess, diagnose psychopathology, formulate treatment plans, and execute treatment using the **DSM** for mental disorders.

NAME OF APPLICANT: _____

NAME OF SUPERVISOR: _____

TITLE OF SUPERVISOR: _____

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LICENSE NUMBER OF SUPERVISOR NAMED ABOVE: _____

TITLE OF LICENSE: (i.e. M.D., D.O., L.P.C./M.H.S.P., L.M.F.T., L.C.S.W., Lic. Psychologist/H.S.P.) _____
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: _____

_____

I HEREBY CERTIFY THAT I SUPERVISED: _____
THIS SUPERVISION INCLUDED: (Name of Applicant)

_____ HRS. INDIVIDUAL SUPERVISION DATES OF SUPERVISION:

_____ HRS. GROUP SUPERVISION FROM _____ TO _____

---

I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT.

_____ _____
SUPERVISOR'S SIGNATURE DATE

SWORN TO BEFORE ME THIS _____ DAY OF _____, _____.

_____
NOTARY PUBLIC

MY COMMISSION EXPIRES _____ Affix Seal Here

SEND TO: Board for PC/MFT/CPT
665 Mainstream Drive
Nashville, TN 37243

JK/G5059291/PC

**THIS PAGE MAY BE DUPLICATED IF NEEDED.**