STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
BOARD FOR CLINICAL PASTORAL THERAPISTS, 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

APPLICATION FOR LICENSE AS A LICENSED CLINICAL PASTORAL THERAPIST

INSTRUCTIONS

1. Complete this application, sign, and return to the above address. **Type or print legibly.**
2. Enclose a non-refundable check for $360, payable to the Board for Professional Counselors, Marital & Family Therapists, and Licensed Pastoral Therapists.
3. If you are applying by endorsement as a fellow or diplomate of the A.A.P.C., disregard instructions 4, and 8 through 13 and do not complete pages 2 and 5. Instead enclose, or have sent, proof of being a fellow or diplomate and proof of current A.A.P.C. membership.
4. If you are applying by endorsement as a certified member of the A.A.P.C., disregard instructions 3, and 8 through 13 and do not complete pages 2 and 5. Instead enclose, or have sent, two (2) notarized affidavits signed by certified mental health professionals attesting to your period of service (5 year minimum) as a clinical pastoral therapist or pastoral counselor.
5. Enclose a notarized photocopy of your birth certificate.
6. All applicants must complete and have notarized the Declaration of Citizenship form found at: https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-3585.pdf
7. Attach a recent passport type photograph to the front of this application.
8. A Criminal Background Check is required. For instructions go to: (http://tn.gov/health/article/CBC-instructions)
9. Enclose, or have sent to the above address, two (2) original and recent letters typed on the signatory's letterhead verifying your good moral character and ethics. These must not be from family members.
10. Have your graduate transcript(s) sent directly from the educational institution(s) to the above address.
11. Have the PES (AAMFT exam), NBCC, EPPP, or ASWB send proof of successful completion of their written examination directly to the above address unless you have not yet taken one of the exams. You may take **any** of the above exams for licensure.
12. Enclose proof of successful completion of a practicum consisting of at least one (1) unit of full-time clinical pastoral education in a program accredited by the Association for Clinical Pastoral Education.
13. Enclose proof of successful completion of an internship consisting of at least two (2) years of clinical pastoral therapy training.
14. Have your supervisor complete page 5 and enclose it or have it sent to the above address.
15. If you have ever been licensed in any other states as a Clinical Pastoral Therapist or any other profession, please contact that state's licensing board and have them send a letter of verification directly to the board administrative office. Please enclose a copy of those state's statutes and rules and a copy of your original license(s) and renewal certificate(s) from those states.
16. You will be registered to take the jurisprudence exam, and contacted accordingly.

Attach
Photo Here

Appl.	3144-001	$200.00
Exam.	3144-001	$150.00
Reg.	3144-006	$ 10.00

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Method of application: _____Exam _____Endorsement _____Temporary

NAME _____

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 an official transcript be submitted directly from the ADA accredited educational institution where you completed your dental program.

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

LICENSURE INFORMATION

Are you or have you ever been licensed in this profession in another state? Yes _____ No _____

Are you or have you ever been licensed in any other profession in Tennessee or another state? Yes _____ No _____

List below ALL state, countries, or provinces in which you have ever been or are currently licensed or permitted. Please request that verification of licensure be submitted directly to the Board's office from each state. Additional pages may be added if necessary.

STATE	PROFESSION	LICENSE #	DATE ISSUED	CURRENT STATUS

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.

COMPETENCY QUESTIONS

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:	**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? Are you currently engaged in the illegal use of 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 marriage and family therapy 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 you 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. _____ _____

COURSE WORK SUMMARY

All courses listed on this page must also appear on the transcript sent directly from your college or university to the Board's Administrative Office.

COURSE NAME	*CREDIT HOURS	INSTITUTION

CORE CLINICAL THEORY (15 hour minimum)

PASTORAL COUNSELING THEORY (15 hour minimum)

AREAS OF SPECIALIZATION (15 hour minimum, examples are psychodynamic psychotherapy, marital & family therapy, cognitive therapy, and behavioral therapy)

DIAGNOSIS AND TREATMENT OF MENTAL DISORDERS (9 hours)

ADDITIONAL COURSES TAKEN

*Convert all quarter credit hours to semester credit hours; # quarter hours x .67 = # of semester hours

AFFIDAVIT AND RELEASE

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

I, being duly sworn and identified as the person referred to in this application attests 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 clinical pastoral therapist 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 clinical pastoral therapist.

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 POST-MASTERS SUPERVISED EXPERIENCE

TO BE COMPLETED BY THE APPLICANT'S SUPERVISOR

PLEASE COMPLETE THIS FORM AND RETURN IT TO THE ADDRESS BELOW. TYPE OR PRINT LEGIBLY. ON YOUR LETTERHEAD STATIONERY DESCRIBE THE SUPERVISED CLINICAL EXPERIENCE, INCLUDING ALL LOCATIONS. ENCLOSE PROOF OF BEING AN APPROVED SUPERVISOR. AN APPROVED SUPERVISOR IS A CERTIFIED CLINICAL PASTORAL THERAPIST WHO HAS MET ONE (1) OF THE THREE (3) FOLLOWING REQUIREMENTS:

1. Is a diplomat of the American Association of Pastoral Counselors;
2. Is a fellow of the American Association of Pastoral Counselors who is under supervision of a supervisor; or
3. Is a Board approved clinical pastoral therapy supervisor who submits evidence of:

   A. Five (5) years full-time experience in clinical pastoral therapy practice and supervision;
   B. One hundred twenty-five (125) hours of supervision specifically in the skill of providing supervision to clinical pastoral therapists; and
   C. A recommendation for Board approved supervisor status from the individual who provided supervision of the one hundred twenty-five (125) hours listed above.

Name Of Applicant: _____

Supervisor's Name: _____

Supervisor's Address _____

_____

Supervisor's Email address: _____ Telephone Number: _____

Supervisor's License Number_____ State _____ Type 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

1. Total hours of **CLINICAL CONTACT IN CLINICAL PASTORAL THERAPY** provided by the applicant during the time you supervised him/her.

_____ hours

2. Total hours of **INDIVIDUAL SUPERVISION** of this work (270 are required).

_____ hours

I CERTIFY THAT THE INFORMATION GIVEN AND THE ENCLOSED PROOF OF SUPERVISORY QUALIFICATIONS ARE CORRECT AND ACCURATE.

_____ _____

SUPERVISOR'S SIGNATURE DATE

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

THIS PAGE MAY BE DUPLICATED IF NEEDED.