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

Applications and Procedures for

Licensed Professional Counselor, Licensed Professional Counselor with Mental Health Services Provider Designation, and Temporary Licensed Professional Counselor with MHSP Designation

UNDERSTANDING THE APPLICATION PROCESS

1. **If you do not hold a master's degree in COUNSELING with sixty hours (60) of graduate courses, you do not qualify for this license.**

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

3. 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)

4. **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.)

5. 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.

6. 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.)**

7. 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.

8. 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.

9. 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.

10. 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.

QUALIFICATIONS FOR LICENSURE AS A LICENSED PROFESSIONAL COUNSELOR (WITHOUT MENTAL HEALTH SERVICE PROVIDER DESIGNATION)

Professional Counselor by Examination. To be eligible to submit an application, a candidate must show completion of the following:

- **You must hold a master's degree in COUNSELING with sixty (60) hours of graduate courses. Other degrees may be acceptable if the required coursework has been completed and must be reviewed by a board consultant.**

- Be at least 18 years of age.

- Must provide evidence that he/she is highly regarded in moral character and professional ethics (Rule 0450-01-.05)(b) by providing letter from two licensed mental health professionals.

- Education. The educational requirements must be completed prior to the date of application.

    1. Sixty (60) graduate semester hours, based upon a program of studies with a major in **counseling**, completed from an institution accredited by the Southern Association of Colleges and Schools, the Counsel for Accreditation of Counseling and Related Educational Programs, or a comparable accrediting body.

    2. The graduate coursework should include, but is not limited to, core areas of (one course may satisfy study in more than one of the study areas):

        (i) Theories of human behavior, learning and personality;
        (ii) Abnormal behavior;
        (iii) Theories of counseling and psychotherapy;
        (iv) Evaluation and appraisal procedures;
        (v) Group dynamics, theories and techniques;
        (vi) Counseling techniques;
        (vii) Multicultural counseling;
        (viii) Ethics;
        (ix) Research; and
        (x) Clinical practicum or internship (pursuant to T.C.A. § 63-22-104)

- A minimum of two (2) years of supervised post master professional experience consisting of not less than ten (10) hours per week and fifty (50) contact hours of supervision per year as defined by Rule 0450-01-.10 (1)(d). (One thousand (1000) total clinical hours one hundred (100) total hours of supervision).

- Pass the National Counselors Examination and the Tennessee Jurisprudence Exam pursuant to Rule 0450-01-.08.

- Until receipt of a license to practice as a Professional Counselor, an applicant will be required to practice under supervision, pursuant to Rule 0450-01-.10(f).

QUALIFICATIONS FOR LICENSURE AS A LICENSED PROFESSIONAL COUNELSOR WITH MENTAL HEALTH SERVICE PROVIDER DESIGNATION (LPC/MHSP).

Professional Counselor by Examination with MHSP designation. To be eligible to submit an application, a candidate must show completion of the following:

- **You must hold a master's degree in COUNSELING with sixty (60) hours of graduate courses. Other degrees may be acceptable if the required coursework has been completed and must be reviewed by a board consultant.**

- Be at least 18 years of age.

- Provide evidence that he or she is highly regarded in moral character and professional ethics (Rule 0450-01-.05)(b) by providing letter from two licensed mental health professionals.

- Education. The educational requirements must be completed prior to the date of application.

  1. Sixty (60) graduate semester hours, based upon a program of studies with a major in **counseling**, completed from an institution accredited by the Southern Association of Colleges and Schools, the Council for the Accreditation of Counseling and Related Educational Programs, or a comparable accrediting body;

  2. The graduate coursework should include, but is not limited to, the following core areas (one course may satisfy study in more than one of the study areas):

     (i) Theories of human behavior, learning and personality;
     (ii) Abnormal behavior;
     (iii) Theories of counseling and psychotherapy;
     (iv) Evaluation and appraisal procedures;
     (v) Group dynamics, theories and techniques;
     (vi) Counseling techniques;
     (vii) Multicultural counseling;
     (viii) Ethics;
     (ix) Research; and
     (x) Clinical practicum or internship (pursuant to T.C.A. § 63-22-104);
     (xi) Use of the DSM;
     (xii) Treatment and treatment planning

- Pursuant to T.C.A. § 63-22-120, a minimum of nine (9) graduate semester hours of coursework must be "specifically related to diagnosis, treatment, appraisal and assessment of mental disorders." This will be interpreted to mean passing nine (9) semester hours, either during the course of a graduate degree or as post-graduate work, in courses in which diagnosis, treatment and treatment planning, appraisal and assessment of mental disorders, psychopathology, and the use of the DSM were the entire focus of the course or comprised a substantial portion of the course work.

- Meet the following requirements for post-masters professional experience:

  1. The post-masters supervised experience must consist of a minimum of three thousand (3000) hours of direct clinical experience which is completed under supervision and which is completed no sooner than two (2) years nor more than four (4) years following the beginning of supervised clinical practice.

  2. Complete three thousand (3,000) hours of supervised post-masters professional experience, including one hundred and fifty (150) contact hours of supervision obtained pursuant to Rule 0450-01-.10(6).

a. One thousand and five hundred (1500) of the three thousand (3000) hours of supervised post-masters professional experience shall be face-to-face client contact hours.

b. One thousand and five hundred (1500) of the three thousand (3000) hours of supervised post-masters professional experience shall be clinically-related activities.

- Pass the National Counselors Examination, the National Clinical Mental Health Counseling Examination, and the Tennessee Jurisprudence Exam pursuant to Rule 0450-01-.08.

TEMPORARY LICENSURE FOR LICENSED PROFESSIONAL COUNSELOR WITH MENTAL HEALTH SERVICE PROVIDER DESIGNATION (LPC/MHSP)

- **You must hold a master's degree in COUNSELING with sixty (60) hours of graduate courses. Other degrees may be acceptable if the required coursework has been completed and must be reviewed by a board consultant.**

- An applicant for licensure as an LPC/MHSP may file an application for temporary licensure by submitting the non-refundable application fee required by Rule 0450-01-.06, and an application for licensure with all required documentation, pursuant to procedures outlined in paragraph (4) of this rule, except as follows:

  1. The applicant need not show proof of the post-master's supervisory hours required by Rule 0450-01-.05(4)(k).
  2. The applicant need not show proof of having passed the National Clinical Mental Health Counseling Examination or the Tennessee Jurisprudence Examination.
  3. The applicant must submit information about the proposed supervisor or supervisors, including proof that the supervisor meets the qualifications of Rule 0450-01-.10(1) and a copy of the proposed supervisory agreement or employment contract.

- No person may be issued more than one (1) temporary license, nor shall a temporary license be valid for more than three (3) years.

- If an applicant is granted a temporary license, the license shall remain valid until the Board grants or denies the regular license application or until it shall become invalid for any of the following reasons:

  1. Expiration of the three (3) year period.
  2. Failure to continue in supervision during the three (3) year period the license may be valid.
  3. Change of supervisors without notifying the Board, submitting the credentials of the proposed supervisor and obtaining the Board's approval.

- When a temporary license holder is notified by the Board that their temporary license is invalid for any reason, the applicant shall return the temporary license to the Board office within ten (10) days. The applicant is expected to cause his supervisor to notify the Board of any reason he is aware of that the license should become invalid. The Board will notify the supervisor when the temporary license becomes invalid.

To replace the temporary license with a regular license for LPC/MHSP, the applicant shall:

1. Notify the Board in writing of intention to seek licensure, using the form provided by the Board.
2. Present proof of the following:
   a. Completion of the required Post Master's supervised experience in a clinical setting which meets the requirement of Rule 0450-01-.10; and
   b. Passage of the National Clinical Mental Health Counseling Examination and the Tennessee Jurisprudence Examination.

3. 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.

Up Grade 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).

- 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.

APPLICATION PROCESS
FOR LICENSED PROFESSIONAL COUNSELOR

SECTION I

LICENSED PROFESSIONAL COUNSELOR BY EXAMINATION:

CHECK LIST FOR PROFESSIONAL COUNSELOR

You send	**You request others to send**
_____ Completed and signed application. _____ Fees of $210.00 ($200.00 application fee plus $10.00 State regulatory fee) payable to the Board for LPC/MFT/CPT. _____ Passport-style photograph taken within the last twelve months. _____ Notarized Declaration of Citizenship form https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-41833.pdf _____ Certified copy of birth certificate. _____ Two letters of recommendation from Licensed Mental Health Professionals. _____ Completed Course Work Summary work Sheet. _____ Verification of completion of a minimum of two (2) years supervised post master's experience. _____ Proof of supervisor's qualifications. (CE certificates showing 12 hours in supervisory training.) _____ Completed Mandatory Practitioner Profile Questionnaire ***(mail with the application)*** https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-3585.pdf	_____ Request that an official transcript be mailed from the educational institution at which you completed your 60 hour **master's degree in counseling** directly to the Board's office. _____ If you are or have ever been licensed, certified, registered, or permitted by any state to practice as a licensed professional counselor (or as any other health care professional), you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s). _____ NCE exam results from the NBCC _____ Tennessee Jurisprudence exam results from the NBCC _____ Criminal Background Check https://www.tn.gov/health/health-professionals/criminal-background-check.html

Licensed Professional Counselor by reciprocity:

- **At this time, Kentucky is the only state who has entered into a reciprocal agreement with Tennessee.** To apply by reciprocity from Kentucky one must have been licensed and practicing in Kentucky for a minimum of five (5) years. All other applicants must meet current requirements for licensure by examination.

APPLICATION PROCESS FOR LICENSED PROFESSIONAL COUNSELOR (LPC) WITH MENTAL HEALTH SERVICE PROVIDER (MHSP) DESIGNATION

SECTION II

LICENSED PROFESSIONAL COUNSELOR/MHSP:

CHECK LIST FOR PROFESSIONAL COUNSELOR/MHSP

You send	**You request others to send**
_____ Completed and signed application. _____ Fees of $210.00 ($200.00 application fee plus $10.00 State regulatory fee) payable to the Board for LPC/MFT/CPT. _____ Passport-style photograph taken within the last twelve months. _____ Notarized Declaration of Citizenship form found at: https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-41833.pdf _____ Certified copy of birth certificate. _____ Two letters of recommendation from Licensed Mental Health Professionals. _____ Completed Course Work Summary work Sheet. _____ Verification of completion of a minimum of two (2) years supervised post master's experience. _____ Proof of supervisor's qualifications. (CE certificates showing 12 hours in supervisory training.) _____ Completed Mandatory Practitioner Profile Questionnaire (**mail with the application)** https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-3585.pdf	_____ Request that an official transcript be mailed from the educational institution at which you completed your **master's degree in counseling** directly to the Board's office. _____ If you are or have ever been licensed, certified, registered, or permitted by any state to practice as a licensed professional counselor (or as any other health care professional), you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s). _____ NCE, NCMHCE, and Tennessee Jurisprudence exam results from the NBCC. _____ Criminal Background Check. https://www.tn.gov/health/health-professionals/criminal-background-check.html

APPLICATION PROCESS BY RECIPROCITY
FOR LICENSED PROFESSIONAL COUNSELOR (LPC) WITH
MENTAL HEALTH SERVICE PROVIDER (MHSP) DESIGNATION

SECTION II A

Please note that this agreement applies only to individuals eighteen (18) years of age or older who were properly licensed according to the statutes and rules of the home state and who demonstrate five (5) years of experience working as an LPCC or LPC/MHSP.

LICENSED PROFESSIONAL COUNSELOR/MHSP BY RECIPROCITY:

CHECK LIST FOR PROFESSIONAL COUNSELOR/MHSP

You send	**You request others to send**
_____ Completed and signed application. (applicants by reciprocity do not complete pages 16-17). _____ Fees of $210.00 ($200.00 application fee plus $10.00 State regulatory fee) payable to the Board for LPC/MFT/CPT. _____ Passport-style photograph taken within the last twelve months. _____ Notarized Declaration of Citizenship form found at: http://tn.gov/assets/entities/health/attachments/PH-4183.pdf _____ Certified copy of birth certificate. _____ Two letters of recommendation from Licensed Mental Health Professionals. _____ Completed Mandatory Practitioner Profile Questionnaire (**mail with the application**) https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-3585.pdf	_____ If you are or have ever been licensed, certified, registered, or permitted by any state to practice as a licensed professional counselor (or as any other health care professional), you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s). _____ Tennessee Jurisprudence exam results from the NBCC. _____ Criminal Background Check. https://www.tn.gov/health/health-professionals/criminal-background-check.html

APPLICATION PROCESS
FOR TEMPORARY LICENSED PROFESSIONAL COUNSELOR (LPC) WITH MENTAL HEALTH SERVICE PROVIDER (MHSP) DESIGNATION

SECTION III

LICENSED PROFESSIONAL COUNSELOR WITH MENTAL HEALTH SERVICE PROVIDER DESIGNATION BY TEMPORARY:

CHECK LIST FOR TEMPORARY PROFESSIONAL COUNSELOR

You Send	You request others to send
_____ Completed and signed application with Temporary application. _____ Fees of $360.00 ($200.00 application fee, $150.00 temporary license fee plus $10.00 State regulatory fee) payable to the Board for LPC/MFT/CPT. _____ Passport-style photograph taken within the last twelve months. _____ Notarized Declaration of Citizenship form found at: http://tn.gov/assets/entities/health/attachments/PH-4183.pdf _____ Certified copy of birth certificate. _____ Two letters of recommendation from licensed Mental Health Professionals. _____ Completed Course Work Summary work Sheet. _____ Request for Temporary Licensure form. _____ Proof of supervisor's qualifications. (CE certificates showing 12 hours in supervisory training.) _____ Completed Mandatory Practitioner Profile Questionnaire (**mail with the application)** https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-3585.pdf	_____ Request that an official transcript be mailed from the educational institution at which you completed your master's degree in counseling directly to the Board's office. _____ If you are or have ever been licensed, certified, registered, or permitted by any state to practice as a licensed professional counselor (or as any other health care professional), you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s). _____ NCE exam results from the NBCC _____ Criminal Background Check https://www.tn.gov/health/health-professionals/criminal-background-check.html

SECTION III A

To replace the temporary license with the regular license for LPC/MHSP, the applicant must do the following:

You Send	You request others to send
_____ Upgrade license form. _____ Verification of completion of a minimum of two (2) years supervised post master's experience. ____ Proof of supervisor's qualifications. (CE certificates showing 12 hours in supervisory training.)	_____ NCMHCE and Tennessee Jurisprudence exam results from the NBCC

APPLICATION PROCESS
FOR LICENSED PROFESSIONAL COUNSELOR BY UPGRADE FROM CERTIFIED

CHECK LIST FOR LICENSED PROFESSIONAL COUNSELOR BY UPGRADE FROM CERTIFIED

You Send	**You request others to send**
_____ Completed and signed application _____ Fees of $60.00 ($50.00 application fee plus $10.00 State regulatory fee) payable to the Board for LPC/MFT/CPT. _____ Pass port-style photograph taken within the last 12 months. _____ Notarized Declaration of Citizenship form found at: http://tn.gov/assets/entities/health/attachments/PH-4183.pdf _____ Certified copy of birth certificate. _____ Two letters of recommendation from Licensed Mental Health Professionals. _____ Completed Course Work Summary work Sheet. _____ Completed Mandatory Practitioner Profile Questionnaire (**mail with the application)** https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-3585.pdf	_____ If you are or have ever been licensed, certified, registered, or permitted by any state to practice as a licensed professional counselor (or as any other health care professional), you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s). _____ NCE exam results from the NBCC (if applicable) _____ Criminal Background Check https://www.tn.gov/health/health-professionals/criminal-background-check.html

Attach
Photo Here

3166-001	$200.00
3166-001	$ 50.00
3166-001	$150.00
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

APPLICATION FOR LICENSE AS A PROFESSIONAL COUNSELOR (LPC)

Please select one:

LPC _____ LPC/MHSP _____ Temporary _____ Reciprocity (KY only)

_____Upgrade from temporary to full LPC/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 in counseling directly to the board's administrative office.

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 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)

Name: _____

LPC COURSE WORK SUMMARY

All graduate courses, titles, and numbers listed on this page must also appear on the transcript(s) sent directly from your college or university to the Board's Administrative Office. If a course is taken in more than one (1) area, list the credit hours in **only one (1)** category. Please do not list the hours more than once on this sheet.

COURSE CATEGORIES (Core Area)	*CREDIT HOURS	INSTITUTION
THEORIES OF HUMAN BEHAVIOR, LEARNING AND PERSONALITY		
ABNORMAL BEHAVIOR AND PSYCHOPATHOLOGY		
THEORIES OF COUNSELING AND PSYCHOTHERAPY		
EVALUATION AND APPRAISAL PROCEDURES		
GROUP DYNAMICS, THEORIES AND TECHNIQUES		
COUNSELING TECHNIQUES		
MULTICULTURAL COUNSELING		
ETHICS		
RESEARCH		
USE OF THE DIAGNOSTIC AND STATISTICAL MANUAL		

Name: _____

TREATMENT AND TREATMENT PLANNING

TOTAL NUMBER OF HOURS _____

If the course work listed above is less than the sixty (60) hours required by T.C.A. §63-22-104, list additional courses below.

ADDITIONAL COURSES	*CREDIT HOURS	INSTITUTION

TOTAL NUMBER OF HOURS _____

*Count all quarter credit hours to semester hours: # of quarter hours x .67 = # of semester hours

CLINICAL PRACTICUM/INTERNSHIP

LIST THE LOCATION, DATES AND HOURS OF SUPERVISED PRACTICUM(S)/INTERNSHIP IN COUNSELING, WHICH INCLUDES A MINIMUM OF FIVE HUNDRED (500) CLOCK HOURS OF TRAINING. AT LEAST THREE HUNDRED (300) HOURS MUST BE COMPLETED IN A MENTAL HEALTH OR COMMUNITY AGENCY SETTING.

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**

REQUEST FOR TEMPORARY LICENSURE
AS A PROFESSIONAL COUNSELOR WITH
MENTAL HEALTH SERVICE PROVIDER DESIGNATION

Applicant: If you desire a temporary license, have your supervisor complete this page, and add $150 to the fee requested in instruction #2 on the first page of this application. Do not send this page separately; a request for temporary license must be returned with entire application.

NOTE: Documentation of twelve (12) contact hours related to counseling supervision and other related supervision topics. Must include most recent three (3) hours required during the renewal cycle. Contact hours must be provided by an approved professional association or approved by a counseling related credentialing organization. This documentation must accompany this form.

Name of Applicant _____
(Please Print) Last First Middle

I, the undersigned, hereby accept responsibility for direct supervision of the above named applicant.

_____
Name of Supervisor (Please Print)

_____
License Number of Supervisor Date of Initial License

For Office Use Only
Temporary License

Number _____

Issued _____

Expires _____

Extended _____

Title of Supervisor's License: _____
(i.e., M.D., D.O., L.P.C./M.H.S.P., L.M.F.T., L.C.S.W., Lic. Psychologist)
If license is M.D. or D.O., are you certified by the American Board of Psychiatry and Neurology? ___ Yes ___ No

Supervisor's: Name: _____

Street Address: _____

_____
City State Zip

Telephone #: (____)_____

_____ _____
Signature of Supervisor Date

Subscribed and sworn to me this _____ day of _____, _____

_____
Notary Public

My commission expires: _____

(SEAL)

VERIFICATION OF SUPERVISED POST-MASTERS EXPERIENCE

(If you 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/MHSP**
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.**
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: _____

Approved Supervisor _____Yes _____No _____ Date of approval

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
- ❑ other (describe) _____
- ❑ treatment planning (for MHSP)
- ❑ DSM/diagnosis (for MHSP)
- ❑ member of treatment team

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

SWORN TO BEFORE ME THIS _____ DAY OF _____, _____

_____
NOTARY PUBLIC

MY COMMISSION EXPIRES _____ AFFIX SEAL HERE

Send to:

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

This Form May Be Duplicated