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 from Temporary License to Licensed Professional Counselor with Mental Health Services Provider Designation

UNDERSTANDING THE APPLICATION PROCESS

1. All documents 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)

2. **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.)

3. 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.

4. 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.)**

5. 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.

6. 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.

7. 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.

8. 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 TEMPORARY LICENSURE FOR LICENSED PROFESSIONAL COUNSELOR WITH MENTAL HEALTH SERVICE PROVIDER DESIGNATION (LPC/MHSP) TO FULL LPC/MHSP LICENSE

To replace the temporary license with a regular license for LPC/MHSP, 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 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.

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 FROM TEMPORARY LICENSE TO HEALTH SERVICE PROVIDER DESIGNATION (LPC/MHSP)

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:
____
____

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 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 <u>may not</u> be supervised by an LPC and one half of the hours <u>MUST</u> 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. **<u>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.</u>**
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