CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR PROFESSIONAL COUNSELOR OF MENTAL HEALTH LICENSURE
INSTRUCTION SHEET

General Information

The application asks you whether you are applying for a license as a Professional Counselor of Mental Health by examination or reciprocity.

- If you hold a *current* Professional Counselor of Mental Health license in another jurisdiction (state, District of Columbia or U.S. territory), apply by reciprocity.
- If you do ***not*** hold a current Professional Counselor of Mental Health license in another jurisdiction, apply by examination.

Read all instructions carefully before completing and submitting your application. Failing to follow instructions may delay your licensure. All auxiliary forms you need are included.

Requirements for *All* Applications

These items are required for all applications, regardless of whether you are applying by examination or reciprocity.

☐ Submit completed, signed and notarized *Application for Professional Counselor of Mental Health Licensure*.
- Applications that are incomplete, unsigned or not notarized will be rejected.

☐ Enclose the non-refundable processing fee by check or money order made payable to the "State of Delaware."
- If you hold an *active* Delaware Associate Counselor of Mental Health license and are applying for upgrade to a Professional Counselor license, enclose the upgrade fee instead of the full processing fee.
- Applications not accompanied by the required fee will be rejected.

☐ Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.

☐ Arrange for the Board office to receive a verification of licensure from each jurisdiction (state, U.S. territory, District of Columbia) where you now hold, or have *ever* held, a license to practice as a mental health professional.
- You may use the *Verification of Licensure* form accompanying the application to request the verification.

☐ Arrange for the Board office to receive verification of your National Counselor Examination scores (NCE), National Clinical Mental Health Counseling Examination (NCMHCE), or other examination acceptable to the Board as follows:
- If you have passed the NCE or NCMHCE, follow the instructions for requesting a ***score report*** on the National Board Certified Counselors (NBCC) website at www.nbcc.org/Exams.
- If you have passed another exam equivalent to the NCE or NCMHCE, arrange for the organization to send your score report directly to the Board office.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.
The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

Additional Requirements for Applications by *Examination*

When applying by examination instead of reciprocity, you must submit documentation of your mental health counseling education and post-Masters mental health counseling experience in addition to the requirements listed in the ***Requirements for All Applicants*** section above. **Both you and your supervisor(s) should carefully follow the instructions for completing the required forms. *Incomplete or incorrectly completed forms delay processing of your application*. A resume will <u>not</u> be accepted in lieu of or in addition to the forms.**

☐ Arrange for your college/university to send an official transcript *directly* to the Board office.

☐ Documentation of your coursework is needed when your graduate program of studies is *not* from a regionally accredited institution of higher education *or* your degree is in a discipline other than clinical mental health counseling. If you do ***not*** have a Master's degree in clinical mental health counseling with at least 60 graduate semester hours *or* an equivalent degree in clinical mental health counseling, submit the following:

- completed *Evaluation of Coursework* form (included with the application)
- course catalog or course descriptions

☐ If you have 30 post-Masters credit hours in the field of counseling, arrange for the Board office to receive an official transcript showing these graduate credits, sent *directly* from the school(s) to the Board office.

- You may substitute these credit hours for up to 1,600 of the 3,200 hours of post-Masters mental health counseling experience that are required.
- For details on the experience requirements, see the inset entitled **Post-Masters Mental Health Counseling Experience Requirements.**

☐ To verify the minimum 1,600 hours of direct supervision, arrange for the Board office to receive one or more *Direct Supervision Reference* forms completed and signed by your **approved clinical supervisor(s)**. The supervisor(s) must mail the forms *directly* to the Board office.

☐ If you do not have 30 post-Master credit hours, you must arrange for the Board office to receive one or more *Counseling Experience Verification* forms to verify the experience that you gained when you were ***not*** under the direct supervision of a clinical supervisor.

- For experience while you were employed, arrange for your clinical or administrative supervisor(s) to complete and mail one or more *Counseling Experience Verification-Employment* forms *directly* to the Board office.
- For experience while you were self-employed, arrange for a professional colleague, supervisor or other individual who has personal knowledge of your professional practice while self-employed to complete and mail one or more *Counseling Experience Verification-Self-Employment* forms *directly* to the Board office. The person who attests to your experience while self-employed cannot be your spouse, former spouse, parent, step-parent, grand-parent, child, step-child, sibling, aunt, uncle, cousin or in-law.
- All *Counseling Experience Verification* forms must clearly state ***the total number of post-Master's mental health counseling hours*** that you have provided. Giving only the dates of your employment or self-employment is not sufficient.
- **When combined, the mandatory 1,600 hours verified on the *Direct Supervision Reference* forms added to the hours verified on all of the *Counseling Experience Verification-Employment* and *Counseling Experience Verification-Self-Employment* forms must total at least 3,200 hours. *All* of these hours must span a period of not less than two but no more than four years**.

Professional Counselor of Mental Health
Post-Masters Mental Health Counseling Experience Requirements

When applying by examination, you must arrange for the Board office to receive verification that you have completed the required hours of post-Masters mental health counseling. The following definitions apply to this requirement:

- *Mental health counseling* means face-to-face interaction with clients and other matters directly related to the treatment of clients in a professional mental health clinical counseling setting.
- *Direct supervision* means overseeing the supervisee's application of clinical counseling principles, methods or procedures to assist individuals in achieving more effective personal and social adjustment.
- An *approved clinical supervisor* must be a licensed professional counselor of mental health, licensed marriage and family therapist, licensed clinical social worker, licensed clinical psychologist, or licensed physician specializing in psychiatry. Certified school counselors and certified school psychologists are *not* approved clinical supervisors.

1. You are required to have provided a total of ***at least 1,600 hours*** of ***post-Masters mental health counseling*** while under the ***direct supervision*** of one or more ***approved clinical supervisors***. When the hours under ***all*** approved clinical supervisors are combined, the 1,600 hours must span a period of *at least two but not more than four years*.
   - When totaled, at least 100 of the 1,600 hours of direct supervision under all approved clinical supervisors must be face-to-face sessions between you and your supervisor.
   - When totaled, at least 60 of the 100 hours of direct supervision under all approved clinical supervisors must be face-to-face one-on-one – that is, you and your supervisor. The remaining 40 may be in a group setting – that is, you, your supervisor, and up to five other supervisees.
2. Whether any further documentation of hours of post-Masters experience is required depends on whether you have completed 30 post-Masters credit hours in the field of counseling.

IF you have…	**THEN**…
completed 30 post-Masters credit hours in the counseling field	no further documentation of post-Masters experience is required other than an official transcript, sent directly from the school(s), showing that you have completed the credit hours.
not completed 30 post-Masters credit hours in the counseling field	your clinical or administrative supervisor(s) must verify that you have provided additional hours of post-Masters mental health counseling. These hours, when added to the 1600 or more hours of direct supervision verified by your clinical supervisor(s), must total at least 3,200 hours.

Example: You do not have 30 post-Masters credit hours in the counseling field. Your clinical supervisor verifies that you have provided 2,200 hours of mental health counseling under his *direct supervision.* Since you do not have 30 post-Masters credit hours, your administrative or clinical supervisor must also verify that you have provided at least 1,000 additional hours of mental health counseling. All 3,200 hours must be within a period of not less than two years but no more than four years.

For more information about the experience requirements, see Sections 2.1.3 and 2.1.4 of the Board's Rules and Regulations available at https://www.dpr.delaware.gov/boards/profcounselors/fees/.

Additional Requirements for Applications by *Reciprocity*

To apply by reciprocity, you must hold a *current* Professional Counselor of Mental Health license in another jurisdiction (state, District of Columbia or U.S. territory), and the license must be in good standing. You must also meet the requirements in the **Requirements for *All* Applicants** section above.

☐ Whether or not you need to submit any more documentation depends on how long you've been licensed in the jurisdictions where your license is *current*.
- If you have been licensed at least five years in any ***one*** jurisdiction, no further documentation is needed. You may be licensed by reciprocity.
- If you have been licensed less than five years in ***each*** of them, submit copies of the licensing law/rules and regulations from each jurisdiction where you hold a current license in good standing.

When required to submit law and rules as explained above, the Board will review the licensing standards of the other jurisdictions and determine if any of them is substantially similar to Delaware's standards.

- If any of the jurisdictions has substantially similar standards, you may be licensed by reciprocity. No further documentation is needed.
- If none of the jurisdictions has substantially similar requirements, the Board office will notify you that you cannot be licensed by reciprocity. However, you may apply for an Associate Counselor of Mental Health license.

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APPLICATION FOR PROFESSIONAL COUNSELOR OF MENTAL HEALTH LICENSURE

TYPE OF APPLICATION

1. Select the type of application you are filing (check one):

   ☐ Reciprocity – I hold a *current* Professional Counselor of Mental Health license in another jurisdiction (state, District of Columbia or U.S. territory).

   ☐ Examination – I do ***not*** hold a current license in another jurisdiction.

2. Do you hold a current Delaware Associate Counselor of Mental Health license? Yes ☐ No ☐ If yes, enter the license number: AC - _____.

IDENTIFYING AND CONTACT INFORMATION – *All* applicants complete this section.

3. Full Name: _____ _____ _____
   Last First Middle

4. Other Names Used: _____ _____ _____ None ☐
   (Include maiden, prior married, alternate spellings)

5. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

6. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ **If yes, enter your SSN:** _____
   If no, you must file a *Request for Exemption from Social Security Number Requirement*.

7. Mailing Address: _____

   _____ _____ _____
   City State Zip

8. Phone: _____ _____ Email: _____ None ☐
   Home Work

EXAMINATION HISTORY – *All* applicants complete this section.

You must have passed the NCE or NCMHCE exam or other examination acceptable to the Board regardless of whether you are applying by examination or reciprocity.

9. Enter the following information about your national examination:

✓	EXAMINATION NAME	DATE OF EXAM
☐	NCE	
☐	NCMHCE	
☐	Other:_____	

Arrange for the Board office to receive verification of your examination scores sent *directly* from the organization.

LICENSURE HISTORY – *All* applicants complete this section.

10. Has any jurisdiction ever denied your application for licensure? Yes ☐ No ☐ If yes, explain fully**:** _____

    _____

11. Have you ever held a license to practice as a mental health professional in any jurisdiction other than Delaware? Yes ☐ No ☐ If yes, enter the following information about *each* mental health license that you have *ever* held.

JURISDICTION	TYPE OF LICENSE HELD	LICENSE NUMBER	LICENSURE DATES	
			From	To

- **Arrange for the Board office to receive a verification of licensure from *each* jurisdiction where you have *ever* held a mental health professional license.**
- **If you are applying by reciprocity but you have *not* held any *active* license listed above for *at least five years*, arrange for the Board office to receive a copy each jurisdiction's law and regulations to be compared to those of Delaware.**

GRADUATE EDUCATION – *All* applicants complete this section.

12. Enter this information about the program from which you received your highest degree.

    Highest Degree Received: _____ Degree Date: _____

    School Name: _____

    Address: _____ _____ _____ _____
    Street City State Zip

    If applying by examination, arrange for the school to send an official transcript *directly* to the Board office.

13. Do you have a Master's degree in clinical mental health counseling with at least 60 graduate semester hours *or* an equivalent degree in clinical mental health counseling? Yes ☐ No ☐ **If no, submit**
    - **completed the *Evaluation of Coursework* form**
    - **course catalog or course descriptions.**

DISCLOSURES – *All* applicants complete this section.

14. Have you received any administrative penalties regarding your actions as a licensed, registered or certified mental health provider, including but not limited to fines, formal reprimands, license suspensions or revocation (except for license revocations for nonpayment of license renewal fees), probationary limitations, and/or have you entered into any "consent agreement" which contains conditions a Board has placed on your professional conduct, including voluntary surrender of a license? Yes ☐ No ☐ **If yes, enclose a detailed explanation of all such penalties.**

15. Are any disciplinary actions pending against you? Yes ☐ No ☐ **If yes, enclose a detailed explanation of any pending actions.**

16. Have you done any of the following grounds for discipline:
    - committed or knowingly cooperated in a fraud or material deception in order to acquire a license? Yes ☐ No ☐
    - impersonated another person holding a license? Yes ☐ No ☐
    - allowed another person to use your license? Yes ☐ No ☐
    - aided or abetted an unlicensed person to represent himself or herself as a licensee? Yes ☐ No ☐

    If yes to *any*, enclose a detailed explanation of the violations.

17. Do you currently excessively use or abuse drugs or have you done so in the past 3 years? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**

18. Have you engaged in an act which involved consumer fraud or deception, restraint of competition, or price fixing? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**

19. Do you have any impairment related to drugs or alcohol or a finding of mental incompetence by a physician that would limit your ability to act as a professional counselor of mental health or associate counselor of mental health in a manner consistent with the safety of the public? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**

20. Have you been penalized for any willful violation of the code of ethics adopted by the Board, the NBCC code of ethics or other similar professional mental health counseling standard? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**

21. Are you presently in violation of any Rule and Regulation set forth by the Delaware Board of Mental Health and Chemical Dependency Professionals? Yes ☐ No ☐ **If yes, enclose a detailed explanation of all such violations,**

DUTY TO REPORT – *All* applicants complete this section.

22. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** duty to report, in writing, within 30 days of becoming aware of information that you reasonably believe indicates that ***any healthcare provider*** including (but not limited to) any practitioner certified and registered to practice medicine in Delaware or licensed by the Board of Mental Health and Chemical Dependency Professionals
    - has engaged, or is engaging, in conduct that would constitute grounds of discipline under their licensing laws, or
    - may be unable to practice with reasonable skill and safety to the public by reason of mental illness or mental incompetence, physical illness (including deterioration through the aging process or loss of motor skill), or excessive abuse of drugs (including alcohol).

    Have you read 24 *Del. C.* §3018, 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and do you understand your *duty to report* to the Division of Professional Regulation? Yes ☐ No ☐

23. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    Have you read 16 *Del. C.* §903 and do you understand your *duty to report*? Yes ☐ No ☐

24. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** duty to **self report** when your license to practice in another jurisdiction has been disciplined, surrendered, suspended or revoked.

    Have you read 24 *Del. C.* §3009 (a)(7) and do you understand your *duty to self report*? Yes ☐ No ☐

PROFESSIONAL CLINICAL EXPERIENCE – Only applicants *by examination* complete this section.

25. Do you have 30 post-Masters credit hours in the counseling field? Yes ☐ No ☐ If yes, complete the following information about your post-Masters credit hours:

    Educational Institution: _____

    Dates: _____ _____ Number of Credits Earned: _____
    From To

    Arrange for the Board office to receive an official transcript showing these graduate credits, sent *directly* from the school(s) to the Board office.

26. On the next page, list your post-Masters professional clinical counseling experience. Begin with your most recent experience and work backward. When listing your experience, remember…
    - If you do not have 30 post-Masters credit hours (Question 25), ***all*** of the experience you list should ***total at least 3,200 hours***. If you have 30 post-Masters credit hours, ***all*** of the experience you list should ***total at least 1,600 hours***.
    - The dates of ***all*** of the employment and self-employment experience you list must span ***at least two years but no more than four years***.
    - In TOTAL HOURS, calculate and enter how many hours of ***actual mental health counseling*** you provided during that period. Answers such as "40 hours/week" will ***not*** be accepted.

If you need more room, you may copy this page.

PERIOD FROM _____ **TO** _____ **TOTAL HOURS**: _____

During this period, I was (check one): ☐ Employed—Position: _____
☐ Self-Employed—Title: _____

Employer Name (DBA if self-employed): _____

Address: _____

_____ _____ _____
City State Zip

Business Phone: _____ Email: _____

Supervisor Name: _____ Title/Professional Status: _____

Job Responsibilities and Activities: _____

_____

_____

_____

PERIOD FROM _____ **TO** _____ **TOTAL HOURS**: _____

During this period, I was (check one): ☐ Employed—Position: _____
☐ Self-Employed—Title: _____

Employer Name (DBA if self-employed): _____

Address: _____

_____ _____ _____
City State Zip

Business Phone: _____ Email: _____

Supervisor Name: _____ Title/Professional Status: _____

Job Responsibilities and Activities: _____

_____

_____

_____

- **To verify the required 1,600 hours of direct supervision, arrange for the Board office to receive *Direct Supervision Reference* forms completed and signed by your clinical supervisor(s) and sent *directly* to the Board office.**
- **If you do *not* have 30 post-Masters credit hours (Question 25), arrange for the Board office to also receive *Counseling Experience Verification* forms—*Employment* or *Self-Employment* versions, as applicable—to verify the remaining hours of the required 3,200 total hours of experience. See Instruction Sheet for information on who must complete and sign *Counseling Experience Verification* forms.**

27. List each current or former clinical supervisor who will be submitting a *Direct Supervision Form* to verify the required hours of direct supervision.

NAME	ADDRESS	PHONE/EMAIL

To ensure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within 12 months of filing may be considered abandoned and discarded. When your application is complete, please allow 4-8 weeks to receive your license.

AFFIDAVIT

The undersigned applicant for Licensed Professional Counselor of Mental Health or Licensed Associate Counselor of Mental Health, being sworn, deposes and affirms that he or she is the person who executed this application; that the statements contained on this application are true in every respect; that he or she has not suppressed or withheld information that might affect this application; that he or she will abide by the laws and the ethical standards of this profession; and that he or she has read and understands this statement.
The applicant authorizes all jurisdictions to release any and all information regarding his/her disciplinary history and current status to the Delaware Board of Mental Health and Chemical Dependency Professionals.

Signature of Applicant: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Notary Signature: _____

SEAL

My commission expires: _____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

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DIRECT SUPERVISION REFERENCE
PROFESSIONAL COUNSELOR OF MENTAL HEALTH

INSTRUCTIONS

The purpose of this form is to verify the ***hours of post-Masters mental health counseling*** that an applicant has provided while under the ***direct supervision*** of an ***approved clinical supervisor***. This form is not required for applicants applying by reciprocity.

Please follow these instructions for completing this form. ***Incomplete or incorrectly completed forms delay processing of the application.*** The clinical supervisor must complete the entire form, sign it and mail it *directly* to the Board office at the address above. Forms not received *directly* from the supervisor will not be accepted.

The applicant is not to complete any portion of this form!

In completing this form, the following definitions apply:

- Mental health counseling means face-to-face interaction with clients and other matters directly related to the treatment of clients in a professional mental health clinical counseling setting.
- Direct supervision means overseeing the supervisee's application of clinical counseling principles, methods or procedures to assist individuals in achieving more effective personal and social adjustment.
- An approved clinical supervisor must be a licensed professional counselor of mental health, licensed marriage and family therapist, licensed clinical social worker, licensed clinical psychologist, or licensed physician specializing in psychiatry. Certified school counselors and certified school psychologists are not approved clinical supervisors.

Applicants are required to have provided a total of at least 1600 hours of post-Masters mental health counseling while under the direct supervision of one or more approved clinical supervisors. When the hours under ***all*** approved clinical supervisors are combined, the 1600 hours must span a period of *at least two but not more than four years*.

- When totaled, at least 100 of the 1,600 hours of direct supervision under all approved clinical supervisors must be face-to-face sessions between the applicant and supervisor.
- When totaled, at least 60 of the 100 hours of direct supervision under all approved clinical supervisors must be face-to-face one-on-one – that is, applicant and supervisor. The remaining 40 may be in a group setting – that is, applicant, supervisor, and up to five other supervisees.

Section 2.1.4 of the Board's Rules and Regulations on https://www.dpr.delaware.gov/boards/profcounselors/fees/ explains the direct supervision requirements.

INFORMATION ABOUT CLINICAL SUPERVISOR

1. Applicant Name: _____ _____ _____
   Last First Middle

2. Supervisor Name: _____ _____ _____
   Last First Middle

3. Provide the following information about your professional licensure:

✓	LICENSES HELD (check all that apply)	JURISDICTION	LICENSE #	ISSUE DATE
☐	Professional Counselor of Mental Health			
☐	Clinical Social Worker			
☐	Marriage and Family Therapist			
☐	Clinical Psychologist			
☐	Psychiatrist			
☐	Other:_____			

4. Supervisor's Practice Name (if applicable): _____

5. Practice Address: _____

_____ _____ _____
City State Zip

6. Phone: _____ Email: _____ ☐ None

DIRECT SUPERVISION HOURS

7. Did you provide ***direct supervision,*** as defined above, to the applicant? Yes ☐ No ☐ If no, skip to the **Signature**.

8. Enter the dates of post-Master's clinical experience that the applicant provided while under your direct supervision:

   From _____ To _____
   Month/Year Month/Year

   This period must not span more than four years.

9. During this period, how many total hours of mental health counseling did the applicant provide while under your direct supervision? _____

   Calculate and enter a total number of hours. Answers such as "40 hours/week" will not be accepted.

10. During this period, how many total hours of face-to-face, individual (one-on-one) supervision did you provide to the applicant? _____

11. During this period, how many total hours of face-to-face, group supervision did you provide to the applicant? _____

CERTIFICATION

I certify that I have personally completed all sections of this form and that the information provided herein is accurate and complete to the best of my knowledge.

Clinical Supervisor Signature: _____ Date: _____

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COUNSELING EXPERIENCE VERIFICATION – EMPLOYMENT
PROFESSIONAL COUNSELOR OF MENTAL HEALTH

INSTRUCTIONS

The purpose of this form is to verify the hours of post-Masters mental health counseling that an employed applicant provided ***in addition to*** the mandatory minimum 1600 hours under direct supervision of an approved clinical supervisor. This form is not required when the applicant has 30 post-Masters credit hours in the field of counseling or is applying by reciprocity.

Please follow these instructions for completing this form. ***Incomplete or incorrectly completed forms delay processing of the application.*** The clinical or administrative supervisor must complete the entire form, sign it and mail it *directly* to the Board office at the address above. Forms not received *directly* from the supervisor will not be accepted.

The applicant is not to complete any portion of this form!

In completing this form, the following definitions apply:

- Mental health counseling means face-to-face interaction with clients and other matters directly related to the treatment of clients in a professional mental health clinical counseling setting.
- Direct supervision means overseeing the supervisee's application of clinical counseling principles, methods or procedures to assist individuals in achieving more effective personal and social adjustment.
- An approved clinical supervisor must be a licensed professional counselor of mental health, licensed marriage and family therapist, licensed clinical social worker, licensed clinical psychologist, or licensed physician specializing in psychiatry. Certified school counselors and certified school psychologists are *not* approved clinical supervisors.

Applicants who do not have 30 post-Masters credit hours in the counseling field are required to have provided a total of 3,200 hours of post-Masters mental health counseling.

- Of the 3200 hours, 1600 or more must be the mandatory hours of direct supervision by approved clinical supervisor(s). Hours of direct supervision are verified on the *Direct Supervision Reference* form. Do not enter direct supervision hours on *Professional Counseling Experience* forms.
- For hours provided while self-employed, use the *Professional Counseling Experience Form-Self Employment*.
- All 3,200 hours, including the mandatory minimum 1,600 hours of direct supervision, must be provided over a period of ***at least two but not more than four years***.

Section 2.1.3 of the Board's Rules and Regulations explains the experience requirements.

INFORMATION ABOUT SUPERVISOR

1. Applicant Name: _____ _____ _____
   Last First Middle
2. Supervisor Name: _____ _____ _____
   Last First Middle
3. Check type of supervision you provided to the applicant: ☐ Clinical ☐ Administrative
4. Supervisor's Practice Name (if applicable): _____
5. Practice Address: _____

   _____ _____ _____
   City State Zip
6. Phone: _____ Email: _____

VERFICATION OF COUNSELING HOURS

7. Enter the period when you supervised the applicant:

   From _____ To _____
   Month/Year Month/Year

   This period must not span more than four years.

8. During this period, how many total hours of mental health counseling did the applicant provide ***while not under direct supervision of an approved clinical supervisor***? _____

   Calculate and enter a total number of hours. Answers such as "40 hours/week" will not be accepted.

9. Describe the practice, agency, or setting where the applicant worked during the period above. (Examples include group practice, community mental health agency, etc.)

   _____

   _____

   _____

CERTIFICATION

I certify that I have personally completed all sections of this form and that the information provided herein is accurate and complete to the best of my knowledge.

Supervisor Signature: _____ Date: _____

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COUNSELING EXPERIENCE VERIFICATION FORM – SELF-EMPLOYMENT
PROFESSIONAL COUNSELOR OF MENTAL HEALTH

INSTRUCTIONS

The purpose of this form is to verify the hours of post-Masters mental health counseling that a self-employed applicant provided ***in addition to*** the mandatory minimum 1,600 hours under direct supervision of an approved clinical supervisor. This form is not required when the applicant has 30 post-Masters credit hours in the field of counseling or is applying by reciprocity.

Please follow these instructions for completing this form. ***Incomplete or incorrectly completed forms delay processing of the application.*** The clinical or administrative supervisor must complete the entire form, sign it and mail it *directly* to the Board office at the address above. Forms not received *directly* from the supervisor will not be accepted.

The applicant is not to complete any portion of this form!

In completing this form, the following definitions apply:

- Mental health counseling means face-to-face interaction with clients and other matters directly related to the treatment of clients in a professional mental health clinical counseling setting.
- Direct supervision means overseeing the supervisee's application of clinical counseling principles, methods or procedures to assist individuals in achieving more effective personal and social adjustment.
- An approved clinical supervisor must be a licensed professional counselor of mental health, licensed marriage and family therapist, licensed clinical social worker, licensed clinical psychologist, or licensed physician specializing in psychiatry. Certified school counselors and certified school psychologists are not approved clinical supervisors.

Applicants who do not have 30 post-Masters credit hours in the counseling field are required to have provided a total of 3,200 hours of post-Masters mental health counseling.

- Of the 3,200 hours, 1,600 or more must be the mandatory hours of direct supervision by an approved clinical supervisor. Hours of direct supervision are verified on the *Direct Supervision Reference* form. Do *not* enter direct supervision hours on *Professional Counseling Experience* forms.
- For hours provided while the applicant was employed, use the *Professional Counseling Experience Form- Employment*.
- The person completing this form to attest to the applicant's experience must be a professional colleague, supervisor or other individual who has personal knowledge of the applicant's professional practice while self-employed. This person cannot be the applicant's spouse, former spouse, parent, step-parent, grand-parent, child, step-child, sibling, aunt, uncle, cousin or in-law.
- All 3,200 hours, including the mandatory minimum 1,600 hours of direct supervision, must be provided over a period of ***at least two but not more than four years***.

Section 2.1.3 of the Board's Rules and Regulations available at https://www.dpr.delaware.gov/boards/profcounselors/fees/ explains the experience requirements.

INFORMATION ABOUT PERSON ATTESTING TO EXPERIENCE

1. Applicant Name: _____ _____ _____
   Last First Middle

2. Your Name: _____ _____ _____
   Last First Middle

3. Do you have personal knowledge of the extent of the applicant's professional practice while he or she was self-employed? Yes ☐ No ☐ If yes, explain your professional relationship to the applicant: _____

   _____

   _____

4. Are you related to the applicant as a spouse, former spouse, parent, step-parent, grand-parent, child, step-child, sibling, aunt, uncle, cousin or in-law? Yes ☐ No ☐ If yes, specify relationship: _____

5. Your Address: _____

_____ _____ _____
City State Zip

6. Phone: _____ Email: _____

EXPERIENCE HOURS

7. Enter the period of the applicant's experience of which you have personal knowledge:

From _____ To _____
Month/Year Month/Year

This period must not span more than four years.

8. During this period, how many total hours of mental health counseling did the applicant provide while *not* under direct supervision of an approved supervisor?

_____

Calculate and enter a total number of hours. Answers such as "40 hours/week" will not be accepted.

CERTIFICATION

I certify that I have personally completed all sections of this form and that the information provided herein is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

VERIFICATION OF LICENSE

Send a separate form to *each* jurisdiction other than Delaware where you have ever held a license to practice as a professional counselor of mental health. Before sending this form to the jurisdiction, it is advisable to find out if the jurisdiction requires a fee to provide a license verification. You may duplicate this form.

This section to be completed by applicant.

Last Name:_____ First:_____ Middle: _____

SSN:_____ Date of Birth:_____

Other Name(s) Used: _____

Jurisdiction Where Licensed: _____

License/Registration Number(s) in Jurisdiction Named Above: _____

I am applying for Delaware licensure as a:

☐ Professional Counselor of Mental Health ☐ Associate Counselor of Mental Health

☐ Marriage and Family Therapist ☐ Associate Marriage and Family Therapist

☐ Professional Art Therapist ☐ Associate Art Therapist

☐ Chemical Dependency Professional

Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Board of Mental Health and Chemical Dependency Professionals.

Applicant Signature: _____ Date: _____

This section to be completed by Licensing Authority.

Our records indicate that the applicant named above was licensed in the State/Province/Jurisdiction of:

_____ as a (type of license) _____

Registration/License Number: _____

Issue Date (month/day/year): _____ Expiration Date (month/day/year): _____

Has the licensee ever been subject to any disciplinary action or had his/her license revoked or suspended?
Yes ☐ No ☐ **If yes, please enclose a certified copy of the board's final order with this license verification.**

Are any disciplinary proceedings or unresolved complaints pending against the licensee? Yes ☐ No ☐

AFFIX OFFICIAL SEAL HERE

I certify that the statements contained herein are true and correct.

Printed Name of Official: _____

Signature of Official: _____ Date: _____

Title:_____

Phone: _____ Fax: _____ Email:_____

Return completed, signed and sealed form *directly* to the Board office at the address above.

Revised 9/2018

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

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BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

EVALUATION OF COURSEWORK

INSTRUCTIONS

Complete and submit this form if you do not have a Master's degree in clinical mental health counseling with at least 60 graduate semester hours *or* an equivalent degree in clinical mental health counseling. This applies when

- your graduate program of studies is *not* from a regionally accredited institution of higher education, *or*
- your degree is *not* in clinical mental health counseling but in a related discipline.

For each topic in the left column, enter the course number and title of the course(s) in the catalog that covered that topic.

CORE CLINICAL MENTAL HEALTH COUNSELING COURSE (44 CREDITS)	COURSE #	COURSE TITLE
Ethics and Practices of Clinical Mental Health Counseling		
Counseling Diverse Populations		
Tools, Techniques, and Strategies of Counseling I		
Human Development		
Theories of Counseling		
Tools, Techniques, and Strategies of Counseling II		
Psychopharmacology for Counselors		
Methods of Research and Program Evaluation		
Family Counseling		
Diagnosis and Treatment of Psychopathology		
Group Counseling		
Addictions Counseling		
Counseling for Career Development		
Appraisal Techniques		
Seminar: Consultation for Counselors		
Seminar: Supervision for Counselors		

CLINICAL MENTAL HEALTH COUNSELING SKILLS & PRACTICES (12 CREDITS)	COURSE #	COURSE TITLE
Practicum		
Internship I		
Internship II		

DIAGNOSING & INTERVENTION STRATEGIES (4 CREDITS)	COURSE #	COURSE TITLE
Advanced Seminar: Counseling Children & Adolescents		
Advanced Seminar: Cognitive Behavioral Counseling		
Advanced Seminar: Evidence Based Family Treatment		
Advanced Seminar: Motivational Interviewing		

Submit a course catalog or course descriptions in addition to this form.

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Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See Title 28, CFR 16.34 for the procedure to obtain a change, correction or update in the FBI record.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 S. Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Thurman Adams State Service Center
546 S. Bedford Street, Rm. 202
Georgetown DE 19947
(across from DelDOT & Troop 4)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. ***Personal checks are not accepted in any county.*** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a FD-258 fingerprint form available on the FBI website at www.fbi.gov – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.

2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.

3. ***Mail*** the *Authorization* form, fingerprint card, and *certified* check or money order ***(personal checks are not accepted)*** for $65.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

AUTHORIZATION FOR RELEASE OF INFORMATION

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

Please print or type all information in black ink.

Check the type of license for which you are applying:

- ☐ Adult Entertainment
- ☐ Charitable Gaming Vendor
- ☐ Chiropractic
- ☐ Dental
- ☐ Funeral
- ☐ Massage
- ☐ Medical (Physicians (MD, DO and Administrative Medical), Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM))
- ☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT, LPAT, LAAT))
- ☐ Nursing (RN, LPN, APRN)
- ☐ Nursing Home Administrator
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
- ☐ Physical Therapy/Athletic Trainer
- ☐ Podiatry
- ☐ Psychology
- ☐ Real Estate Appraiser (includes Appraisal Management Company)
- ☐ Speech/Hearing
- ☐ Social Work
- ☐ Texas Hold'em Individual

Print your current full name:

_____ _____ _____ _____
Last Name First Name Middle Initial Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date**: _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

Revised 9/2018

NONCRIMINAL JUSTICE APPLICANT'S PRIVACY RIGHTS

As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for a job or license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below.

- **You must be provided written notification[1] that your fingerprints will be used to check the criminal history records of the FBI.**
- **If you have a criminal history record, the officials making a determination of your suitability for the job, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.**
- **The officials must advise you that the procedures for obtaining a change, correction, or updating of your criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.**
- **If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the job, license, or other benefit based on information in the criminal history record.[2]**

You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.[3]

If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at http://www.fbi.gov/about-us/cjis/background-checks.

If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)

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[1] Written notification includes electronic notification, but excludes oral notification.
[2] See 28 CFR 50.12(b).
[3] See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 42 U.S.C. 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d) and 906.2(d).