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.

Revised 12/2018
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 not 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:
  o completed Evaluation of Coursework form (included with the application)
  o course catalog or course descriptions

• The degree you obtained must include the following areas:
  o Professional Counseling Orientation and Ethical Practice,
  o Social and Cultural Diversity,
  o Human Growth and Development,
  o Career Development,
  o Counseling and Helping Relationships,
  o Group Counseling and Group Work,
  o Assessment and Testing, and
  o Research and Program Evaluation

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

☐ 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.
  o 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/or 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 consecutive years.

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:

• Professional mental health counseling is the application of clinical counseling principles, methods or procedures including the diagnosis and treatment of mental and emotional disorders to assist individuals in achieving more effective personal and social adjustment. (24 Del C. § 3031(4)).

• Professional direct supervision is face-to-face consultation, on a regularly scheduled basis, between a supervisee and a Licensed Professional Counselor of Mental Health (LPCMH) or other behavioral health professional approved by the Board. The services rendered must be consistent with the supervisee's education, training and experience. (24 Del C. § 3031(3)).

Revised 12/2018
Post-Masters Mental Health Counseling Experience Requirements, continued

You must complete at least 3,200 hours of mental health counseling services over a period of at least two but not more than four consecutive years.

- Of the required 3,200 hours of total experience, at least 1,600 hours must be completed under the direct clinical supervision of an approved or acceptable supervisor.
  - An approved supervisor is a Licensed Professional Counselor of Mental Health
  - An acceptable supervisor must be Board-approved, which could be a Licensed Behavioral Health Professional (Marriage and Family Therapist, Clinical Social Worker, Clinical Psychologist, Advanced Practice Nurse or Physician) with a specialty or expertise in a clinical competency essential to the applicant’s training.
  - Certified school counselors and certified school psychologists are not approved clinical supervisors.

- At least 100 hours must be face-to-face professional direct supervision with your supervisor. Face to face supervision includes both in person and live video conferencing. Live video conferencing must not exceed 50 percent of the total 100 hours of supervision.
  - Individual Direct Supervision must be one to one, face to face meetings between the you and your supervisor. The entire 100 hour requirement may be fulfilled by individual supervision.
  - Group Supervision must be face to face meetings between the supervisor and no more than six supervisees. No more than 40 hours of group supervision shall be acceptable towards fulfillment of the 100 hour direct supervision requirement.

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.
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:

<table>
<thead>
<tr>
<th></th>
<th>EXAMINATION NAME</th>
<th>DATE OF EXAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑</td>
<td>NCE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NCMHCE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other:________</td>
<td></td>
</tr>
</tbody>
</table>

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

Revised 12/2018
LICENSURE HISTORY – All applicants complete this section.

10. Has any jurisdiction ever denied your application for licensure? Yes ☐ No ☐ If yes, provide an explanation:
_____________________________________________________________________________________________
_____________________________________________________________________________________________

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.

<table>
<thead>
<tr>
<th>JURISDICTION</th>
<th>TYPE OF LICENSE HELD</th>
<th>LICENSE NUMBER</th>
<th>LICENSURE DATES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>From</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>To</td>
</tr>
</tbody>
</table>

- 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.

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

14. 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…

- 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.
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.

• To verify the experience that you gained when you were not under the direct supervision of a clinical supervisor, arrange for the Board office to receive one or more Counseling Experience Verification forms.

Revised 12/2018
DISCLOSURES – All applicants complete this section.

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.

15. Have you received any administrative penalties regarding your practice of professional mental health counseling in any jurisdiction (state, U.S. Territory or District of Columbia), including but not limited to the following:
   - Fines? Yes [ ] No [ ]
   - Formal reprimands? Yes [ ] No [ ]
   - License suspensions? Yes [ ] No [ ]
   - License revocations (except for non-payment of fees)? Yes [ ] No [ ]
   - Probationary limitations? Yes [ ] No [ ]
   - Other? Yes [ ] No [ ] If yes, what kind of penalty: _______________________________________________

   If yes to any item, enclose a detailed explanation and all relevant documents.

16. Are any disciplinary actions pending against you? Yes [ ] No [ ] If yes, enclose a detailed explanation of any pending actions and all relevant documents.

17. 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 and all relevant documents.

18. 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 and all relevant documents.

19. 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 and all relevant documents.

20. 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 and all relevant documents.

21. 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 and all relevant documents.

22. 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 and all relevant documents.

DUTY TO REPORT – All applicants complete this section.

23. 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 [ ]

Revised 12/2018
24. 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 ☐

25. 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 ☐

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.

**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.

Revised 12/2018
INSTRUCTIONS
This form is not required for applicants applying by reciprocity.

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 or acceptable supervisor.

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 (excluding the applicant name), 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.

In completing this form, the following applies:

• Applicants must complete at least 3,200 hours of mental health counseling services over a period of at least two but not more than four consecutive years.
• Of the required 3,200 hours of total experience, at least 1,600 hours must be completed under the direct clinical supervision of an approved or acceptable supervisor.
  o An approved supervisor is a Licensed Professional Counselor of Mental Health
  o An acceptable supervisor must be Board-approved, which could be a Licensed Behavioral Health Professional (Marriage and Family Therapist, Clinical Social Worker, Clinical Psychologist, Advanced Practice Nurse or Physician) with a specialty or expertise in a clinical competency essential to the applicant’s training.
  o Certified school counselors and certified school psychologists are not approved clinical supervisors.
• When totaled, at least 100 of the 1,600 hours of direct clinical supervision must be face-to-face sessions between the applicant and supervisor. At least 60 of the 100 hours 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 2.4 of the Board’s Rules and Regulations explains the supervision requirements.

1. Applicant Name: ________________________________ _____________________________ ________________
   Last      First   Middle

INFORMATION ABOUT CLINICAL SUPERVISOR

2. Supervisor Name: ________________________________ ____________________________ ________________
   Last      First   Middle

3. Provide the following information about your professional licensure:

<table>
<thead>
<tr>
<th>✓</th>
<th>LICENSES HELD (check all that apply)</th>
<th>JURISDICTION</th>
<th>LICENSE #</th>
<th>ISSUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Professional Counselor of Mental Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical Social Worker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Marriage and Family Therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical Psychologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychiatrist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other:_____________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Revised 12/2018
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: _______________
COUNSELING EXPERIENCE VERIFICATION – EMPLOYMENT
PROFESSIONAL COUNSELOR OF MENTAL HEALTH

INSTRUCTIONS
This form is not required for applicants applying by reciprocity.

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 clinical supervision of an approved or acceptable supervisor.

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.

In completing this form, the following applies:

- Applicants must complete at least 3,200 hours of mental health counseling services over a period of at least two but not more than four consecutive years.
- Of the required 3,200 hours of total experience, at least 1,600 hours must be completed under the direct clinical supervision of an approved or acceptable supervisor.
  - An approved supervisor is a Licensed Professional Counselor of Mental Health
  - An acceptable supervisor must be Board-approved, which could be a Licensed Behavioral Health Professional (Marriage and Family Therapist, Clinical Social Worker, Clinical Psychologist, Advanced Practice Nurse or Physician) with a specialty or expertise in a clinical competency essential to the applicant’s training.
  - Certified school counselors and certified school psychologists are not approved clinical supervisors.

Hours of direct clinical supervision are verified on the Direct Supervision Reference form. Do not enter direct clinical supervision hours on Counseling Experience Verification forms.

- For hours provided while self-employed, use the Counseling Experience Verification Form-Self Employment.
- All 3,200 hours, including the mandatory minimum 1,600 hours of direct clinical supervision, must be provided over a period of at least two but not more than four consecutive years.

Section 2.4 of the Board’s Rules and Regulations explains the supervision requirements.

---

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Applicant Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Last</td>
<td>First</td>
</tr>
</tbody>
</table>

INFORMATION ABOUT SUPERVISOR

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Supervisor Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Last</td>
<td>First</td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Check type of supervision you provided to the applicant:</td>
<td>Clinical</td>
<td>Administrative</td>
</tr>
</tbody>
</table>

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Supervisor’s Practice Name (if applicable):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Practice Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Phone:</td>
<td>Email:</td>
</tr>
</tbody>
</table>

Revised 12/2018
VERIFICATION 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: ______________

Revised 12/2018
COUNSELING EXPERIENCE VERIFICATION FORM – SELF-EMPLOYMENT
PROFESSIONAL COUNSELOR OF MENTAL HEALTH

INSTRUCTIONS
This form is not required for applicants applying by reciprocity.

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 clinical supervision of an approved or acceptable supervisor.

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.

In completing this form, the following applies:
• Applicants must complete at least 3,200 hours of mental health counseling services over a period of at least two but not more than four consecutive years.
• Of the required 3,200 hours of total experience, at least 1,600 hours must be completed under the direct clinical supervision of an approved or acceptable supervisor.
  o An approved supervisor is a Licensed Professional Counselor of Mental Health
  o An acceptable supervisor must be Board-approved, which could be a Licensed Behavioral Health Professional (Marriage and Family Therapist, Clinical Social Worker, Clinical Psychologist, Advanced Practice Nurse or Physician) with a specialty or expertise in a clinical competency essential to the applicant’s training.
  o Certified school counselors and certified school psychologists are not approved clinical supervisors.
• Hours of direct clinical supervision are verified on the Direct Supervision Reference form. Do not enter direct clinical supervision hours on Counseling Experience Verification forms.
• For hours provided while the applicant was employed, use the Counseling Experience Verification 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 clinical supervision, must be provided over a period of at least two but not more than four consecutive years.

Section 2.4 of the Board’s Rules and Regulations explains the supervision 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: ______________________

Revised 12/2018
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: ______________

Revised 12/2018
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.

The degree you received must encompass the following eight (8) common core areas:

<table>
<thead>
<tr>
<th>PROFESSIONAL COUNSELING ORIENTATION AND ETHICAL PRACTICE</th>
<th>COURSE #</th>
<th>COURSE TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>History and philosophy of the counseling profession &amp; its specialty areas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The multiple professional roles and functions of counselors across specialty areas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselor’s roles and responsibilities as members of interdisciplinary community outreach &amp; emergency management response teams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The role and process of the professional counselor advocating on behalf of the profession</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocacy processes needed to address institutional and social barriers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional counseling organizations &amp; current issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional counseling credentialing and the effects of public policy on these issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current labor market information relevant to opportunities for practice within the counseling profession</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethical standards of professional counseling organizations and applications of ethical and legal considerations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technology’s impact on the counseling profession</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategies for personal and professional self-evaluation and implications for practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-care strategies appropriate to the counselor role</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The role of counseling supervision in the profession</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SOCIAL AND CULTURAL DIVERSITY</th>
<th>COURSE #</th>
<th>COURSE TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diverse groups multicultural and pluralistic characteristics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theories and models of multicultural counseling, cultural identity development and social justice and advocacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multicultural counseling competencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The impact of heritage, attitudes, beliefs, understandings, and acculturative experiences on views of others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The effects of power &amp; privilege for counselors &amp; clients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help-seeking behaviors of diverse clients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The impact of spiritual beliefs on clients’ and counselors’ worldviews</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategies for identifying and eliminating barriers, prejudices, &amp; oppression and discrimination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HUMAN GROWTH AND DEVELOPMENT</td>
<td>COURSE #</td>
<td>COURSE TITLE</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------</td>
<td>--------------</td>
</tr>
<tr>
<td>Theories of individual and family development across the lifespan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theories of learning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theories of normal &amp; abnormal personality development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theories &amp; etiology of addictions &amp; addictive behaviors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biological, neurological and physiological factors that affect human development, functioning, and behavior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systemic and environmental factors that affect human development, functioning, and behavior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effects of crisis, disasters, and trauma on diverse individuals across the lifespan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A general framework for understanding differing abilities and strategies for differentiated interventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethical and culturally relevant strategies for promoting resilience and optimum development and wellness across the lifespan</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CAREER DEVELOPMENT</th>
<th>COURSE #</th>
<th>COURSE TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theories and models of career development, counseling, and decision making</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approaches for conceptualizing the interrelationships among and between work, mental well-being, relationships, and other life roles and factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Processes for identifying and using career, vocational, educational, occupational and labor market information resources, technology, and information systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approaches for assessing the conditions of the work environment on clients’ life experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategies for assessing abilities, interests, values, personality and other factors that contribute to career development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategies for career development program planning, organization, implementation, administration, and evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategies for advocating for diverse clients’ career and educational development and employment opportunities in a global economy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategies for facilitating client skill development for career, educational, and life-work planning and management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methods of identifying and using assessment tools and techniques relevant to career planning and decision making</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethical and culturally relevant strategies for addressing career development</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COUNSELING AND HELPING RELATIONSHIPS</th>
<th>COURSE #</th>
<th>COURSE TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theories and models of counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A systems approach to conceptualizing clients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theories, models &amp; strategies for understanding &amp; practicing consultation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethical &amp; culturally relevant strategies for in-person &amp; technology-assisted relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The impact of technology on the counseling process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselor characteristics &amp; behaviors influencing counseling process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Essential interviewing, counseling &amp; case conceptualization skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmentally relevant counseling treatment or intervention plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development of measurable outcomes for goals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theories and models of counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GROUP COUNSELING AND GROUP WORK</td>
<td>COURSE #</td>
<td>COURSE TITLE</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------</td>
<td>--------------</td>
</tr>
<tr>
<td>Evidence-based counseling strategies and techniques for prevention and intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategies to promote client understanding of and access to a variety of community-based resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide prevention models and strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis intervention, trauma-informed, and community-based strategies, such as Psychological First Aid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Processes for aiding students in developing a personal model of counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theoretical foundations of group counseling and group work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dynamics associated with group process and development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapeutic factors and how they contribute to group effectiveness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Characteristics and functions of effective group leaders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approaches to group formation, including recruiting, screening, and selecting members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Types of groups and other considerations that affect conducting groups in varied settings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethical and culturally relevant strategies for designing and facilitating groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct experiences in which students participate as group members in a small group activity (min of 10 clock hours)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASSESSMENT AND TESTING</td>
<td>COURSE #</td>
<td>COURSE TITLE</td>
</tr>
<tr>
<td>Historical perspectives concerning the nature and meaning of assessment and testing in counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methods of effectively preparing for and conducting initial assessment meetings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedures for assessing risk of aggression or danger to others, self-inflicted harm, or suicide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedures for identifying trauma and abuse and for reporting abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of assessments for diagnostic and intervention planning purposes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic concepts of standardized and non-standardized testing, norm-referenced and criterion-referenced assessments, and group and individual assessments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statistical concepts, including scales of measurement, measures of central tendency, indices of variability, shapes and types of distributions, and correlations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reliability and validity in the use of assessments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of assessments relevant to academic/educational, career, personal, and social development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of environmental assessments and systematic behavioral observations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of symptom checklists, and personality and psychological testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of assessment results to diagnose developmental, behavioral, and mental disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethical &amp; and culturally relevant strategies for selecting, administering, and interpreting assessment and test results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RESEARCH AND PROGRAM EVALUATION</td>
<td>COURSE #</td>
<td>COURSE TITLE</td>
</tr>
<tr>
<td>The importance of research in advancing the counseling profession, including how to critique research to inform counseling practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identification of evidence-based counseling practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needs assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development of outcome measures for counseling programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation of counseling interventions and programs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Revised 12/2018
<table>
<thead>
<tr>
<th>RESEARCH AND PROGRAM EVALUATION, continued</th>
<th>COURSE #</th>
<th>COURSE TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualitative, quantitative, and mixed research methods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Designs used in research and program evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statistical methods used in conducting research and program evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analysis and use of data in counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethical and culturally relevant strategies for conducting, interpreting, and reporting the results of research and/or program evaluation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Submit a course catalog or course descriptions in addition to this form.
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.**  
**DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.**  
*ALERT: ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.*
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
☐ Mental Health (LPCMH, LCDP, LMFT, LACMH, LAMFT, LPAT, LAAT)
☐ Nursing (RN, LPN, APRN)
☐ Nursing Home Administrator
☐ Occupational Therapy
☐ Optometry
☐ Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
☐ 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 12/2018
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.)

\(^1\) 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 906.21(d).