

Form #1B: APPLICATION FOR REGISTERED INTERN METHOD

Licensed Professional Counselor
OR
Licensed Marriage & Family Therapist

Name: _____ **Gender:** [] F [] M
[Last] [First] [M.I.]

Other Names **Birth Date** **SSN**
Used:(maiden) _____ /____/____ -- --

You are required to provide your Social Security Number (SSN) to the Oregon Board of Licensed Professional Counselors and Therapists as part of your application for an initial or renewed professional license. This record of your SSN will be used for child support enforcement, tax administration purposes (including identification) and criminal background checks only unless you authorize other uses. If any disciplinary action is taken against your license, your SSN will be reported to the federal Health Care Integrity and protection Data Bank. Authority: ORS 25.785, ORS 305.385, USC Title 42, § 666(a)(13).

Have you ever applied for a license with our Board prior to this application? **Yes** [] **No** []
If yes, under what name did you apply? _____
What was the result? _____

ADDRESSES:

Official Mailing Address: [] home address, [] place of practice, [] mail drop, [] a POB
This will be public information, unless you choose a [] confidential home address.

Agency Name [if applicable] _____
Street Addr. & P O Box _____
City, State, Zip _____
E-Mail Address: _____

Place[s] of Practice: List the name and address of *each current* place of practice. Attach additional page if you need to. *If PO Box is used, include the location address.* Indicate one as your primary place of practice. These addresses are public information. If you are not practicing *at all*, you should enter "NOT PRACTICING" but may also list a work address and request it be used in the Board directory.

#1 Primary Practice

Business Name & Address _____

Phone: [] _____

#2 Business Name & Address _____

Phone: [] _____

Home Address: *If PO Box is used, include the location address.* This may not be left blank. If you have taken care to keep this address private (e.g., not listing it on your checks, in telephone books, or with professional associations, not seeing clients at your home), you may request that the Board keep your home address confidential, **Check to indicate confidentiality is requested.** []

Home Address: _____
[] _____
Phone (optional)

EDUCATION [Qualifying Degree]: I hold the following graduate degree in counseling, marriage and family therapy, or a comparable degree:

Degree [Title]: _____ Date granted: _____

From [College or University]: _____

I also hold the following academic degrees:

_____ in _____ from _____ Date granted: _____

_____ in _____ from _____ Date granted: _____

Check the appropriate approval designation regarding your graduate degree:

- CACREP approved [LPC]
- CORE approved [LPC]
- Oregon Board approved [LPC or LMFT]
- COAMFTE approved [LMFT]
- CACREP approved [LMFT]
- Approved by none of the above

If you checked "none of the above", submit Form #6A with original signature by a graduate school representative and attachments. Form #6A may be submitted directly from the school or included with this Form #1. **Check here to indicate if the form:** [] is enclosed [] will be forthcoming.

If you checked CACREP approved for LMFT, submit course descriptions.

If you are claiming graduate coursework from outside the degree program, have the school send the transcript directly to the Board office. Submit copies of course descriptions for claimed coursework with this Form #1 and list them below:

<u>Course No. & Title</u>	<u>Name of School</u>

LICENSES & CERTIFICATIONS: I hold the following state license and/or national certification as a counselor or therapist:

_____ Date issued: _____

_____ Date issued: _____

_____ Date issued: _____

Registered Intern Method of Application

1. Check here to indicate you are **not submitting proof of another exam** and that you are requesting state examination following approval and acceptance of your education and experience.

-or-

Arrange to have the other state licensing board or national exam service send directly to the Board, an **official verification of passing a Board-approved exam** within the past 10 years of the date of this application. Use Form #3 unless exam service provides a similar form. List exam documentation below.

Name of exam	Date taken
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2. **Have the graduate school send an official transcript directly to the Board office:**
Board of Counselors & Therapists, 3218 Pringle Rd SE #250, Salem, OR 97302-6312.

3. **Check the appropriate approval designation regarding your graduate degree:**

- | | |
|--|--|
| <input type="checkbox"/> CACREP approved [LPC] | <input type="checkbox"/> COAMFTE approved [LMFT] |
| <input type="checkbox"/> CORE approved [LPC] | <input type="checkbox"/> CACREP approved [LMFT] |
| <input type="checkbox"/> Oregon Board approved [LPC or LMFT] | <input type="checkbox"/> Approved by none of the above |

If you checked "none of the above", submit Form #6A with original signature by a graduate school representative and attachments. Form #6A may be submitted directly from the school or included with this Form #1. **Check here to indicate if the form:** [] is enclosed [] will be forthcoming.

If you checked CACREP approved for LMFT, submit course descriptions.

4. If you are claiming graduate coursework from outside the degree program, have the school send the transcript directly to the Board office. Submit copies of course descriptions for claimed coursework with this Form #1 and list them below:

<u>Course No. & Title</u>	<u>Name of School</u>

PLEASE NOTE THAT YOU CANNOT START ACCRUING DIRECT CLIENT CONTACT HOURS UNTIL YOUR APPLICATION IS COMPLETE AND APPROVED BY THE BOARD.

Certification: Read and answer the following questions carefully. Explain **Yes** responses on attachment.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you ever been the subject of a complaint to a self-regulated professional organization, licensing board or agency? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever received a disciplinary sanction under any professional license or certification? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever voluntarily surrendered a license to practice? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has any professional licensing authority refused to issue, refused to renew, or denied you a license to practice a health care profession? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been named as a defendant in a lawsuit or other legal action? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you aware of any current, proposed, pending or threatened professional complaints or civil or criminal action against you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any condition that in any way impairs or may impair your capacity to perform the duties of a counselor or marriage and family therapist with reasonable skill and safety? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you been found in any civil, administrative, or criminal proceeding to have possessed, used, or distributed controlled substances or prescription drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been cited, arrested for, charged with or convicted of the commission of any crime, offense or violation of the law in any state or by the federal government even if those charges were dismissed? | <input type="checkbox"/> | <input type="checkbox"/> |

Race, Ethnicity, and Language Skills (Please check one – this is voluntary, not required)

- American Indian/Alaska Native
- Asian
- Black/African American (not of Hispanic origin)
- Hispanic/Latino
- Native Hawaiian/Other Pacific Islander
- White/Caucasian (not of Hispanic origin)
- Other: _____

Ethnicity: _____

Languages: _____

I certify that all representations made in this application are true and correct to the best of my knowledge. I understand that my failure to provide complete and accurate information on my application forms may result in civil penalty, denial, or suspension or revocation of licensure.

X _____
Signature of Applicant (required)

Date