

# STATE OF MAINE

## BOARD OF COUNSELING PROFESSIONALS LICENSURE

### APPLICATION FOR FULL OR CONDITIONAL LICENSED CLINICAL PROFESSIONAL COUNSELOR



Department of Professional and Financial Regulation  
Office of Licensing and Registration  
35 State House Station  
Augusta, ME 04333-0035

Office Telephone: (207) 624-8674  
Office Facsimile: (207) 624-8637  
HEARING IMPAIRED (888) 577-6690  
Internet: [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing)

Office located at: 76 Northern Avenue, Gardiner, Maine

Revised 9/2009

## **APPLICANT INFORMATION GUIDE**

The application material you have requested from the Board of Counseling Professionals is enclosed. It contains all the relevant materials you need to complete your application for licensure as a Clinical Professional Counselor in the State of Maine. Please read all the information carefully. If you have any questions after reading this packet, please call or e-mail our office.

### **FURNISHED TO APPLICANT**

- Applicant Information Guide
- Individual License Application
- Accommodation Request Form
- Reference Form
- Supervisor's Affidavit Form
- Proposed Supervision Plan Form
- Degree/Internship Verification Form
- Verification of Licensure Form
- Examination Information Sheet
- Request for Examination Form
- Educational Requirements Worksheet for Licensed Clinical Professional Counselor
- Disclosure Statement Information Sheet
- NPDB/HIPDB Self-query Report Information Sheet

## **ADDITIONAL RESOURCES**

- Licensing Law for Counseling Professionals

**Please read these carefully and review periodically for changes. You are responsible for knowing and complying with all Maine Laws throughout your licensure.**

Available: <http://www.mainelegislature.org/legis/statutes/32/title32ch119sec0.html> or call (207) 624-8674

- Licensing Rules for Counseling Professionals

**Please read these carefully and review periodically for changes. You are responsible for knowing and complying with all Board Rules throughout your licensure.**

Available: <http://www.maine.gov/sos/cec/rules/02/chaps02.htm#514> or call (207) 624-8674

- Licensing Rules for the Department of Professional and Financial Regulation

Available: <http://www.maine.gov/sos/cec/rules/02/chaps02.htm#041>

- Statutory Authority, Titles 5 & 10

Available: <http://www.mainelegislature.org/legis/statutes/10/title10ch901sec0.html>

<http://www.mainelegislature.org/legis/statutes/5/title5ch341sec0.html>

## **APPLICATION PROCEDURE**

- Please submit your application materials by mail or hand delivery to our offices. Fax submissions will not be accepted. If the application you submit to us is complete, it will be prepared and presented to the Board for official action.
- **If all components of the application are not complete ten (10) days prior to the Board meeting, the application will not be reviewed at that meeting.** Due to the volume of applications being reviewed by the Board at any given time, we cannot guarantee a particular review date, but the Board will endeavor to expedite the review of your application.
- If there are deficiencies with your application, you will be notified by mail.
- Please do not call our office regarding the status of your application. Information regarding the status of applications may be found at the Office of Licensing & Registration's website: <http://www.maine.gov/professionallicensing>. We appreciate your thoughtful attention to this request.

## **CONTINUING EDUCATION**

Continuing education is required for the renewal of a license. A minimum of fifty-five (55) contact hours of approved continuing education including fifteen (15) hours of supervision and four (4) hours of ethics must be completed during the preceding twenty-four (24) month period. Please be sure to periodically review the Rules, Chapter 8 §4 for more information or for possible changes to continuing education requirements.

### **Full/Conditional Licensure**

Please read and review Chapter 3 of the Board's Rules for requirements. A complete application shall include the following:

- A completed and signed Application; (Pages 8 – 11)
- Official Transcript forwarded directly to the Board by the Academic Institution;
- A completed Verification of Internship Form (Page 18) by the university that attests to the number of internship hours, and also describes the counseling activities, setting, and supervisor credentials of the internship experience;

#### **Full licensure:**

- Completed Supervisor's Affidavit Forms; (Page 15)

#### **Conditional Licensure:**

- A completed Proposed Supervision Plan Form; (Page 16)
- Three (3) Reference Forms to be completed by professionals in the counseling field and dated within one (1) year prior to the date of application; (Page 14)
  - Official proof of a passing score on the examination(s) as prescribed in the Rules, forwarded to the Board directly by the organization holding the test scores;
- or**
- A request for Examination (Please be sure to indicate test date on form); (Page 22)
- A copy of your Disclosure Statement;
- A completed Educational Requirements Worksheet accompanied by course brochures/catalogs; (Page 23)
- NPDB/HIPDB Self-Query Reports;
- Payment of an Application fee of \$25.00;
- Payment of a Licensure fee (Permanent \$200, Conditional \$150); and
- Payment of a Criminal History Check fee of \$21.00.

**Note: All fees can be in one payment.**

## Licensure for Applicants Licensed in Another Jurisdiction

Please read and review Chapter 6 of the Board's Rules for requirements. There are three (3) pathways to licensure as outlined below:

- **Pathway 1:** Reciprocal agreement between the State of Maine and another jurisdiction. Currently, the State of Maine Board of Counseling Professionals Licensure has not entered into any reciprocal agreements with other jurisdictions. Therefore, applicants should submit their application according to either Pathway 2 or Pathway 3 if already licensed in another jurisdiction.
- **Pathway 2 (Substantially Equivalent License):** Applicant submits evidence of five (5) years actively practicing with a substantially equivalent license immediately preceding application that is in good standing, or
- **Pathway 3 (Substantially Similar Qualifications):** The applicant's qualifications are substantially similar to Maine's licensing requirements with a license that is in good standing.

Pathway 2 applications shall include the following:

- A completed and signed Application; (Pages 8 – 11)
- Official Transcript forwarded directly to the Board by the Academic Institution;
- Three (3) Reference Forms to be completed by professionals in the counseling field and dated within one (1) year prior to the date of application; (Page 14)
- A copy of the relevant licensing law and Board rules of the licensing or certifying state of jurisdiction from which you are applying;
- A copy of all mental health licenses under which applicant practiced during the five (5) consecutive years immediately preceding this application;
- A completed Verification of Licensure Form from the jurisdiction(s) in which the applicant was ever licensed; (Pages 19 – 20)
- A copy of your Disclosure Statement;
- A resume and summary of applicant's mental health practice;
- NPDB/HIPDB Self-Query Reports;
- Payment of an Application fee of \$25.00;
- Payment of a Permanent Licensure fee of \$200.00; and
- Payment of a Criminal History Check fee of \$21.00.

**Note: All fees can be in one payment.**

Pathway 3 applications shall include the following:

- A completed and signed Application; (Pages 8 – 11)
- Official Transcript forwarded directly to the Board by the Academic Institution;
- Three (3) Reference Forms to be completed by professionals in the counseling field and dated within one (1) year prior to the date of application; (Page 14)
- A completed Verification of Internship Form (Page 18) by the university that attests to the number of internship hours, and also describes the counseling activities, setting, and supervisor credentials of the internship experience;
- A completed Educational Requirements Worksheet accompanied by course brochures/catalogs; (Page 22)
- Completed Supervisor's Affidavit Forms; (Page 15)
  - Official proof of a passing score on the examination(s) as prescribed in the Rules, forwarded to the Board directly by the organization holding the test scores;
- or**
- A Request for Examination (Please be sure to indicate test date on form); (Page 22)
- A copy of the relevant licensing law and Board rules of the licensing or certifying state of jurisdiction from which you are applying;
- A copy of all mental health licenses under which applicant has practiced;
- A completed Verification of Licensure Form from the jurisdiction(s) in which the applicant was ever licensed; (Pages 19 – 20)
- A copy of your Disclosure Statement;
- NPDB/HIPDB Self-Query Reports;
- Payment of an Application fee of \$25.00;
- Payment of a Permanent Licensure fee of \$200.00; and
- Payment of a Criminal History Check fee of \$21.00.

**Note: All fees can be in one payment.**

## **Change of Status from Conditional to Full Licensure**

If you are submitting an application for full licensure near the expiration date of your conditional license, you should include a completed and signed renewal application in your application packet to the board. The inclusion of your renewal application is intended to avoid a potential gap in licensure between your conditional license and the board's approval of your application for full licensure. In the event that your renewal application needs to be processed, you will be contacted by the board and will be requested to pay the renewal fee before the renewal application is processed.

A complete application shall include the following:

- A completed and signed Application; (Pages 8 – 11)
- Submission of evidence of completing the required continuing education activities for current conditional licensing cycle;
- A copy of your Disclosure Statement;
- A completed and signed Supervisor's Affidavit's Form (Page 15);
  - Official proof of a passing score on The National Clinical Mental Health Counseling Examination, forwarded to the Board directly by the organization holding the test scores
- or**
- A Request for Examination (Please be sure to indicate test date on form); (Page 22)
- NPDB/HIPDB Self-Query Reports if not previously submitted to this office;
- Payment of an Application fee of \$25.00;
- Payment of a Licensure fee of \$200.00; and
- Payment of a Criminal History Check fee of \$21.00.

**Note: All fees can be in one payment.**

### Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035.
- **Where are you located?** 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** 8:00 a.m. to 5:00 p.m. weekdays.
- **Can I come to Gardiner to drop off my application?** Yes. You will not leave with a license, though.
- **Can I come to Gardiner to pick up my license?** No. Your license will be mailed to you.
- **How can I check the status of my application?** You can check our website: [www.maine.gov/professionallicensing/license\\_search.htm](http://www.maine.gov/professionallicensing/license_search.htm).
- **How far back do I go answering the criminal conviction question?** Any conviction, ever.
- **Can I fax my application?** No.

### NOTICES

**BACKGROUND CHECK:** Pursuant to 5 M.R.S.A. §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration requires a criminal history records check as part of the application process for all applicants.

**PUBLIC RECORD:** This application is a public record for purposes of the Maine Freedom of Access Law (1 MRSA §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

**SOCIAL SECURITY NUMBER:** The following statement is made pursuant to the Privacy Act of 1974 (§7(B)). Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 35 MRSA §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(C)(2)(C)(1)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRSA §191.

Before you seal the envelope, did you:

- Complete every item on the application including the criminal background disclosure question.
- Sign and date your application.
- Include the required fee(s). Make checks payable to "Maine State Treasurer" or complete the credit card section on the application. **DO NOT SEND CASH.**
- Make a copy of your application to keep for your records.



**STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
OFFICE OF LICENSING AND REGISTRATION  
INDIVIDUAL LICENSE APPLICATION**

<b>APPLICANT INFORMATION</b> (please print)			
FULL LEGAL NAME	<i>FIRST</i>	<i>MIDDLE INITIAL</i>	<i>LAST</i>
ANY OTHER NAMES EVER USED			
DATE OF BIRTH	<i>mm / dd / yyyy</i>	SOCIAL SECURITY NUMBER	
MAILING ADDRESS			
CITY	STATE	ZIP CODE	COUNTY
PHONE (    )	FAX (    )	E-MAIL	

<b>CRIMINAL BACKGROUND DISCLOSURE</b>	
<i>NOTE: Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.</i>	
<b>1. Have you ever been convicted by any court of any crime? (circle one)    NO    YES</b> If yes, enclose a detailed description of what happened (including dates) and a copy of the court judgment.	
<b>2. Has any jurisdiction taken disciplinary action against any professional license you hold or have held, or denied your application for licensure? (circle one)    NO    YES</b> If yes, enclose a detailed explanation and copies of all documents.	
By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Licensing and Registration will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.	
<b>SIGNATURE</b>	<b>DATE</b>

<b>Board of Counseling Professionals Licensure</b>	
<b>Please Select License Type:</b>  <input type="checkbox"/> Clinical Professional Counselor, Standard (CC1421) <input type="checkbox"/> Clinical Professional Counselor, Other Jurisdiction (CC1421)  <p align="center"><b>Required Fee: \$246</b> <b>(includes Criminal History Records Check Fee)</b></p> <input type="checkbox"/> Clinical Professional Counselor, Conditional (XL1421)  <p align="center"><b>Required Fee: \$196</b> <b>(includes Criminal History Records Check Fee)</b></p>	<b>Office Use Only:</b>  1421 - \$200.00 1421 - \$150.00 1446 - \$25.00 2619 - \$21.00  <small>Office Use Only:</small> Check # _____ Amount: _____ Cash # _____ Lic. # _____
<small>Rev. 7/2008</small>	

<b>PAYMENT OPTIONS:</b>			
Make checks payable to "Maine State Treasurer" - If you wish to pay by Mastercard or Visa, fill out the following:			
NAME OF CARDHOLDER (please print)	<i>FIRST</i>	<i>MIDDLE INITIAL</i>	<i>LAST</i>
I authorize the Dept. of Professional and Financial Regulation, Office of Licensing and Registration to charge my			
<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	the following amount: \$ _____	
Card number: <i>XXXX-XXXX-XXXX-XXXX</i>	Expiration Date <i>mm / yyyy</i>		
<b>SIGNATURE</b>	<b>DATE</b>		

**Employment Information**

Workplace Name:		Work Phone ( <i>include area code</i> ):
Mailing Address:		
City:	State:	Zip Code:

**Undergraduate and Graduate Education**  
**(Official transcripts must be submitted directly from Institution)**

Name of Academic Institution:		
Mailing Address:		
City:	State:	Zip Code:
Degree Granted:		Date Conferred:

Name of Academic Institution:		
Mailing Address:		
City:	State:	Zip Code:
Degree Granted:		Date Conferred:

Name of Academic Institution:		
Mailing Address:		
City:	State:	Zip Code:
Degree Granted:		Date Conferred:

**Counseling Experience**

Workplace Name:	Dates Employed:
Mailing Address:	
City:	Zip Code:

**Counseling Experience (continued)**

Workplace Name:		Dates Employed:
Mailing Address:		
City:	State:	Zip Code:

Workplace Name:		Dates Employed:
Mailing Address:		
City:	State:	Zip Code:

**Supervisors**

Name:		
Mailing Address:		
City:	State:	Zip Code:

Name:		
Mailing Address:		
City:	State:	Zip Code:

**Credentialing History**

Have you ever held a professional license/certification/registration in this or any other state/country?  YES  NO

If yes:

Profession	License #	State/Country	Date Issued	Expiration Date

Have you ever taken a counseling examination?  YES  NO

If yes:

Which Exam?	Where?	Date Taken:
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**Disciplinary History**

1. Do you have pending against you any complaints from a regulatory board or professional organization? If yes, please enclose a detailed explanation. [ ] YES [ ] NO
2. Have you ever been or are you currently a defendant in a civil proceeding related to your professional activities? If yes, please enclose a detailed explanation. [ ] YES [ ] NO

**Other State/Jurisdiction Licensure  
(See Chapter 6 of the Board Rules)**

Issuing Authority:	License Type:
State/Country:	License Issue Date:

**Affirmation**

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Licensing and Registration will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



JOHN ELIAS BALDACCI  
GOVERNOR

STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
**Board of Counseling Professionals Licensure**  
35 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0035

ANNE L. HEAD  
DIRECTOR

**ACCOMMODATION REQUEST FORM**

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission. **Please note:** Some accommodation requests may require additional documentation (see next page).

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Telephone (include area code): \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Accommodations Requested for the \_\_\_\_\_ Examination.

Check all that apply:

- Accessible Testing Site
- Separate Testing Site
- Braille
- Large Print
- Tape
- Reader as Accommodation for Visual Impairment
- Scribe/Amanuensis as Accommodation for Visual or Motor Impairment
- Reader as Accommodation for Learning Disability
- Scribe/Amanuensis as Accommodation for Learning
- Sign Language Interpreter
- Extended Time
  - Time-and-a-half
  - Double time
  - More than double time (specify) \_\_\_\_\_
- Use of Computer or Other Adaptive Equipment (specify) \_\_\_\_\_
- Other: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



**DOCUMENTATION OF DISABILITY NEEDS**

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

**If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.**

I have known \_\_\_\_\_ since \_\_\_\_\_ in my capacity as a  
(test applicant) (date)  
\_\_\_\_\_  
(professional title)

The applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, he/she should be accommodated by providing the following (check all that apply):

- Taped test
- Large print test
- Reader
- Scribe/amanuensis
- Extended time
  - Time-and-a-half
  - Double time
  - More that double time (please justify) \_\_\_\_\_
- Separate Testing Area
- Use of Computer or Other Adaptive Equipment (please specify) \_\_\_\_\_
- Other (please specify) \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ TITLE: \_\_\_\_\_

DATE \_\_\_\_\_ LICENSE # (if applicable) \_\_\_\_\_



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**Board of Counseling Professionals Licensure**  
35 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0035

ANNE L. HEAD  
DIRECTOR

**REFERENCE FORM**

**EACH APPLICANT MUST HAVE ONE (1) FORM COMPLETED BY THREE (3) DIFFERENT COUNSELING PROFESSIONALS. PLEASE PRINT OR TYPE.**

Name of Applicant:		
Mailing Address:		
City:	State:	Zip Code:
Telephone (include area code):		Social Security Number:

Name of Counseling Professional:	Telephone (include area code):	
Mailing Address:		
City:	State:	Zip Code:
Professional Title:	Relationship to Applicant:	

It is required that each applicant shall demonstrate trustworthiness, ethical integrity and competence to engage in the practice of counseling in such a manner as to safeguard the interests of the public.

Do you believe that the above said applicant demonstrates trustworthiness, ethical integrity and competence? Yes\_\_\_\_\_ No\_\_\_\_\_

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Counseling Professional

\_\_\_\_\_  
Date





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Name of Applicant:		
Mailing Address:		
City:	State:	Zip Code:
Telephone (include area code):		Social Security Number:

Name of Counseling Professional:	Telephone (include area code):	
Mailing Address:		
City:	State:	Zip Code:
Professional Title:	Relationship to Applicant:	

It is required that each applicant shall demonstrate trustworthiness, ethical integrity and competence to engage in the practice of counseling in such a manner as to safeguard the interests of the public.

Do you believe that the above said applicant demonstrates trustworthiness, ethical integrity and competence? Yes\_\_\_\_\_ No\_\_\_\_\_

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Counseling Professional

\_\_\_\_\_  
Date





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Mailing Address:		
City:	State:	Zip Code:
Telephone (include area code):		Social Security Number:

Name of Counseling Professional:	Telephone (include area code):	
Mailing Address:		
City:	State:	Zip Code:
Professional Title:	Relationship to Applicant:	

It is required that each applicant shall demonstrate trustworthiness, ethical integrity and competence to engage in the practice of counseling in such a manner as to safeguard the interests of the public.

Do you believe that the above said applicant demonstrates trustworthiness, ethical integrity and competence? Yes\_\_\_\_\_ No\_\_\_\_\_

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Counseling Professional

\_\_\_\_\_  
Date



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JOHN ELIAS BALDACCI  
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04333-0035

ANNE L. HEAD  
DIRECTOR

**SUPERVISOR'S AFFIDAVIT**

**To be completed by supervisor in accordance with Chapters 2 through 6 of the Board's Rules**

Check one: <input type="checkbox"/> New Applicant <input type="checkbox"/> Conditionally licensed			
Name of Applicant:		Social Security Number:	
Name of Approved Supervisor:	Supervisor's License Title:	Supervisor's License Number:	
State of Licensure:	Original Date:	Expiration Date:	Years in Practice:
Facility or Agency:		Telephone (include area code):	
Mailing Address:			
City:	County:	State:	Zip Code:
<b>IN WHICH SPECIALTY AREA:</b> (Please check)		<b>SUPERVISION:</b> (List number of hours):	
Clinical Professional Counselor	<input type="checkbox"/>	Individual	_____
Marriage and Family Therapist	<input type="checkbox"/>	Group Supervision	_____
Professional Counselor	<input type="checkbox"/>	Total number of supervision hours	_____
Pastoral Counselor	<input type="checkbox"/>		
<b>SUPERVISED EXPERIENCE</b> (List number of hours)*			
Hours of direct counseling with individuals _____ couples _____ families _____ groups _____			
Total hours of direct counseling _____			
Supervised experience in counseling other than the direct provision of counseling _____			
Total number of hours of supervised experience _____			
<b>On the supervisor's stationary, signed and dated, please comment on the following:</b>			
1. Please describe the applicant's functions in terms of prevention, diagnosis and treatment of mental illness/disorders and psychosocial treatment. <b>(For the clinical licenses only – LCPC, LMFT, Pastoral).</b>			
2. Please state briefly the licensee's personal character, ethical conduct, and competence.			
3. Please comment on the licensee's ability to function as a counselor (i.e. strengths and weaknesses).			
I HEREBY ATTEST THAT THE ABOVE-NAMED APPLICANT IS/WAS UNDER MY SUPERVISION FROM THE PERIOD OF _____ TO _____. I ALSO ATTEST THAT ALL INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.			
Supervisor's Signature: _____		Date: _____	
Applicant's Signature: _____		Date: _____	



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04333-0035

ANNE L. HEAD  
DIRECTOR

**PROPOSED SUPERVISION PLAN  
CONDITIONAL COUNSELOR LICENSURE**

Name of Applicant:	Social Security Number:
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**SUPERVISION PLAN**

Name of Supervisor:	Title:	
Supervisor's License Number:	First Date of Issue:	
Facility or Agency:	Work Telephone Number <i>(include area code)</i> :	
Mailing Address:		
City:	State:	Zip Code:

**SUPERVISION MUST EQUAL 1 HOUR/30 HOURS OF DIRECT COUNSELING SERVICE.  
PLEASE DOCUMENT SPECIFIC PLANS THAT COVER THE FOLLOWING:** (Use separate sheet if needed)

Goals of Plan:

Objectives of Plan:

If providing clinical supervision for a clinical license, please focus on diagnosis and treatment:

I HEREBY ATTEST THAT THE ABOVE NAMED APPLICANT IS UNDER MY SUPERVISION FOR THE PERIOD BEGINNING\_\_\_\_\_. I ALSO ATTEST THAT ALL OF THE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## APPROVED SUPERVISOR FORM

Name of Supervisor: \_\_\_\_\_

Number of years of counseling experience in the modality (e.g. clinical, marriage & family therapy, pastoral) which you intend to do supervision: \_\_\_\_\_

Answer one (1) or both of the following:

1. Describe training received in counseling supervision:

2. List the number of years and types of experiences in providing supervision to mental health professionals:

Provide a separate written statement detailing your supervision philosophy, orientation and experience.

I HEREBY ATTEST THAT ALL THE INFORMATION ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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04333-0035

ANNE L. HEAD  
DIRECTOR

**DEGREE/INTERNSHIP VERIFICATION FORM**

To: Board of Counseling Professionals Licensure  
35 State House Station  
Augusta, ME 04333-0035  
Date:

Student Name:	Social Security Number:	
Institution:		
Mailing Address:		
City:	State:	Zip Code:

Degree Verification	
Date of Graduation:	Program:
Degree Awarded:	Concentration of Degree Awarded:
Accreditation:	

Internship Verification		
Dates of Internship:	Direct Client Contact Hours:	Total Contact Hours:
Internship Experience: Please indicate whether the counseling activities, setting and supervisor were or were not clinical in nature ("clinical" is defined as the diagnosis and treatment of mental health disorders).		
Signature of Person Verifying Degree/Internship: _____		
Printed Name: _____	Title: _____	
Department: _____	Date: _____	





JOHN ELIAS BALDACCI  
GOVERNOR

STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
**Board of Counseling Professionals Licensure**  
35 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0035

ANNE L. HEAD  
DIRECTOR

**VERIFICATION OF LICENSURE FORM**

The applicant listed below is applying for licensure to practice as a clinical professional counselor in the State of Maine. The Maine Board of Counseling Professionals Licensure requests written verification from each state that applicant holds or has held any certification, licensure, or credential. This is your authority to release any information in your files, favorable or otherwise. **Please mail this verification directly to the Maine Board of Counseling Professionals Licensure at the above listed address.**

**The section below is to be completed by the applicant and forwarded to the State Board in which you hold or have held a license to practice counseling, family therapy or pastoral counseling. Any associated fees are the responsibility of the applicant. If verification of licensure is needed for more than one (1) state, please copy form as needed.**

Name:		
Mailing Address:		
City:	State:	Zip Code:
License Number:	State:	Date of Issue:
Signature of Applicant:		Date:

**The remaining portion is to be completed by the State Licensing Board where the applicant holds or has held a license to practice counseling, family therapy or pastoral counseling.**

Name of Licensee:	License Type:	
License Number:	Is License Current? [ ] YES [ ] NO	
Date Issued:	Original License Date:	Expiration Date:



**VERIFICATION OF LICENSURE (PAGE 2)**

Name of Exam Taken:	Date Exam Passed:
---------------------	-------------------

If no examination was taken, how was licensure obtained?

Grandfathered     
  Endorsement/Comity     
  State

What were the requirements for education and supervision at the time the license was issued?

  
  
  
  

Are there any pending complaints against this licensee? If yes, please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

Have there been any other actions taken against this licensee? If yes, please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
---	--

Is the licensee considered to be in good standing in your state? If no, please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

State Board Seal	Signature: _____ Printed Name: _____ Title: _____ State: _____ Phone Number _____ Date: _____
------------------	---



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## Examination Information

### The National Counselors Examination

To qualify for conditional licensure as a Professional Counselor, a Clinical Professional Counselor, or a Pastoral Counselor applicants must achieve a passing score on The National Counselor Examination (NCE) administered by NBCC. The computer-based NCE is offered monthly. After the Board approves your eligibility for examination, a registration form will be sent to you. This form will list the exam dates, registration dates and exam location.

- There is a study guide available for the NCE. More information is available at the following website: <http://www.nbcc.org/extras/pdfs/nceprepguideorder.pdf>

### The National Clinical Mental Health Counseling Examination

As of January 1, 2008, to qualify for full licensure as a Clinical Professional Counselor or a Pastoral Counselor applicants must achieve a passing score on The National Clinical Mental Health Counseling Examination (NCMHCE) administered by NBCC. The computer-based NCMHCE is offered monthly. After the Board approves your eligibility for examination, a registration form will be sent to you. This form will list the exam dates, registration dates and exam location.

- There is a study guide available for the NCMHCE. More information is available at the following website: <http://www.nbcc.org/extras/pdfs/nceprepguideorder.pdf>

### The Marital and Family Therapy Examination

To qualify for either a conditional or full license as a Marriage and Family Therapist applicants must achieve a passing score on The Marital and Family Therapy Examination administered by AMFTRB.

- A request for examination (next page) must be submitted at least ninety (90) days prior to exam.
- Please note, applicants who apply for examination must submit all materials required for licensure before approval to sit for an examination will be granted.
- More information regarding this exam is available at the following website: <http://www.amftrb.org/exam.cfm>

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OFFICE PHONE: (207)624-8674

FAX: (207)624-8637

(888)577-6690 (HEARING IMPAIRED)  
OFFICES LOCATED AT: 76 NORTHERN AVENUE,  
GARDINER, MAINE  
[www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing)



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04333-0035

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DIRECTOR

**REQUEST FOR EXAMINATION**  
**APPLICANTS WHO APPLY FOR EXAMINATION MUST SUBMIT ALL MATERIALS REQUIRED FOR LICENSURE BEFORE APPROVAL TO SIT FOR AN EXAMINATION WILL BE GRANTED.**

Please fill in the information requested below and **return this form** with all other required application materials to the Board at the above address.

**Check Appropriate Category**

- NCE** (applicants for conditional licensure as a Professional, Clinical, or Pastoral Counselor)
- NCMHCE** (applicants for full licensure as a Clinical Counselor or Pastoral Counselor)
- PES** (applicants for conditional/full licensure as a Marriage and Family Therapist)

**Marriage and Family Therapist applicants only:**

Please circle Requested date	Registration Deadline	Exam Dates
	11/17/2008	1/12/2009 to 2/7/2009
	3/23/2009	5/18/2009 to 06/13/2009
	7/20/2009	9/14/2009 to 10/10/2009

If you require special accommodations, please fill out the **Accommodation Request Form** and return it with your application materials.

Name of Applicant:		
Mailing Address:		
City:	State:	Zip Code:
Telephone (work):		Telephone (home):
Date of Birth:	Social Security Number:	Today's Date:





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04333-0035

ANNE L. HEAD  
DIRECTOR

**Educational Requirements Worksheet for  
Licensed Clinical Professional Counselor**

**INSTRUCTIONS:** Place the relevant course(s) from your transcripts into the appropriate category on the worksheet. A course cannot be used twice to fulfill more than one (1) content area. **NOTE:** You must attach a college catalog, description or syllabus to substantiate the specific material included in each course listed on the worksheet.

Content Area	Course No.	Course Title	Credit Hours	
			Qrt.	Sem.
1. Human Growth and Development				
2. Helping Relationships				
3. Groups				
4. Measurement				
5. Research and Evaluation				
6. Diagnosis and Treatment				
7. Professional Orientation				
8. Social and Cultural Foundations				
9. Practicum				
10. Internship				

**NOTE:** The following page contains the definitions of the above content areas



## **Educational Requirements for Licensed Clinical Professional Counselor**

### **Chapter 3, Section 1**

**Human Growth and Development:** Studies that provide an understanding of the nature and needs of individuals at different developmental levels throughout the life span.

**Helping Relationships:** Studies that provide an understanding of philosophic bases of helping processes, counseling theories and their applications, basic and advanced counseling skills, consultation theories and skills, self-understanding and self-development, and facilitation of client or consultee change.

**Groups:** Studies that provide an understanding of group development, dynamics, group counseling theories, group leadership styles, and group counseling methods and skills.

**Measurement:** Studies that provide an understanding of group and individual educational and psychometric theories and approaches to measurement, data and information-gathering methods, validity, reliability, psychometric statistics, factors influencing measurements, and use of measurement results in the helping process.

**Research and Evaluation:** Studies that provide an understanding of the types of research, basic statistics, research report development, research implementation, program evaluation, needs assessment, and ethical and legal consideration associated with research and evaluation.

**Diagnosis and Treatment:** Studies that provide an understanding of psychopathology, the diagnosis and statistical manual and its use in counseling, psychopathology, the development of treatment plans and the use of related services, and the role of assessment, intake interviews, and reports.

**Professional Orientation:** Studies that provide an understanding of professional roles and functions, professional organizations and associations, history and trends within the profession, ethical and legal standards, and professional preparation standards and professional credentialing.

**Social and Cultural Foundations:** Studies that provide an understanding of the development of multicultural awareness, cultural foundations of human growth and development, and cultural values and traditions covering the life span.

**Practicum:** A course of clinical instruction is required that provides practical experience in counseling for the purpose of developing individual counseling skills and for developing of group counseling skills. These experiences allow students to perform, on a limited basis, some of the counseling activities that a regularly employed Licensed Clinical Professional Counselor would be expected to perform.

**Internship:** A full academic year of supervised clinical counseling experience consisting of at least 900 clock hours, including a minimum of 360 clock hours of direct client contact. The internship provides an opportunity for the student to perform all the activities that a regularly employed clinical counselor would be expected to perform.

**Educational Requirements Worksheet for  
Licensed Clinical Professional Counselor--cont'd**

**INSTRUCTIONS:** Place the relevant course(s) from your transcripts into the appropriate category on the worksheet. A course cannot be used twice to fulfill more than one (1) content area. **NOTE:** You must attach a college catalog, description or syllabus to substantiate the specific material included in each course listed on the worksheet.

**A minimum of three (3) credits in three (3) of the following areas are required.**

Content Area	Course No.	Course Title	Credit Hours	
			Qrt.	Sem.
11. Lifestyle and Career Development				
12. Marriage & Family Therapy*				
13. Human Sexuality for Counselors				
14. Supervision				
15. Consultation				
16. Crisis Intervention				
17. Addictive Disorders*				
18. Treatment Modalities*				

\* Denotes that up to six (6) semester hours may be used in one category in meeting the additional coursework requirements.

**NOTE:** The following page contains the definitions of the above content areas

**PLEASE BE SURE TO INCLUDE THIS COMPLETED WORKSHEET WITH YOUR APPLICATION**

## **Educational Requirements for Licensed Clinical Professional Counselor-cont'd**

### **Chapter 3, Section 1**

**Lifestyle and Career Development:** Studies that provide an understanding of career development theories, occupational and educational information services, career counseling, and career decision-making.

**Marriage and Family Counseling:** Up to six (6) semester hours of study that provide an understanding of the structure and dynamics of the family, and methods of marital and family intervention and counseling.

**Human Sexuality for Counselors:** Studies that provide an understanding of human sexual function and dysfunction, the relationship between sexuality, self-esteem, sex roles and life styles over the life cycle, and counseling treatment approaches and techniques.

**Supervision:** Studies that provide an understanding of approaches and conceptual models, individual and group supervision, clinical evaluation, and ethical and legal considerations.

**Consultation:** Studies that provide an understanding of consultation skills, evaluation of organizational structure and individual client management, and theoretical orientation.

**Crisis Intervention:** Studies that provide an understanding of the theory and practice of crisis intervention, short-term crisis counseling strategies, and the responsibilities of all those involved in the intervention.

**Addictive Disorders:** Up to six (6) semester hours of study that provide an understanding of the stage, processes, and effects of addictions, social and psychological dynamics of chemical dependency, and the professional's role in prevention, intervention, and aftercare.

**Treatment Modalities:** Up to six (6) semester hours of study that provide an understanding of specific treatment approaches (for example, cognitive, client-centered, expressive therapy, feminist).



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AUGUSTA, MAINE  
04333-0035

ANNE L. HEAD  
DIRECTOR

**SUGGESTED FORMAT FOR DISCLOSURE STATEMENT**

**Disclosure Statement**

- A. Name, M.S.**  
Such-and-such Counseling Service  
555 Main Street  
City, Maine (207) 666-7777
- B. Degree:** Highest degree and related field of study  
**Licensure:** Please indicate here the license/registration type, original or renewal license, and the projected begin and end date of license term (2 year cycle). **(If conditionally licensed, please indicate).**  
(Example: LCPC, original: 9/03 expiration: 9/05)
- C. Areas of competence** - I am trained for work with individuals, couples, and ....(continued concisely, but with a much detail as necessary to give clients an idea of the range of your skills and scope of your license/registration).
- D. Course of Action-** At the first interview ....(Include a description of your usual process of intake, assessment, and goal setting. If clinically licensed, please also explain your process for diagnosing and treating. This is designed to give your prospective client an idea of what to expect in counseling).
- E. Confidentiality** - A statement indicating the limits and scope of confidentiality. The following exceptions **must** be included:
  1. Threat of serious harm to self or others.
  2. Reasonable suspicion of child abuse, or abuse of elder or any incapacitated person.
  3. Court order.
  4. Voluntary release signed by client or guardian.
  5. In defense against legal action or formal complaint which client makes before a court or regulatory board.
  6. During supervisory consultations.
- F. Supervision** – A statement indicating supervision arrangement of counselor, when applicable.
- G. Fee schedule, hours of business, policy regarding third party payments** – explained with words that are clearly understood.
- H. Accountability** - A statement to the effect that “the practice of counseling is regulated by the Department of Professional and Finance Regulation, and complaints may be registered by contacting: Board of Counseling Professionals Licensure  
35 State House Station  
Augusta, ME 04333  
(207) 624-8674





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GOVERNOR

STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
OFFICE OF LICENSING & REGISTRATION  
35 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0035

ANNE L. HEAD  
DIRECTOR

**National Practitioner Data Bank (“NPDB”) and  
Healthcare Integrity and Protection Data Bank (“HIPDB”)  
Self-Query Reports**

Pursuant to 10 M.R.S.A. §8003, sub-§10\*, the Office of Licensing and Registration will require all applicants to submit a NPDB/HIPDB Self-Query Report as part of the initial application for licensure within each of the following allied health licensure programs effective **November 1, 2007**. Applications received without the NPDB/HIPDB self-query report will be considered incomplete which will further delay the application process.

\* **“National disciplinary record system.** Within the limits of available revenues, all bureaus, offices, boards or commissions internal or affiliated with the department shall join or subscribe to the national disciplinary record system used to track interstate movement of regulated professionals who have been the subject of discipline by state boards, commissions or agencies and report disciplinary actions taken within this State to that system.”

**Alcohol and Drug Counselors**

License Alcohol and Drug Counselors  
Certified Alcohol and Drug Counselor  
Certified Clinical Supervisor  
Alcohol and Drug Counselor Aide

**Athletic Trainers**

Athletic Trainers

**Chiropractic Licensure**

Chiropractor, Chiropractic Assistant  
Chiropractic Acupuncture

**Complementary Health Care**

Acupuncturist, Naturopathic Doctor,  
Naturopathic Acupuncture, Chinese Herbal  
Formulation Certification

**Counseling Professionals**

LP, PC, LMFT, LCPC, RC  
Including Conditional

**Dietetic Practice**

DI, DT / Including Temporary

**Hearing Aid Dealers and Fitters**

Hearing Aid Dealer and Fitter / Trainees

**Massage Therapists**

Massage Therapist

**Nursing Home Administrators**

AD, MLA, RC

**Occupational Therapy**

OT, OTA / Including Temporary

**Physical Therapy**

Physical Therapists  
Physical Therapists Assistants

**Pharmacy**

Pharmacist  
Pharmacist Technician  
Pharmacies  
Mail Order Pharmacies  
Mail Order Contact Lens Suppliers  
Wholesale Distributor  
Manufacturer

**Podiatric Medicine**

Podiatrist, Resident Podiatrist

**Psychologists**

Psychologist, Psychologist Examiners  
Including Conditional and Temporary

**Radiologic Technologists**

Radiologic Technologists – 3 authorities  
Limited Radiographers / Special Permit  
Including Temporary

**Respiratory Care**

Respiratory Therapist  
Respiratory Technician  
Associate

**Social Worker Licensure**

LS, LX, LM, LC, MC

**SLP and Audiologists**

SLP, Audiologist

The instructions to request a self-query report are available at NPDB/HIPDB’s website:  
[www.npdb-hipdb.hrsa.gov](http://www.npdb-hipdb.hrsa.gov)

The website includes a Fact Sheet on self-querying, as well as FAQs to assist you in requesting a report. Customer Service Contact information is provided below:

**NPDB-HIPDB Customer Service Center**

**Tel: (800)767-6732**

**TDD: (703)802-9395**