

**STATE OF MAINE  
BOARD OF COUNSELING PROFESSIONALS  
LICENSURE**

NCE OR NCMHCE EXAMINATION APPLICATION  
TO QUALIFY FOR  
CONDITIONAL OR FULL  
PASTORAL LICENSURE



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

Office Telephone: (207) 624-8623  
Office Facsimile: (207) 624-8637  
TTY USERS CALL MAINE RELAY 711  
Internet: [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing)

Office located at: 76 Northern Avenue, Gardiner, Maine

Revised 12/2019

## **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>

- 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>

- Licensing Rules for the Department of Professional and Financial Regulation

**Please read these carefully and review periodically for changes. You are responsible for knowing and complying with Office of Professional and Occupational Regulation Rules, Chapters 10, 11 and 13, throughout your licensure.**

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. Submissions by fax or e-mail will not be accepted. The application will be reviewed in the order it was received.
- If there are deficiencies with your application, you will be notified by email. **Please note:** Candidates whose applications have been incomplete for more than one (1) year will be required to submit **new** applications and fees if they still wish to be considered for licensure.
- **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 Professional and Occupational Regulation's website: <http://www.maine.gov/professionallicensing>. We appreciate your thoughtful attention to this request.

STATE OF MAINE DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION  
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION

**Mailing Address:** 35 State House Station, Augusta, Maine 04333 **Courier/Delivery address:** 76 Northern Avenue, Gardiner, Maine 04345  
Phone: (207) 624-8603 Fax: (207) 624-8637 TTY users call Maine relay 711 Web: [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing)

### 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.
- **Can I come to Gardiner to pick up my license?** No. Your license will be emailed to you.
- **How can I check the status of my application?** You can check our website:
- <http://pfr.informe.org/almsonline/almquery/welcome.aspx>.
- **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 Professional and Occupational Regulation 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.
- ◆ 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.

## **Conditional License Examination**

Applicants must submit the documentation and fees as outlined in the checklist below. Please review Chapter 5 of the Board's Rules. Chapter 5 outlines the requirements for licensure as a pastoral counselor. An application will not be approved unless the applicant meets all qualifications as outlined in the Board's Rules.

- A completed and signed Application;
- Payment of an Application fee of \$25.00;
- A copy of your Official Transcript;
- A completed Educational Requirements Worksheet accompanied by course descriptions, syllabi and/or catalogs; (Submit **only** if your mental health counseling program was not CACREP accredited at the time the degree was awarded)

**Note: Course descriptions should be taken directly from course catalogues current at the time the courses were completed.**

- A completed Verification of Internship Form from the university that attests to the number of internship hours, and also describes the counseling activities, setting, and supervisor credentials of the internship experience, and whether or not the internship was clinical;
- Evidence of call to ministry.

### **Please note:**

**Once you have passed the examination, you must submit an application for licensure.**

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

A complete application shall include the following:

- A completed and signed Application;
- Payment of an Application fee of \$25.00;
- A completed and signed Supervisor's Affidavit's Form;

### **Please note:**

**Once you have passed the examination, you must submit an application for licensure.**



**STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION  
INDIVIDUAL EXAMINATION APPLICATION**

APPLICANT INFORMATION (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	COUNTY
PHONE # ( )	FAX # ( )	E-MAIL	
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 Professional and Occupational Regulation 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 Examination</b>	
<b>Please Select License Type:</b>	
<input type="checkbox"/> Pastoral Counselor, Full (LP1421)	<b>Office Use Only:</b> 1447 - \$25.00
<input type="checkbox"/> Pastoral Counselor, Conditional (XP1421)	
<b>Required Fee: \$25 (Non-refundable)</b>	<b>Office Use Only:</b> Check # _____ Amount: _____ Cash # _____ Lic. # _____
Rev. 12/2019	

<b>PAYMENT OPTIONS:</b>			
Make checks payable to "Maine State Treasurer" – if you wish to pay by Mastercard, Visa, Discover or American Express fill out the following:			
NAME OF CARDHOLDER (please print)	<i>FIRST</i>	<i>MIDDLE INITIAL</i>	<i>LAST</i>
I authorize the Department of Professional and Financial Regulation, Office of Professional & Occupational Regulation to charge my <input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD <input type="checkbox"/> DISCOVER <input type="checkbox"/> AMERICAN EXPRESS the following amount: \$ _____			
<input type="checkbox"/> I understand that fees are non-refundable			
Card number:	<i>XXXX-XXXX-XXXX-XXXX</i>	Expiration Date	<i>mm / yyyy</i>
<b>SIGNATURE</b>		<b>DATE</b>	

**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:

**Undergraduate Education**

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

### 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 national counseling examination?       YES  NO

If yes:

Exam Title:	Location:
Date Taken:	Select One: <input type="checkbox"/> Pass <input type="checkbox"/> Fail

Exam Title:	Location:
Date Taken:	Select One: <input type="checkbox"/> Pass <input type="checkbox"/> Fail

### 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 Professional and Occupational Regulation 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: \_\_\_\_\_



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35 STATE HOUSE STATION  
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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, registration information will be sent to you.

- More information is available at the following website: <http://www.nbcc.org/>

### **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, registration information will be sent to you.

- More information is available at the following website: <http://www.nbcc.org/>





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**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): \_\_\_\_\_

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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**SUPERVISOR'S AFFIDAVIT**

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

Check one: [ ] New Applicant [ ] Conditionally licensed			
Name of Applicant:			
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 [ ]	Marriage and Family Therapist [ ]	Professional Counselor [ ]	Pastoral Counselor [ ]
		Individual _____	Group Supervision _____
		Total number of supervision hours _____	
<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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**DEGREE/INTERNSHIP VERIFICATION FORM**

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



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**Educational Requirements Worksheet for Licensed Pastoral Counselor**  
Complete this form ONLY if your Degree Program was not CACREP Accredited at the time of Graduation

Applicant's Name: \_\_\_\_\_ Applicant's School: \_\_\_\_\_

**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.
A. Pastoral Theology and Psychology				
B. Testing & Measurement <u>or</u> Research Methods				
C. Studies in two (2) of the following areas:  1. Basic Pastoral Care 2. Crisis Intervention 3. Cross-cultural Issues 4. Faith Development 5. Grief Counseling 6. Helping Relationships 7. History of Pastoral Care and Counseling 8. Hospital Ministry 9. Life Cycle Ritual 10. Psychology of Religion 11. Professional Orientation 12. Spiritual Direction 13. Human Growth and Development 14. Theories of Counseling				

**Educational Requirements Worksheet for  
Licensed Pastoral Counselor--cont'd**

**Applicant's Name:** \_\_\_\_\_ **Applicant's School:** \_\_\_\_\_

**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.
D. Studies in at least one (1) of the following:  1. Psychopathology 2. Clinical/pastoral assessment 3. Diagnosis and Treatment				
E. Professional Ethics				
F. Clinical Pastoral Education*				

**\*Clinical Pastoral Education is defined below:  
Chapter 5, Section 2(F)**

Clinical Pastoral Education: One unit of 400 contact hours in clinical pastoral education in a program accredited by ACPE. This is a supervised internship in ministry to persons in crisis. Development of a pastoral identity and the integration of the person of the student chaplain in to the ministry is a central goal. A typical program of clinical pastoral education would include ministry to individuals and their families, written reports of visits reviewed in individual and/or group supervision, group dynamics sessions, and didactic seminars. The ministry is in the context of teamwork and other professionals.

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