DEPARTMENT OF HEALTH

BOARD OF CLINICAL SOCIAL WORK, MARRIAGE AND FAMILY THERAPY AND MENTAL HEALTH COUNSELING

APPLICATION FOR LIMITED LICENSURE and Instructions

Rule 64B4-3.009
DH-MQA 1178 (Revised 04/15)

APPLICATION FOR LIMITED LICENSURE INSTRUCTIONS

You must read the laws and rules in order to determine your eligibility prior to applying. The laws and rules may be accessed through our website at http://floridasmentalhealthprofessions.gov and click on "Resources". The requirements for limited licensure are in Section 456.015, Florida Statutes, and Rule 64B4-3.009, Florida Administrative Code.

COMPLETING THE FORMS: Application for Limited Licensure [6 pages]
Complete all forms by printing neatly in ballpoint pen or typing the information on the forms. It is your responsibility to notify this office in writing if the answer to any application question changes.

1. Applicant Profile Data:

List your legal name as it should appear on your license. Your mailing address is used whenever you are sent documents, renewals, licenses, etc. from the Department of Health. When you become a licensee, your name, license number and practice location address will be shown on our Internet License Verification. If you do not want your mailing address on the website, fill in the "practice location address" on the Application for Limited Licensure as you want it to appear on the website. If you only provide one address, it will be used for both the mailing address and the practice location address. Please note that the practice location address must be a street address.

2. Licensure Data:

List all counseling related professional licenses, including inactive or expired licenses issued from any state, U.S. territory, or foreign country.

3. Applicant History – Professional:

If you answer "yes" to any question in this section, you must provide complete details. A "yes" answer does not mean the application will be denied, however, failure to provide the correct information may result in licensure denial.

4. Applicant History – Pursuant to Section 456.0635, Florida Statutes:

IMPORTANT NOTICE: Applicants for licensure and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes.

5. Applicant History – General:

If you answer "yes", you must provide complete details and certified copies of court records/dispositions.

6. Certification:

Your signature is required. By signing you are attesting that you have provided true and correct information on the application and supporting documents, as well as having read the laws and rules.

7. Social Security Number: Your social security number is required.

8. Applicant History – Health:

The Board reviews each applicant's history to determine that the applicant is able to practice the profession with reasonable skill and safety. If you answer "YES" to any of the questions in this section, you must submit a current mental health status report from a licensed mental health professional, wherein this professional practitioner opines that you are able to practice with reasonable skill and safety to patients or clients.

The report should include: a description and summary of the diagnosis, onset, course of treatment, medications, inpatient treatments, outpatient treatments, group settings, factors which have triggered setbacks, compliance with treatment, prognosis, and recommendations for continued treatment.

Submit the completed application, affidavit for limited license applicant, and either the $25.00 fee or the limited license fee waiver form to the Board of CSW, MFT, MHC, 4052 Bald Cypress Way, Bin C08, Tallahassee, FL 32399-3258. You may pay with a credit or debit card, if you submit your application online at www.flhealthsource.com and click on "Apply for a License".

DEPARTMENT OF HEALTH	**Board of Clinical Social Work Marriage and Family Therapy & Mental Health Counseling**

APPLICATION FOR LIMITED LICENSURE

1. APPLICANT PROFILE DATA *(PLEASE TYPE OR PRINT IN BLACK INK)*

Name	Last	First	Middle
Mailing Address	Street and No.		Apt. No.
	City	State	Zip
Practice Location Address*	Street and No.		Apt. No.
	City	State	Zip

DO NOT WRITE IN THIS SPACE
FOR OFFICE USE ONLY

Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name? ❑YES ❑NO
If "YES", list names and dates of changes.

(**Check One**)
❑ Clinical Social Work (5201)
❑ Marriage & Family Therapy (5202)
❑ Mental Health Counseling (5203)

Primary Telephone: area code ( )	Business Telephone: area code ( )
E-mail Address (optional):	Date of birth: ________/________/___________
Place of Birth: (City, State, Country)	Gender: ❑ Male ❑ Female

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Race: ❑ Caucasian ❑ African-American ❑ Hispanic ❑ Asian ❑ Native American ❑ Other _________________________

* **Your Practice Location Address Will Show On The Internet License Verification**

Our Internet license verification provides the public with information on licensed health care practitioners in the State of Florida, including an "address of record". The "location address" from the licensure database will show as the "address of record" on the Internet.

Please check the box applicable to your proposed practice setting:

❑ Paid Employee **MUST REMIT $25.00**

❑ Volunteer – not paid for services **Must remit Fee Waiver Affidavit.**

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APPLICANT NAME____

2. LICENSURE DATA

A. Do you hold or have you ever held a license to practice any counseling-related professions in any state, U.S. territory, or foreign country? ❑ YES ❑ NO

If YES, list all licenses and the issuing state, territory, or foreign country, regardless of status.

Type of License/Certificate	Issuing State, Territory, Foreign Country

B. Do you have any applications for licensure or certification in a counseling-related profession currently pending in any state (including Florida), U.S. territory, or foreign country? ❑ YES ❑ NO

If YES, list all pending applications and the issuing state, territory, or foreign country:

List Place of Practice in Florida, if known. The director of the agency or institution must submit a letter of intention to employ. Section 456.015, Florida Statutes, requires that within 30 days of any change of employment, the department must be notified of the new address and place of employment.

Place of Employment	Location Address (street, city, state, zip)	Employment Setting
		❑ State Mental Institution ❑ State Institution for the Mentally Retarded ❑ Department of Corrections ❑ Health Manpower Shortage Area established by the U.S. Dept. of Health & Human Services

3. APPLICANT HISTORY - PROFESSIONAL

A. Have you ever been denied a license to practice any counseling-related profession or any other health care profession, or the renewal thereof by any state, U.S. Territory or foreign country?	☐Yes ☐No
B. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature, including, but not limited to, a charge of violation of a practice act, unprofessional or unethical conduct?	☐Yes ☐No
C. Have you ever had a license to practice any profession revoked, suspended or otherwise acted against in a disciplinary proceeding in any state, U.S. territory or foreign country?	☐Yes ☐No
D. Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was alleged negligence, malpractice or lack of professional competence?	☐Yes ☐No
E. Is there currently pending, in any jurisdiction, a complaint against your professional conduct or competency in any profession?	☐Yes ☐No

If you answered "YES" to any question in Section 3 you must provide complete details.

APPLICANT NAME ____

4. APPLICANT HISTORY - Pursuant to Section 456.0635(2), Florida Statutes,

IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation. Supporting documentation includes court dispositions or agency orders where applicable.

	Question	YES	NO
1.	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded "no", skip to # 2.)	❑YES	❑NO
a.	If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea or conviction, and completion of any sentence or subsequent period of probation?	❑YES	❑NO
b.	If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).	❑YES	❑NO
c.	If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?	❑YES	❑NO
d.	If "yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation).	❑YES	❑NO
2.	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	❑YES	❑NO
a.	If "yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?	❑YES	❑NO
3.	Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 3a.)	❑YES	❑NO
a.	If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?	❑YES	❑NO
4.	Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If "No", do not answer 4a or 4b.)	❑YES	❑NO
a.	Have you been in good standing with a state Medicaid program for the most recent five years?	❑YES	❑NO
b.	Did the termination occur at least 20 years before the date of this application?	❑YES	❑NO
5.	Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	❑YES	❑NO
6.	If "yes" to any of the questions 1 through 5 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? (If "yes", please provide official documentation verifying your enrollment status.)	❑YES	❑NO

APPLICANT NAME ____

5. APPLICANT HISTORY - GENERAL

Have you ever been convicted of, or entered a plea of guilty or nolo contendere (no contest) to any crime in any jurisdiction, other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. ☐Yes ☐No

If you answer YES, you must explain in detail on a separate sheet. In your explanation, include dates, jurisdictions, offenses, specific circumstances, and dispositions. You must include a certified copy of the court records/dispositions.

6. CERTIFICATION

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all government agencies and instrumentalities (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals, and groups listed above any information which is material to my application.

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for examination or licensure. Such supplement is required by Sections 456.072, F.S. and 456.013(1)(2), F.S. Failure to do so may result in disciplinary action by the Board or denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind. I declare that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to s. 456.067, F.S., or criminal penalties pursuant to s. 775.082, s. 775.083, or s. 775.085, F.S. Should I furnish any false information on this application, I hereby acknowledge that such act may constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida.

I hereby acknowledge that I have read the regulations in Chapter 491, F.S., and related rules. I understand that I am under a continuing obligation to keep informed of any changes to Chapter 491, F.S., and related rules.

I understand that pursuant to Section 456.013(1)(a), F.S., an incomplete application shall expire one (1) year after initial filing.

I further state that I will comply with all requirements for licensure renewal, including continuing education credits.

______________________________________ ______________________

Applicant's Signature Date

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

DEPARTMENT OF HEALTH

Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling

Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 USCA § 666 (a)(13); and Sections 456.013, 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to assure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L 193, Section 317.

Name: ____
Last First Middle

7. Social Security Number: ______________________________

8. APPLICANT HISTORY – HEALTH

If you answer "YES" to any of the following questions, you must submit a current mental health status report from a licensed mental health professional, wherein this professional practitioner opines that you are able to practice with reasonable skill and safety to patients or clients.

	Question	Answer
A.	In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past 5 years?	❑ YES ❑ NO
B.	In the last 5 years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	❑ YES ❑ NO
C.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
D.	In the last 5 years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last 5 years?	❑ YES ❑ NO
E.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
F.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice your profession?	❑ YES ❑ NO

AFFIDAVIT FOR LIMITED LICENSE APPLICANT

Pursuant to s. 456.015, F.S., any person desiring to obtain a limited license shall submit an affidavit stating that he or she has been licensed to practice in any jurisdiction in the United States for at least 10 years in the profession for which he or she seeks a limited license.

The affidavit shall also state that he or she has retired or intends to retire from the practice of that profession and intends to practice only pursuant to the restrictions of the limited license granted. Your application is incomplete without this affidavit.

Before me, the undersigned authority, personally appeared ________________________________
Print Applicant's Full Name
who deposes and says that the following statements are true and correct:

1. I ____________________________________ am of legal age and have personal
   Print Applicant's Full Name
   knowledge of the matters stated in this affidavit.

2. I affirm that I have practiced _______________________________________ as a licensed
   Print Name of Profession
   ____ for at least 10 years in the United States.
   Print Title of License

3. I affirm that I retired OR I intend to retire on ____________________ from the
   Month/Day/Year
   practice of ____.
   Print Name of Profession

4. I affirm that I will only practice as specified in Rule 64B4-3.009, Florida Administrative Code, if granted a limited license in Florida.

____
Signature of Applicant

Sworn to and subscribed before this ________ day of _________________________, ____________
Day Month
Year

____
Signature of Notary Public

____
(Print or Stamp Commissioned Name of Notary Public)

Personally Known ___________ OR Produced Identification ___________

Type of Identification Produced ___________________________________

LIMITED LICENSE FEE WAIVER FORM

TO BE COMPLETED BY EMPLOYER

Pursuant to section 456.015, Florida Statutes, and Rule 64B4-3.009, Florida Administrative Code, if a person applying for a limited license submits a notarized statement from the employing agency or institution stating that he/she will not receive monetary compensation for any services involving the practice of clinical social work, marriage and family therapy, and mental health counseling, the licensure fees shall be waived.

AFFIDAVIT

I, ____, being first duly sworn, state that the following clinical social worker, marriage and family therapist, or mental health counselor:

____
Type or print the licensee's name

will NOT receive monetary compensation for any service involving the practice of clinical social work, marriage and family therapy, or mental health counseling from:

Agency/Institution:____

Address:____

City/State/Zip:____

Signed: ____

Name: (Type or Print)____

Title: ____

STATE OF FLORIDA
COUNTY OF: ____________________________________

The above person is personally known to me or has produced ________________________ as identification.

SWORN AND SUBSCRIBED BEFORE ME THIS _____ DAY OF _______________,20___

My Commission expires on: _____________________ (Notary stamp or seal)

____
Notary Signature