DEPARTMENT OF HEALTH

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

Intern Registration Application and Instructions

Department of Health
Florida Board of CSW/MFT/MHC
4052 Bald Cypress Way, C-08
Tallahassee, FL 32399-3258
Telephone: (850) 245-4474
www.floridasmentalhealthprofessions.gov
Email: MQA.491@flhealth.gov
INTERN REGISTRATION APPLICATION INSTRUCTIONS

COMPLETING THE APPLICATION FOR INTERN REGISTRATION [5 PAGES]

Section I – 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 registered intern, your name, license number and practice location address will be shown on our Internet License Verification.

**STEP 1**
- If you do not want your mailing address on the website, fill in the “practice location address” on the Intern Registration Application 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.
- Answer the question concerning name change(s).
- Indicate the registration category for which you are applying by checking one box. If you wish to apply for more than one category, you must submit a separate application, application fee, and supporting documents.
- Check appropriate box or fill in requested information on remainder of Section I.

Section II - Post-Secondary Education Background:
- List the degree(s) you hold, beginning at the master’s level. Identify your program of study at the college or university where you received this degree. Include the month, day, and year in which the degree was received. List any schools where you completed additional graduate or post-graduate coursework.

Section III - Qualified Supervisor(s):
- List the qualified supervisor(s) who will be providing individual and/or group supervision, their license title, Florida license number, and the year they received their license. You may attach additional sheets, if necessary.
- Each supervisor you list must provide our office with written correspondence. This correspondence must state that the supervisor has agreed to provide you with supervision while you are a registered intern. The correspondence may be faxed or e-mailed, but it must originate from the supervisor. Your file will not be complete until we have received this documentation.

Section IV - Applicant History – General:
- If you answer “yes”, you must provide complete details and certified copies of court records/dispositions.

Section V - 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.

Section VI – Applicant History Pursuant to Section 456.0635, 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.
Section VII - 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.

Section VIII – Social Security Number: Your social security number is required.

Section IX – Applicant History – Health:
• The Board reviews each applicant’s history to determine that the applicant is able to practice the profession with reasonable skill or competence. 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.

EDUCATION WORKSHEET: CSW, MFT OR MHC
• Locate the worksheet for the profession for which you are applying: CSW or MFT or MHC. Write your name at the top and complete the form.

STEP 2
• The education worksheet must be filled out completely in order for the Board to determine if your education meets the requirements of Chapter 491, F.S. All coursework listed on this worksheet must be supported by official transcripts and course descriptions.

PRACTICUM/INTERNSHIP/FIELD PLACEMENT VERIFICATION
• Contact your university and request that an official of the university submit a letter, on university letter head, that verifies you completed at least one supervised clinical practicum, internship, or field experience which meets the requirements outlined in the corresponding law for your profession. This letter may be mailed to the board office by the university. If the letter accompanies your application, it must be in a sealed envelope bearing the signature of the official across the flap.
• The practicum, internship, or field experience requirement is part of the educational requirements for your profession. This requirement must be met for your education to be certified complete.
• The education worksheet for your profession includes the practicum/internship/field placement requirement. Read the appropriate definition for your profession in the statute section listed below:
  CSW: 491.005(1)(b)2.a., F.S. and s. 491.005(2)(b), F.S.
  MFT 491.005(3)(b)1.d., F.S.
  MHC 491.005(4)(b)1.c., F.S.

STEP 4
• You may access the Florida Statutes through our website at http://floridasmentalhealthprofessions.gov and click on “Resources”.

TRANSCRIPTS
• You must request an official transcript from the regionally accredited institution(s) from which you received your degree or have taken coursework. These transcripts must be sent directly to the board office from the registrar’s office of the institution or they will not be considered official. You may submit your official transcript with your application, but only if the official transcript is in a sealed envelope with a school official’s signature across the flap.
• If the course title on your transcript does not clearly identify the content of the coursework, a course description or syllabus will be required.
• FOREIGN EDUCATION for CSW Intern Applicants
If you received your social work degree from a program outside the U.S. or Canada, documentation must be received that it was determined to have been a program equivalent to programs approved by the Council on Social Work Education by the Foreign Equivalency Determination Service of the Council on Social Work Education.

• FOREIGN EDUCATION for MFT and MHC Intern Applicants
For the Board to consider education completed outside the U.S. or Canada, documentation must be received which verifies the institution at which the education was completed was equivalent to a regionally accredited U.S. institution and the coursework met the content and credit hour requirement for graduate level coursework in the U.S. It is the applicant's responsibility to obtain an evaluation from a recognized foreign equivalency determination service that documents the acceptability of the coursework. The board office must receive an original evaluation mailed directly from the educational evaluation service.

• DOCUMENTS IN A FOREIGN LANGUAGE – A certified translator who is not related to the applicant must translate any document in a foreign language into ENGLISH.

MAKE COPIES OF ALL DOCUMENTS THEN MAIL THE ORIGINALS TO THE BOARD OFFICE

STEP 5 MAILING THE INFORMATION AND REQUIRED FEE OF $150.00
• Make your cashier’s check or money order payable to the Department of Health and securely attach to the application.
• You may pay by credit or debit card if you submit your application online at www.flhealthsource.com and click on “Apply for a License”.
• Mail the intern registration application and nonrefundable application fee of $150.00 to:

  BOARD OF CSW, MFT, MHC
  P O BOX 6330
  TALLAHASSEE, FL  32314-6330

• Any additional documentation that you mail, or others mail on your behalf, should be sent to the address shown below. Any variation or abbreviation of this address may cause a delay in processing. If information is mailed from a source other than the applicant, the applicant’s full name must appear on the correspondence or documentation.

  BOARD OF CSW, MFT, MHC
  4052 BALD CYRESS WAY, BIN #C08
  TALLAHASSEE, FL  32399-3258
Section I  APPLICANT PROFILE DATA  (TYPE OR PRINT NEATLY IN BLACK INK)

<table>
<thead>
<tr>
<th>Name</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
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<tr>
<td>Mailing Address</td>
<td>Street Address or P.O. Box</td>
<td>Apt. No.</td>
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<tr>
<td>City</td>
<td>State</td>
<td>Zip</td>
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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 name(s)

Registration Category - Check one:
☐ CLINICAL SOCIAL WORKER Intern (5207)  
☐ MARRIAGE & FAMILY THERAPIST Intern (5208)  
☐ MENTAL HEALTH COUNSELOR Intern (5209)

Primary Telephone:  
area code ( )

Business Telephone:  
area code ( )

E-Mail Address (Optional. Will be public record if provided.):

May we send correspondence through e-mail?  
☐ YES  ☐ NO

Gender:  ☐ Male  ☐ Female

Equal Opportunity Data: 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 FR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☐ Male  ☐ Female  U.S. Citizen: ☐ Yes  ☐ No  RACE: ☐ White  ☐ Black  ☐ Asian/Pacific  ☐ Hispanic  ☐ Other

SECTION II  POST-SECONDARY EDUCATION BACKGROUND

<table>
<thead>
<tr>
<th>DEGREE (If Applicable)</th>
<th>MAJOR</th>
<th>COLLEGE OR UNIVERSITY</th>
<th>DEGREE CONFERRED DATE</th>
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</table>

For clinical social work applicants only. Were you an advanced standing student?  ☐ YES  ☐ NO
**SECTION III QUALIFIED SUPERVISOR(S)**

<table>
<thead>
<tr>
<th>*NAME</th>
<th>LICENSE TITLE</th>
<th>FLORIDA LICENSE NO.</th>
<th>YEAR</th>
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You must provide our office with written correspondence from each supervisor you list. The correspondence must state that the supervisor has agreed to provide you with supervision while you are a registered intern.

**SECTION IV APPLICANT HISTORY – GENERAL**

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a 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 or conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question.

If you answered “Yes” to the question above you are required to send the following items:

- **Self Explanation** describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.
- **Final Dispositions and Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
- **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

**SECTION V APPLICANT HISTORY - PROFESSIONAL**

A. Have you ever been denied a psychotherapy or counseling-related license or the renewal thereof in any state?  
   □ YES □ NO

B. Have you ever been denied the right to take a psychotherapy or counseling-related licensure examination?  
   □ 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?  
   □ YES □ NO

D. Is there currently pending, in any jurisdiction, a complaint against your professional conduct or competency in a psychotherapy or counseling-related profession?  
   □ YES □ NO

E. Have you ever been involved in, reprimanded for or disciplined by an employer or educational institution for misconduct including:
   1. Acts of dishonesty, fraud, or deceit  
      1. □ YES □ NO
   2. Lying on a resume or misrepresentation  
      2. □ YES □ NO
   3. Academic misconduct, including acts such as cheating or plagiarism  
      3. □ YES □ NO
   4. Theft  
      4. □ YES □ NO
   5. Sexual harassment  
      5. □ YES □ NO

If you answered "YES" to any question in Section V, you must provide the Board complete details.
**SECTION VI  APPLICANT HISTORY PURSUANT TO SECTION 456.0635, 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.

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?**
   - YES
   - NO
   
   *(If you responded “no”, skip to # 2.)*

   **Subsection 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

   **Subsection 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

   **Subsection 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

   **Subsection 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
   
   *(If “No”, do not answer 2a.)*

   **Subsection 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?**
   - YES
   - NO
   
   *(If “No”, do not answer 3a.)*

   **Subsection 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?**
   - YES
   - NO
   
   *(If “No”, do not answer 4a or 4b.)*

   **Subsection a.** Have you been in good standing with a state Medicaid program for the most recent five years?
   - YES
   - NO

   **Subsection 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

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Rule 64B4-3.0085
DH-MQA 1175 (Revised 11/18)
SECTION VII CERTIFICATION

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 registration 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 including denial of licensure.

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 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. 775.084, 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 1 year after initial filing.

Applicant Signature ___________________________ Date ______________________
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

VIII. Social Security Number: __________________________________________

IX. APPLICANT HISTORY – HEALTH

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<td>A. Do you have any condition that currently impairs your ability to practice your profession with reasonable skill and safety?</td>
<td>☐ YES ☐ NO</td>
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<tr>
<td>B. Are you using medications, other drugs, narcotics, or intoxicating chemicals that impair your ability to practice your profession with reasonable skill and safety?</td>
<td>☐ YES ☐ NO</td>
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</table>

If you answered "yes" to either of the above questions, please provide a letter from a licensed health care practitioner, who is qualified by skill and training to address your condition, which explains the impact your condition may have on your ability to practice your profession with reasonable skill and safety, and stating either that you are safe to practice your profession without restriction or indicating what restrictions are necessary. If necessary, you may attach additional sheets. Documentation must be current within the last year. If you fail to disclose the information requested in this section, your application may be denied.
**EDUCATION WORKSHEET**  
**CLINICAL SOCIAL WORK**

Print clearly or type the following information.

**APPLICANT NAME** __________________________

I. **GENERAL INFORMATION**
   You are required to complete 24 semester hours or 32 quarter hours of graduate level coursework in theory of human behavior and practice methods as courses in clinically oriented services within an accredited school of social work program. (Only one research course may be counted towards the coursework requirement). Do NOT list fieldwork. Course numbers and titles should be listed as they appear on your official transcripts. You must submit a course description photocopied from a school catalog or a course syllabus for all courses listed below. If you were admitted to an advanced standing program, an official of the school which awarded your master’s degree in social work must provide a letter, on university letterhead, verifying the specific courses completed at the baccalaureate level, which were used to waive or exempt completion of similar courses at the graduate level.

<table>
<thead>
<tr>
<th>SCHOOL</th>
<th>COURSE NUMBER</th>
<th>COURSE TITLE</th>
<th>CREDIT HOURS</th>
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II. **PSYCHOPATHOLOGY**
   List the graduate level psychopathology course you completed within an accredited school of social work program. You must submit a course description photocopied from a school catalog or a course syllabus for the course listed.

<table>
<thead>
<tr>
<th>SCHOOL</th>
<th>COURSE NUMBER</th>
<th>COURSE TITLE</th>
<th>CREDIT HOURS</th>
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III. **ADVANCED SUPERVISED FIELD PLACEMENT**
   You are required to complete a supervised field placement which was part of your advanced concentration in direct practice, during which you provided clinical services directly to clients. An official of the school (Dean, Department Chair) which awarded your graduate degree must provide a letter on university letterhead verifying: 1) that the supervised field placement was completed during the master’s or doctorate program; and 2) the setting in which you provided clinical services directly to clients.

<table>
<thead>
<tr>
<th>ADVANCED SUPERVISED FIELD PLACEMENT COURSE TITLE</th>
<th>COURSE NUMBER</th>
<th>SCHOOL</th>
<th>DATES</th>
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</table>
Print clearly or type the following information.

APPLICANT NAME ________________________________________________

I. COURSEWORK VERIFICATION

You must indicate the graduate level course(s) you completed that satisfy the educational requirement in the content areas listed. Course numbers and titles should be listed as they appear on your official transcripts. If the course title on your transcript does not clearly identify the content of the coursework, a course description or syllabus may be required.

You are required to complete 36 semester hours or 48 quarter hours of graduate level coursework.

Each of the following content areas must have a minimum of 3 semester hours or 4 quarter hours in graduate level coursework.

<table>
<thead>
<tr>
<th>CONTENT AREA</th>
<th>SCHOOL</th>
<th>COURSE NUMBER</th>
<th>COURSE TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dynamics of Marriage &amp; Family Systems</td>
<td>1. ______________</td>
<td>1. ___________</td>
<td>1. ___________</td>
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<td>2. ______________</td>
<td>2. ___________</td>
<td>2. ___________</td>
</tr>
<tr>
<td>Marriage Therapy &amp; Counseling Theory &amp; Techniques</td>
<td>1. ______________</td>
<td>1. ___________</td>
<td>1. ___________</td>
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<tr>
<td></td>
<td>2. ______________</td>
<td>2. ___________</td>
<td>2. ___________</td>
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<tr>
<td>Family Therapy &amp; Counseling Theory &amp; Techniques</td>
<td>1. ______________</td>
<td>1. ___________</td>
<td>1. ___________</td>
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<td></td>
<td>2. ______________</td>
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<tr>
<td>Individual Human Development Theories Throughout the Life Cycle</td>
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<td>2. ___________</td>
<td>2. ___________</td>
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<tr>
<td>Personality Theory or General Counseling Theory &amp; Techniques</td>
<td>1. ___________</td>
<td>1. ___________</td>
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<td>2. ___________</td>
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<tr>
<td>Psychopathology</td>
<td>1. ___________</td>
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<tr>
<td>Human Sexuality Theory &amp; Counseling Techniques</td>
<td>1. ___________</td>
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<td>2. ___________</td>
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</table>
### The following courses must be a minimum of one graduate-level course of 3 semester or 4 quarter hours.

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<thead>
<tr>
<th>Course</th>
<th>1. ___________</th>
<th>2. ___________</th>
<th>3. ___________</th>
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<tbody>
<tr>
<td>Psychosocial Theory</td>
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<tr>
<td>Substance Abuse Theory &amp; Counseling Techniques</td>
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<tr>
<td>Legal, Ethical, Professional Standards Issues in the Practice of Marriage &amp; Family Therapy</td>
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<tr>
<td>Diagnosis, Appraisal, Assessment, and Testing for Individual or Interpersonal Disorder or Dysfunction</td>
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<tr>
<td>Behavioral Research (Course must focus on the interpretation and application of research data as it applies to clinical practice)</td>
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II. **SUPERVISED CLINICAL PRACTICUM, INTERNSHIP, FIELD EXPERIENCE**

You are required to complete a minimum of one supervised practicum, internship, or field experience in a marriage and family counseling setting, during which you provided 180 direct client contact hours of marriage and family services under the supervision of a qualified supervisor.

This requirement may be met by a supervised practice experience which took place outside the academic arena but is certified (by the University) as equivalent to a graduate-level practicum with 180 direct client contact hours of marriage and family services offered within an academic program of an accredited college or university. An official of the school (Dean, Department Chair) which awarded your graduate degree must provide a letter on university letterhead verifying that the supervised practicum was completed in a marriage and family counseling setting, during which you provided 180 direct client contact hours of marriage and family services.

The practicum letter should also include the following:

a. Course Title of Practicum/Internship/Field Experience
b. Course Number
c. Setting (was it a marriage and family counseling setting)
d. Total Number of Direct Client Contact Hours in Marriage and Family Services

Rule 64B4-3.0085
DH-MQA 1175 (Revised 11/18)
# EDUCATION WORKSHEET
## MENTAL HEALTH COUNSELING

Print clearly or type the following information:

**APPLICANT NAME**

If the program you graduated from was not accredited by the Council for Accreditation of Counseling and Related Education Programs (CACREP) or if the program you graduated from was a CACREP accredited program that was not mental health counseling, then sections I, II, and III apply to you. (There are CACREP accredited programs in community counseling; marital, couple, and family counseling; and school counseling, for example.) If you graduated from a CACREP mental health counseling program, then section IV applies to you.

### I. GENERAL INFORMATION
Your overall degree program must be a minimum of 60 semester hours or 80 quarter hours. Within the degree program, you'll be required to complete 3 semester hours or 4 quarter hours of individualized graduate level coursework at an accredited college or university in each of the content areas listed below. Course numbers and titles should be listed as they appear on your official transcripts. If the course title on your transcript does not clearly identify the content of the coursework, a course description or syllabus will be required.

### II. COURSEWORK VERIFICATION
You must indicate below the graduate level course you completed that satisfies the education requirement in the specific content area. You must have a minimum of 3 semester hours or 4 quarter hours to satisfy each content area.

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<th>Content Area</th>
<th>School</th>
<th>Course Number</th>
<th>Course Title</th>
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<tbody>
<tr>
<td>Counseling Theories and Practice</td>
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<td>Human Growth and Development</td>
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<td>Diagnosis and Treatment of Psychopathology</td>
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<td>Human Sexuality</td>
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<td>Group Theories and Practice</td>
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<td>Individual Evaluation and Assessment</td>
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<td>Career and Lifestyle Assessment</td>
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<td>Research and Program Evaluation</td>
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<td>Social and Cultural Foundations</td>
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<td>Counseling in Community Settings</td>
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<td>Substance Abuse</td>
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<tr>
<td>Legal, Ethical &amp; Professional Standards</td>
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To qualify for mental health counseling intern registration, an applicant must have completed a minimum of 7 of the above required course content areas, one of which must be a course in psychopathology or abnormal psychology. Please see s. 491.005(4)(c), F.S.
## III. UNIVERSITY SPONSORED SUPERVISED CLINICAL PRACTICUM, INTERNSHIP OR FIELD EXPERIENCE.

You must complete at least 1,000 hours of university-sponsored supervised clinical practicum, internship, or field experience as required in the accrediting standards of CACREP for mental health counseling programs.

The accrediting standards of CACREP for these hours are:

- At least 280 of these hours must be in direct service with actual clients that contributes to the development of counseling skills, including experience leading groups
- An average of one hour per week of individual and/or triadic supervision
- The opportunity for the applicant to become familiar with a variety of professional activities and resources in addition to direct service (e.g., record keeping, assessment instruments, supervision, information and referral, in-service and staff meetings)
- The opportunity for the applicant to develop program-appropriate audio/video recordings for use in supervision or to receive live supervision of the applicant’s interactions with clients
- Evaluation of the applicant’s counseling performance throughout the practicum/internship, including a formal evaluation after the completion of the practicum/internship hours

An official of the school (Dean, Department Chair) which awarded your graduate degree must provide a letter on university letterhead verifying that the supervised practicum/internship was completed in accordance with CACREP standards. The practicum letter should also include the following:

- Course Title(s) of Practicum/Internship/Field Experience
- Course Number(s)
- School or Site Where Experience was Completed
- Dates of Practicum/Internship or Field Experience
- Total Number of Clock Hours Completed

If you did not complete a minimum of 1,000 hours in your master’s program, you may complete the practicum/internship requirement outside the university setting. When completing practicum/internship hours outside the university setting, the above listed CACREP standards must be met. In addition, you must be supervised by a qualified supervisor. If you have fewer than 1,000 practicum/internship hours when you register as an intern, you will be sent a form for documenting these hours outside the university setting. This form must be completed and signed by your qualified supervisor. You cannot begin your post-master’s supervision experience until you meet the 1,000 hours of practicum/internship requirement.

IV. If you graduated from a mental health counseling program accredited by CACREP, your overall degree program must be a minimum of 60 semester hours or 80 quarter hours, including a course in human sexuality and a course in substance abuse.

Indicate below the graduate level course you completed that satisfies the two specific content areas. You must have a minimum of 3 semester hours or 4 quarter hours in each content area.

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