DEPARTMENT OF HEALTH

CERTIFICATION/LICENSE VERIFICATION

Print clearly or type the following information.

APPLICANT NAME _____

❑Clinical Social Work Applicant ❑Marriage & Family Therapy Applicant ❑Mental Health Counseling Applicant

Applicant's Address:
Title of License: License Number:
THE FOLLOWING SECTIONS MUST BE COMPLETED BY THE STATE LICENSING BOARD OFFICE AND MAILED DIRECTLY TO: BOARD OF CLINICAL SOCIAL WORK, MARRIAGE & FAMILY THERAPY, AND MENTAL HEALTH COUNSELORS 4052 BALD CYPRESS WAY, BIN #C08 TALLAHASSEE, FLORIDA 32399-3258
The individual listed above has applied for licensure in Florida. Before further consideration is given to this application, we need the information requested on this form.
Title of License: License Number:
Original Issue Date: Expiration Date:
License Status: ❑ Active ❑ Inactive ❑ Temporary ❑ Other (Explain)
Licensure Method: ❑ Grandfathering ❑ Reciprocity/Endorsement ❑ Examination
If licensed by examination, complete the following: Name of Exam: Level of Exam: Date of Exam: Score Achieved:
Has any disciplinary action been taken against this license? ❑ YES ❑ NO If "YES", please provide our office with any documentation regarding the disciplinary action.

Affix Board Seal	Signature:
	Title:
	Date:
	Phone Number:
	Board of:
	State of: