APPLICATION INSTRUCTIONS
Transfer from LGPC to LCPC

Application: Fill out application. Send the application and clinical documentation form(s) and reference forms in ONE packet.

Board of Professional Counselors and Therapists
4201 Patterson Avenue, Suite 316
Baltimore, Maryland 21215
410-764-4732 or 410-764-4735
www.dhmh.maryland.gov/bopc/

1. **Application**. An application for the LCPC and **ATTACHMENT FORMS** are required of all applicants. The application must be typed or printed legibly.

2. **Fee:** Application fee of $200.00 must be included with the application. Make your check payable to the Board of Professional Counselors and Therapists. **FEES ARE NON-REFUNDABLE**

   The Board will review your application and notify you of your eligibility. At that time you will be required to pay the license fee which is $150.00.

3. **Experiential Requirement:** 3 years/3,000 hours of supervised clinical experience in professional counseling. 2years/2,000 hours must be post-master's. 1,500 hours must be face-to-face client contact hours with the client **physically** present and 100 hours post-graduate clinical supervision with the supervisor **physically** present. The Clinical Supervision Forms must be notarized.

4. **Professional Reference Forms:** Three are required.

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Baltimore, MD 21215 3rd Floor
410-764-4732
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APPLICATION FOR LICENSE CLINICAL PROFESSIONAL COUNSELOR

APPLICATION DATE:

I AM APPLYING FOR LCPC [☐]

GENERAL INFORMATION

Name:	Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐			
	Last	First	MI	
Date of Birth:				
Home Address:				
	Street	City	State	Zip Code
Business Address:				
	Street	City	State	Zip Code
Social Security Number:				
Telephone Number:				
	Home	Work		
E-Mail Address:				

EXAMINATION REQUIRED

Have you successfully passed the National Counselors Examination (NCE) and the State Law Test?
☐ Yes ☐ No

If answer is No, you must meet the education requirements before receiving approval by the Board to take the NCE and the Law test. Submit this application and supporting documents to enable the aboard to evaluate your education.

a. Have you ever been denied an initial application, reinstatement or renewal of a license and /or certificate by any state licensing or disciplinary board? ☐ Yes ☐ No

If "yes" explain reason(s).

b. Has any state licensing or disciplinary board ever taken any action against your license and/or certification, including but not limited to limitations of practice, required education, admonishment, reprimand, revocation, suspension? ☐ *Yes* ☐ *No*

If yes, explain circumstance(s).

c. *Has an investigation or charges ever been brought against you by any licensing or disciplinary board?*
☐ *Yes* ☐ *No*

If yes, explain circumstance(s).

d. *Have you pled guilty, nolo contendre, or been convicted of or received probation before judgment or any criminal act (excluding traffic violations)?* ☐ *Yes* ☐ *No*

If "yes" provide the following information: Date of Conviction:

Where convicted *Charge*

If conviction was set aside, give date and explain using additional pages if necessary. Include required information on all felony convictions attaching additional sheets behind this page if necessary.

ACADEMIC TRAINING -

*List all **graduate** college(s) or universitie(s) attended to satisfy academic requirements for licensure. Do not list degrees unrelated to Counseling. List most recent colleges first. Attach additional sheets behind this one, if necessary.*

ALL APPLICANTS MUST COMPLETE THIS SECTION

***1. Name of School**:*

(City) *(State)*

Inclusive dates attended: From (mo./yr.) *To (mo./yr.)*

Degree granted: *Date granted (mo./yr.)*

Major Field of Study:

***2. Name of School**:*

(City) *(State)*

Inclusive dates attended: From (mo./yr.) *To (mo./yr.)*

Degree granted: *Date granted (mo./yr.)*

Major Field of Study:

***3. Name of School**:*

(City) *(State)*

Inclusive dates attended: From (mo./yr.) *To (mo./yr.)*

Degree granted: *Date granted (mo./yr.)*

Major Field of Study:

***4. Name of School**:*

(City) *(State)*

Inclusive dates attended: From (mo./yr.) *To (mo./yr.)*

Degree granted: *Date granted (mo./yr.)*

Major Field of Study:

***5. Name of School**:*

(City) *(State)*

Inclusive dates attended: From (mo./yr.) *To (mo./yr.)*

Degree granted: *Date granted (mo./yr.)*

Major Field of Study:

Supervised Counseling Experience:

NOTE: You may use up to 1,000 practicum/internship hours toward the overall 3,000 hours required for licensure

Practicum/Internship Experience(s)

1.	Name of agency, school, organization where practicum/internship was obtained.
	Name and credential(s) of supervisor:
	Address of agency, school, or organization:
	Inclusive dates of experience: From (mo./yr.) To (mo. /yr.)
	a.
	b.
	Total number of months worked: Total number of hours worked per week:

Total number of hours worked during internship/practicum. (Number of months times 4, times number of hours worked each week.)

2.	Name of agency, school, organization where practicum/internship was obtained.
	Name and credential(s) of supervisor:
	Address of agency, school, or organization:
	Inclusive dates of experience: From (mo./yr.) To (mo. /yr.)
	a.
	b.
	Total number of months worked: Total number of hours worked per week:

Total number of hours worked during internship/practicum. (Number of months times 4, times number of hours worked each week.)

Supervised Practice Documentation (Post Masters or Post Doctorate)

Supervised Work Experience (Must be professional work completed after the transcript date the Master's or Doctorate Degree was conferred). *List most current position first. Attach additional sheets behind this one, if necessary.)*

Name of agency, school or organization:	
Address of agency, school, or organization:	
Telephone Number:	
Inclusive dates of experience: From (mo./yr.)	To (mo. /yr.)
Name, Title and Credential(s) of Supervisor:	
a.	
b.	
Application's Job Title:	
Job Duties:	
Total number of months worked:	Total number of hours worked per week:

Total number of hours worked :

Name of agency, school or organization:	
Address of agency, school, or organization:	
Telephone Number:	
Inclusive dates of experience: From (mo./yr.)	To (mo. /yr.)
Name, Title and Credential(s) of Supervisor:	
a.	
b.	
Application's Job Title:	
Job Duties:	
Total number of months worked:	Total number of hours worked per week:

Total number of hours worked :

Professional References:

COMPLETE THIS SECTION

List below at least (3) professional references who can attest to your counseling skills, professional standards of practice, and supervised clinical work.

1. Name of Reference:	
Degree Held:	Certification/License Held:
Position Held:	
Business name and address:	
Business telephone number (include area code:	
Will this reference be verifying some or all of your supervised clinical experience? ☐ Yes ☐ No	

2.Name of Reference:	
Degree Held:	Certification/License Held:
Position Held:	
Business name and address:	
Business telephone number (include area code:	
Will this reference be verifying some or all of your supervised clinical experience? ☐ Yes ☐ No	

3.Name of Reference:	
Degree Held:	Certification/License Held:
Position Held:	
Business name and address:	
Business telephone number (include area code:	
Will this reference be verifying some or all of your supervised clinical experience? ☐ Yes ☐ No	

AFFIDAVIT

In making this application to the Maryland Board of Professional Counselors and Therapists for the issuance of a license, I agree to abide by the rules and regulations of the Maryland Board of Professional Counselors and Therapists and to take all examinations necessary to the processing of my application. Upon issuance of a license, I agree to be bound by the Code of Ethics. I further understand that the fee submitted with this application is non-refundable.

I agree to hold the Maryland Board of Professional Counselors and Therapists, its members, officers, agents, and examiners free from any damage or claim for damage or complaint by reason of any action they or any one of them take in connection with this application, the attendant examination, the grades with respect to any examination, and/or failure of the Board to issue me a license. I hereby grant permission to the Board to seek any information or references it deems fit in securing my credentials pertinent to this application.

I understand, by law, it is my responsibility to notify the Board in writing if I change my address of residence.

Signed _____

Date: _____

NOTARY

State of _____

City/County of _____

I HEARBY CERTIFY that on this _____ day of _____, before me, a Notary Public of the State and City/County aforesaid, personally appeared _____

_____, and made oath in due form that the contents of the foregoing Affidavit are true.

Notary Public _____

Commission Expires _____

ATTACH YOUR PHOTOGRAPH
IN THIS AREA (RECENT 2"x2")

PROFESSIONAL REFERENCE FORMS

Three (3) references are required from three licensed professional counselors, or another mental health care provider, approved by the Board, who can address issues of professional education, professional supervised experience, competence, professional conduct, and moral character. At least one reference must be from the supervisor of your post-graduate clinical training. Do not list relatives, individuals with whom you have a close personal relationship or who work under your supervision.

RETURN REFERENCE FORMS IN A SEALED ENVELOPE WITH OTHER APPLICATION MATERIALS

PROFESSIONAL REFERENCE ASSESSMENT FORM

Applicant's Name:

The applicant must complete items 1 and 3

The person named above has applied to the Maryland Board of Professional Counselors & Therapists to become a State Licensed Professional Counselor. Your assessment of the applicant's characteristics will enable the Board to evaluate whether this applicant meets its standards. Please respond to all questions to the best of your ability. (Questions 1,2 and 3 apply to reference). **PLEASE RETURN COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPE.**

1. Reference's Name :	Profession:
Business Address:	Degree:
	Position Title:
	Telephone:
2. Professional Certification or License:	
State or Certifying Organization:	
3. Relationship with applicant:	
☐ Trainer or Educator	Supervisor (Be sure to complete #5 on reverse side)
☐ Professional Colleague	Other

Length of time you have known this applicant: Dates from to

Please rate the applicant compared to other counselors you know on the following characteristics. Place a check in every category. (Counselor Educators should be evaluated on the basis of their ability to train students to counseling skill areas).

	Outstanding	Above Average	Average	Below Average	Poor	Cannot Evaluate
Individual Counseling skills	☐	☐	☐	☐	☐	☐
Appropriate referral making skills	☐	☐	☐	☐	☐	☐
Group counseling skills	☐	☐	☐	☐	☐	☐
Personal integrity	☐	☐	☐	☐	☐	☐
Consulting skills	☐	☐	☐	☐	☐	☐
Insight into client's problems	☐	☐	☐	☐	☐	☐
Ability to relate to co-workers	☐	☐	☐	☐	☐	☐
Ability to be objective on the job	☐	☐	☐	☐	☐	☐
Ethical conduct	☐	☐	☐	☐	☐	☐
Concern for welfare of clients	☐	☐	☐	☐	☐	☐
Sense of responsibility	☐	☐	☐	☐	☐	☐
Recognition of own limits	☐	☐	☐	☐	☐	☐
Supervisory abilities	☐	☐	☐	☐	☐	☐
Ability to keep material confidential	☐	☐	☐	☐	☐	☐

5. FOR SUPERVISORS ONLY: If you are verifying applicant's experience, you must complete this section.

I verify that this applicant for licensure as a Maryland Licensed Professional Counselor has spent under my supervision in the following capacity:

Applicant's Position:	**Name of Agency/Institution:**
From (mo./yr.) **To (mo. /yr.)**	

_____

Supervisor's Signature

6. Recommendation: I recommend this applicant for licensure as a Maryland Licensed Professional Counselor.

☐ Yes ☐ No

Additional Comments:

7. The above information is based upon my best judgment. I am willing to answer additional questions concerning this evaluation if the Board deems it necessary.

_____ _____

Signature of Reference Date

After completing this form, please enclose it in a sealed envelope, sign the sealed flap and return it to this applicant.

PROFESSIONAL REFERENCE ASSESSMENT FORM

Applicant's Name:

The applicant must complete items 1 and 3

The person named above has applied to the Maryland Board of Professional Counselors & Therapists to become a State Licensed Professional Counselor. Your assessment of the applicant's characteristics will enable the Board to evaluate whether this applicant meets its standards. Please respond to all questions to the best of your ability. (Questions 1,2 and 3 apply to reference). **PLEASE RETURN COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPE.**

4. Reference's Name :	Profession:
Business Address:	Degree:
	Position Title:
	Telephone:
5. Professional Certification or License:	
State or Certifying Organization:	
6. Relationship with applicant:	
☐ Trainer or Educator	Supervisor (Be sure to complete #5 on reverse side)
☐ Professional Colleague	Other

Length of time you have known this applicant: Dates from to

Please rate the applicant compared to other counselors you know on the following characteristics. Place a check in every category. (Counselor Educators should be evaluated on the basis of their ability to train students to counseling skill areas).

	Outstanding	Above Average	Average	Below Average	Poor	Cannot Evaluate
Individual Counseling skills	☐	☐	☐	☐	☐	☐
Appropriate referral making skills	☐	☐	☐	☐	☐	☐
Group counseling skills	☐	☐	☐	☐	☐	☐
Personal integrity	☐	☐	☐	☐	☐	☐
Consulting skills	☐	☐	☐	☐	☐	☐
Insight into client's problems	☐	☐	☐	☐	☐	☐
Ability to relate to co-workers	☐	☐	☐	☐	☐	☐
Ability to be objective on the job	☐	☐	☐	☐	☐	☐
Ethical conduct	☐	☐	☐	☐	☐	☐
Concern for welfare of clients	☐	☐	☐	☐	☐	☐
Sense of responsibility	☐	☐	☐	☐	☐	☐
Recognition of own limits	☐	☐	☐	☐	☐	☐
Supervisory abilities	☐	☐	☐	☐	☐	☐
Ability to keep material confidential	☐	☐	☐	☐	☐	☐

5. **FOR SUPERVISORS ONLY:** If you are verifying applicant's experience, you must complete this section.

I verify that this applicant for licensure as a Maryland Licensed Professional Counselor has spent under my supervision in the following capacity:

Applicant's Position:	**Name of Agency/Institution:**
From (mo./yr.) **To (mo. /yr.)**	

_____

Supervisor's Signature

6. Recommendation: I recommend this applicant for licensure as a Maryland Licensed Professional Counselor.

☐ Yes ☐ No

Additional Comments:

7. The above information is based upon my best judgment. I am willing to answer additional questions concerning this evaluation if the Board deems it necessary.

_____ _____

Signature of Reference Date

After completing this form, please enclose it in a sealed envelope, sign the sealed flap and return it to this applicant.

Maryland Board of Professional Counselors and Therapists
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SUPERVISED CLINICAL DOCUMENTATION FORM

The Information provided on this form must be completed by the applicant's supervisor(s) at the agency or organization(s) where the applicant was employed for the period of time claimed. **This form should be photocopied and completed for each separate counseling experience claimed to meet the required clinical supervision including your practicum or internship, if applicable.** Please review the table and glossary of terms to help you understand the requirements.

APPLICATION DATE:

Please Type or Print all Information:

APPLICANT'S NAME AND CONTACT INFORMATION

1. Name:	Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐			
		Last	First	MI

2. Social Security Number:	
3.Name and address of organization, agency or any other counseling setting where the applicant gained supervised experience:	Name:

Address:					
Street		City	County	State	Zip Code

4. Did this applicant perform 3,000 clinical hours under your supervision?

☐ Yes ☐ No. If no, how many hours

5. From:	To:
(Month/Day/Year)	(Month/Day/Year)

6. Did this applicant complete 1,500 face-to-face client contact hours under your supervision with client(s) physically present? ☐ **Yes** ☐ **No**

If no, indicate the number of hours:

7. Did you provide 100 post master's degree face-to-face clinical supervision hours with this applicant?

☐ **Yes** ☐ **No.** If no, indicate the number of hours:

100 post master's clinical supervision hours with the supervisor physically present is required. These hours must be completed after the transcript date the Masters Degree was conferred.

8 Are you a licensed Professional Counselor?

☐ **Yes** ☐ **No**

License Number: State: Expiration Date:

9. Are you licensed as another mental health care provider? ☐ **Yes** ☐ **No**

If yes, ***where*** are you licensed? State: License Number: Expiration Date:

10. As supervisor of this applicant, do you have any reservations about the applicant receiving a license for the independent practice of counseling? ☐ Yes ☐ No

If yes, please specify (attach additional sheet if necessary)

I VERIFY THE INFORMATION ON THIS FORM IS ACCURATE FOR THE APPLICANT			
(Supervisor Print Name)			(Supervisor's Signature)
Address:			
(City)	(State)	(Zip)	(Phone)
		Witnessed by	
			Name of Notary