



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

**APPLICATION FOR LIMITED LICENSURE
and
Instructions**

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 web site at www.doh.state.fl.us/mqa/491. The requirements for limited licensure are in Section 456.015, Florida Statutes, and Rule 64B4-3.009, Florida Administrative Code.

COMPLETING THE FORMS

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:

Your "practice location address" will show on the Internet license verification screen. Our licensure database requires two addresses for each licensee. One is the mailing address and the other is the practice location address. The "mailing address" is used whenever documents, renewals, etc. are mailed to the applicant/licensee. Our Internet license lookup provides the public with information on licensed health care practitioners in the state of Florida, including an "address of record". The "practice location address" from the licensure database will show as the "address of record" on the Internet. If you only provide one address, it will be used for both the mailing address and the practice location address.

Photo: Attach one passport-style photograph (less than 6 months old) to the form. Your name must be printed on the back of the photograph.

2. Education Data:

List the degree(s) you hold, beginning at the master's level. Identify your program of study at the school where you received this degree. Include the month and year in which the degree was received.

3. Licensure Data:

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

4. Applicant History – General:

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

5. 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.

6. Applicant History – Pursuant to Section 456.0635, Florida Statutes: Follow directions in this section.

7. 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.

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

9. 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 competence. If you have a history of serious, chronic, or recent mental health problems or addiction to drugs, you must submit a current mental health status report. Mental health status reports must come from a licensed mental health professional, with which you have no personal or professional relationship. **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.



Board of CSW, MFT, MHC
4052 Bald Cypress Way, Bin C08
Tallahassee, FL 32399-3258

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

*Your Location Address Will Show On The Internet Licensure Lookup Screen. Our Internet license lookup 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.

- (Check One)
- CLINICAL SOCIAL WORK (5201)
 - MARRIAGE & FAMILY THERAPY (5202)
 - MENTAL HEALTH COUNSELING (5203)

Home Telephone: area code ()

Business Telephone: area code ()

E-mail Address (optional):

Date of birth: ____/____/____

Place of Birth: (City, State, Country)

Sex: 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 _____

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.

TAPE ONE PHOTO HERE

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.**

APPLICANT NAME _____

2. EDUCATION DATA

Name and address of School, College or University	Degree	Date of Graduation

3. LICENSURE DATA

A. Do you hold or have you ever held a license or certificate to practice any counseling-related profession in any state (including Florida), U.S. territory, or foreign country? YES NO
 If YES, list all licenses and/or certificates 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
		<input type="checkbox"/> State Mental Institution <input type="checkbox"/> State Institution for the Mentally Retarded <input type="checkbox"/> Department of Corrections <input type="checkbox"/> Health Manpower Shortage Area established by the U.S. Dept. of Health & Human Svcs.

4. 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. 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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APPLICANT NAME _____

5. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. Is there currently pending, in any jurisdiction, a complaint against your professional conduct or competency in any profession?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered "YES" to any question in Section 5, you must provide complete details	
6. APPLICANT HISTORY - Pursuant to Section 456.0635(2), Florida Statutes	
If you answer yes to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation	
1a. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? (If no, do not answer 1b.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
1b. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for such conviction?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2a. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If no, do not answer 2b.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
2b. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3a. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? (If no, do not answer 3b and 3c.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
3b. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3c. Did the termination occur at least 20 years prior to the date of this application?	<input type="checkbox"/> YES <input type="checkbox"/> NO

7. CERTIFICATION

I state that I am the person referred to in the forgoing licensure application and supporting documentation, that said application and any supporting documentation are true and accurate, and that the attached photograph is a true likeness of myself.

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 instrumentality's (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 Chapter 456.013(1)(a) F.S. Failure to do so may result in disciplinary action by the Board including denial of limited licensure.

I understand that, once my limited license is granted, I may only practice in the employ of public agencies or institutions or nonprofit agencies or institutions which meet the requirements of s. 501(c)(3) of the Internal Revenue Code, and which provide professional liability coverage for my acts or omissions as the limited licensee. I also understand that, as a limited licensee, I may provide services only to the indigent or critical need populations within the state.

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 state that I have read and understand Chapter 491, F.S., and Rule Chapter 64B4, Florida Administrative Code, and acknowledge that I must abide by them. 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 Chapter 456.013(1)(a), F.S., an incomplete application shall expire 1 year after initial filing.

Applicant's Signature

Date

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