



# MARYLAND Department of Health

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D.,M.P.H., Secretary

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## BOARD OF PROFESSIONAL COUNSELORS AND THERAPISTS 4201 Patterson Avenue, Suite 316, Baltimore, Maryland 21215-2299

### LICENSED CLINICAL PROFESSIONAL COUNSELOR

(LCPC)

### APPLICATION INSTRUCTIONS

**\*\*IMPORTANT\*\* This application is for other Maryland clinical license holders. Do not use this form if you currently hold a LGPC under this Board. If you hold an LGPC, please use the "LG to LC Application" form.**

BEFORE submitting your application, please:

- Retain a copy of all documents for your records. Documents **will not** be returned once received by the Board.
- All forms must be legible, complete, signed, and dated (where applicable) or processing may be delayed.
- Include a check or money order in the amount of \$200 payable to: *Maryland Board of Professional Counselors and Therapists*. A separate license fee of \$150 will be due upon notification of eligibility from the Board. Fees are **non-refundable and non-transferable**.
- Applications **may not** be submitted via fax or email. Please mail to:

*Board of Professional Counselors and Therapists*  
Attn: LCPC Licensing Coordinator  
4201 Patterson Avenue, Suite 316  
Baltimore, MD 21215

ELIGIBILITY/REQUIREMENTS: *The following is a summary only. For complete requirements and definitions, see Md. Code Ann. Health Occ., §17-101, et. seq. which may be found on the Board's website, [www.dh.maryland.gov/bopc](http://www.dh.maryland.gov/bopc).*

- Education:** Applicant shall:
  - Hold a master's degree (minimum of 60 credits) or a doctoral degree (minimum of 90 credits) in a professional counseling or related field from an accredited educational institution approved by the Board.
  - Documentation of graduate coursework as set forth in COMAR 10.58.01.05A(2) and B, which includes 3 semester credits in each of the following areas:

- Human growth and personality development;
- Social and cultural foundations of counseling;
- Counseling theory;
- Counseling techniques;
- Group dynamics, processing, and counseling;
- Lifestyle and career development;
- Appraisal;
- Research and evaluation;
- Professional, legal, and ethical responsibilities;
- Marriage and family therapy;
- Supervised field experience;
- Alcohol and drug counseling;
- Diagnosis and psychopathology;
- Psychotherapy and treatment of mental and emotional disorders.

□ **Clinical Supervision Requirements:**

If you hold a *master's degree*, as set forth above, you must have not less than three (3) years and a minimum of 3000 hours of supervised clinical experience in professional counseling, of which two (2) years and 2,000 hours shall have been completed after the award of the master's degree obtained under the supervision of an approved supervisor. See COMAR 10.58.01.05B(2).

If you hold a *doctoral degree*, as set forth above, you must have not less than two (2) years and a minimum of 2000 hour of supervised clinical experience in professional counseling, one year of which shall have been completed after the award of the doctoral degree and obtained under the supervision of an approved supervisor. See COMAR 10.58.01.05B(3).

□ **Examinations.** Applicant must pass the following:

- 1) The National Counselors Exam (NCE); and
- 2) Maryland Law Assessment.

1) **NCE:** Upon review of your application, the Board will determine if you are eligible to take the NCE. Once you are deemed eligible, the Board will send you written authorization and instructions on how to register for the exam. The exam is computerized. Exam dates and locations can be found on the Board's website. If you have already passed the NCE, please include a copy of your scores with the application.

2) **Maryland Law Assessment**

The purpose of the assessment is to determine if a candidate is familiar with the state laws and ethical code related to safe and effective practice across several content areas. The MLA is a no-fail, no score assessment. Content areas include supervision and ethics questions based on excerpts from the Code of Maryland Regulations (COMAR) and Md. Code Ann., Health Occupations Art., Title 17.

The MLA consists of 36 questions. You will be presented with readings and questions until all items are answered correctly. Upon successful completion, you will receive a Certificate of Completion that you will submit to the Board with your application for licensure or certification.

Prior Board approval is not required to take the MLA. However, if you take the MLA before you submit an application for licensure/certification with the Board, please note the following:

- Should you later decide not to apply for licensure/certification with the Board, the MLA fee will not be refunded.

- You are responsible for submitting the MLA Certificate of Completion to the Board with your application for licensure/certification. Do not email, fax or mail the certificate of completion separately to the Maryland Board. MLA Certificates of Completion received without a completed application will not be retained.

- MLA Certificates of Completion are valid for one year from the date of the MLA. If you do not apply for licensure/certification within one year from the date of the MLA, you will be required to re-take the MLA at your additional expense.

**To take the MLA, use the following link: [www.academy.cce-global.org](http://www.academy.cce-global.org).**

If you experience any issues, please contact the assessment administrator, CCE, Monday thru Friday 8:30am – 5pm at 336.482.2856. You may also email for technical support at [support@cce-global.org](mailto:support@cce-global.org). Please do not contact the Board regarding technical support issues.

If you have already taken and passed the previous Maryland Law Exam, this notice does not apply to you and no further action is necessary.

- **Criminal History Records Check** (instructions and form attached). All applicants must complete a criminal history records check (CHRC). Applicant must include a **copy of the receipt** from the CHRC with this application. This allows the Board to access the report online from the Criminal Justice Information System.

***Please note:*** A license will not be issued unless and until the Board determines that the applicant has completed **ALL** requirements including required coursework, examinations, CHRC, and any other requirements set by the Board in accordance with Maryland law.



# MARYLAND Department of Health

Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

## BOARD OF PROFESSIONAL COUNSELORS AND THERAPISTS

4201 Patterson Avenue, Suite 316, Baltimore, Maryland 21215-2299

### LICENSED CLINICAL PROFESSIONAL COUNSELOR

#### (LCPC)

#### APPLICATION

**\*\* IMPORTANT \*\* This application is for other Maryland clinical license holders. Do not use this form if you currently hold a LGPC under this Board. If you hold an LGPC, please use the "LG to LC Application" form.**

*Please type or print all information.*

#### I. VETERANS AND SPOUSAL PREFERENCE

Are you an active service member or the spouse of any active service member?  Yes  No

Are you a veteran or the spouse of a veteran who was discharged from active duty under circumstances other than dishonorable within one year of filing this application?  Yes  No

#### II. DEMOGRAPHIC INFORMATION

Name: \_\_\_\_\_  
*Last First MI Maiden*

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: \_\_\_\_\_  
*Street City State Zip*

Prior address: \_\_\_\_\_  
*(If less than 3 years at current address) Street City State Zip*

Mailing Address: \_\_\_\_\_  
*(If different than above) Street City State Zip*

Business: \_\_\_\_\_  
*Name Street City State Zip*

Gender and Ethnicity: *This information is optional and may be used for statistical purposes by authorized personnel.*

Gender:        Male                Female

Ethnicity:    Are you of Hispanic or Latino origin?    Yes                No

*Check all that apply:*

American Indian or Alaska Native    Asian                White

Black or African American            Native Hawaiian or Pacific Islander

### III. INFORMATION REGARDING BACKGROUND

*Please answer Yes or No to each question.*

**YES    NO**

1. Has any state licensing or disciplinary board ever taken any disciplinary action against your license or certification, including, but not limited to, charges, admonishment, reprimand, revocation, or suspension?

*If yes, attach a separate page with a complete explanation of each occurrence (include date, time, location, disposition, etc.) and a copy of the disciplinary/court document from the issuing agency, if applicable.*

2. Have you pled guilty, nolo contendere, or been convicted of, received probation before judgment or had a conviction set aside for any criminal act in any state, territory, or jurisdiction (excluding minor traffic violations)?

*If yes, attach a separate page with a complete explanation of each occurrence (include date, time, location, disposition, etc.) and a certified copy of the disciplinary/court document from the issuing agency.*

*Please note that if you do not answer this question or fail to disclose and provide the requested information your application will be administratively closed without further review. You will be required to submit a new application and pay the required fee. In addition, you may be required to appear before the Board regarding your failure to provide the required information.*

3. Are you currently on parole, probation or under any other court ordered supervision in any state, territory, or jurisdiction related to a criminal conviction? If so, you must submit official documentation indicating the terms and conditions, start and end dates, compliance and/or completion of the parole, probation or court ordered supervision with your application.

*Please note that if you fail to disclose and provide the requested information your application will be administratively closed without further review. You will be required to submit a new application and pay the required fee.*

4. Are you currently licensed or certified by another **Maryland** board in mental health counseling or other health occupation? *If so, specify license/certificate (Ex: LCSW-C, Psychologist, Registered Nurse, etc.) \_\_\_\_\_.*

**IV. EDUCATION:** List colleges or universities attended to satisfy academic requirements for licensure or certification. Do not list degrees unrelated to counseling. Please list the most recent colleges/universities first and provide **official** transcripts. Attach additional sheets, if necessary.

A. \_\_\_\_\_  
*Name of School* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_  
 Dates attended: From (mo./yr.) \_\_\_\_\_ To (mo./yr.) \_\_\_\_\_  
 Degree awarded: \_\_\_\_\_ Date awarded: \_\_\_\_\_  
 Major field of study: \_\_\_\_\_

B. \_\_\_\_\_  
*Name of School* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_  
 Dates attended: From (mo./yr.) \_\_\_\_\_ To (mo./yr.) \_\_\_\_\_  
 Degree awarded: \_\_\_\_\_ Date awarded: \_\_\_\_\_  
 Major field of study: \_\_\_\_\_

C. \_\_\_\_\_  
*Name of School* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_  
 Dates attended: From (mo./yr.) \_\_\_\_\_ To (mo./yr.) \_\_\_\_\_  
 Degree awarded: \_\_\_\_\_ Date awarded: \_\_\_\_\_  
 Major field of study: \_\_\_\_\_

**V. QUALIFICATIONS:** Complete the chart below. If the title of your course differs from those listed, you must include a catalog course description or syllabus for each course. A course applied to one topic area **may not** be used to fulfill another topic area. Official transcript(s) must be attached to this application. You may attach separate sheet(s) for additional relevant coursework.

Topic Area	Course Title and Number (Must appear on transcript)	Credits Earned	College/Univ.	Date	Grade
Human Growth and Personality Development					
Social and Cultural Foundations of Counseling					
Counseling Theory					
Counseling Techniques					
Group Dynamics, Processing, Counseling					
Lifestyle and Career Development					
Appraisal and Diagnosis					

Research and Evaluation					
Prof., Legal, Ethical Resp.					
Marriage and Family Therapy					
Alcohol and Drug Counseling					
Supervised Field Exp.					
Diagnosis and Psychopathology					
Psychotherapy/ treatment of mental and emotional disorders					

**Total credits earned:** \_\_\_\_\_

**ADDITIONAL COURSES (ELECTIVES)**

Topic Area	Course Title and Number (Must appear on transcript)	Credits Earned	College/Univ.	Date	Grade

**VI. EXAMINATIONS**

A. Have you passed the NCE exam?  Yes  No If yes, please include a copy of test score.

B. Have you passed the Maryland Law Assessment?  Yes  No If yes, please include a copy of test score.

**VII. PROFESSIONAL REFERENCES (3):** List at least 3 professional references who can attest to your counseling skills, professional standards of practice and supervised clinical work. You must include

three (3) Professional Reference assessment forms in their original sealed envelopes with the application. Forms are attached.

A. Name of Reference: \_\_\_\_\_

Degree: \_\_\_\_\_ Certification/License: \_\_\_\_\_

Position: \_\_\_\_\_ Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Will this reference be verifying some or all of your supervised clinical experience?  Yes  No

B.

Name of Reference: \_\_\_\_\_

Degree: \_\_\_\_\_ Certification/License: \_\_\_\_\_

Position: \_\_\_\_\_ Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Will this reference be verifying some or all of your supervised clinical experience?  Yes  No

C. Name of Reference: \_\_\_\_\_

Degree: \_\_\_\_\_ Certification/License: \_\_\_\_\_

Position: \_\_\_\_\_ Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Will this reference be verifying some or all of your supervised clinical experience?  Yes  No

**VIII. SUPERVISED CLINICAL EXPERIENCE:** I have:

attained no less than 3 years and 3000 hours of supervised clinical experience, two years of which was earned after the award of my master's degree OR

attained no less than 2 years and 2000 hours of supervised clinical experience, one year of which was earned after the award of my doctoral degree; as set forth below:

A. Practicum/Internship (up to 1000 hours may be applied toward 3000 hours required)

1. Agency/school/organization where internship was obtained: \_\_\_\_\_



Name and credential of supervisor: \_\_\_\_\_  
Inclusive dates of experience: from (mo./yr.) \_\_\_\_\_ to (mo.yr.) \_\_\_\_\_  
Total number of months worked: \_\_\_\_\_ Total number of hours per week: \_\_\_\_\_  
Total number of hours worked during practicum/internship (No. of months x 4 x no. hours worked each week): \_\_\_\_\_

2. Agency/school/organization where internship was obtained: \_\_\_\_\_  
Name and credential of supervisor: \_\_\_\_\_  
Inclusive dates of experience: from (mo./yr.) \_\_\_\_\_ to (mo.yr.) \_\_\_\_\_  
Total number of months worked: \_\_\_\_\_ Total number of hours per week: \_\_\_\_\_  
Total number of hours worked (No. of months x 4 x no. hours worked each week): \_\_\_\_\_

B. Clinical counseling experience obtained *after* the award of master's or doctoral degree:

1. Agency/ /organization name and address: \_\_\_\_\_  
Name and credential of supervisor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Inclusive dates of experience: from (mo./yr.) \_\_\_\_\_ to (mo.yr.) \_\_\_\_\_  
Applicant's job title and duties: \_\_\_\_\_  
Total number of months worked: \_\_\_\_\_ Total number of hours per week: \_\_\_\_\_  
Total number of hours worked (No. of months x 4 x no. hours worked each week): \_\_\_\_\_

2. Agency/ /organization name and address: \_\_\_\_\_  
Name and credential of supervisor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Inclusive dates of experience: from (mo./yr.) \_\_\_\_\_ to (mo.yr.) \_\_\_\_\_  
Applicant's job title and duties: \_\_\_\_\_  
Total number of months worked: \_\_\_\_\_ Total number of hours per week: \_\_\_\_\_  
Total number of hours worked (No. of months x 4 x no. hours worked each week): \_\_\_\_\_

AND

- attached completed Supervised Clinical Documentation form(s) to this application.

**IX. AFFIDAVIT**

In making this application to the Maryland Board of Professional Counselors and Therapists (the "Board") for the issuance of a Licensed Clinical Professional Counselor credential:

- I agree to abide by the rules and regulations of the Board and to take all examinations necessary for the processing of my application;
- Upon issuance of certification, I agree to abide by the Code of Ethics as set forth in COMAR;
- I understand that the fee submitted with this application is **NON-REFUNDABLE**;
- I agree to hold the Board, its members, officers, agents, and examiners free from any damage or claim of damage or complaint by reason of any action taken in connection with this application, the attendant examination, the grades with respect to any examination, and/or the failure or refusal of the Board to issue me a license or certificate.

- I grant permission to the Board to seek any information or references it deems appropriate or necessary in verifying my credentials as it pertains to this application.
- I understand, by law, it is my responsibility to notify the Board, in writing, of any change of contact information including address, phone number, and/or email address.

I do hereby affirm that all of the statements made herein are true and correct to the best of my knowledge and belief. I voluntarily consent to a thorough review of the information in this application and other activities for the purpose of verifying my qualifications for certification or licensure.

\_\_\_\_\_  
Applicant's Signature                      Date

**NOTARY**

State of \_\_\_\_\_  
City/County of \_\_\_\_\_

I HEREBY 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  
APPLICANT PHOTO

(Recent 2"x2")



# MARYLAND Department of Health

Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

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## BOARD OF PROFESSIONAL COUNSELORS AND THERAPISTS

4201 Patterson Avenue, Suite 316, Baltimore, Maryland 21215-2299

### CLINICAL SUPERVISION VERIFICATION

***To Applicant:* You must submit this form for each counseling experience (including internships/practicum) that you intend to apply toward the hours required for licensure. Make additional copies as needed.**

I hereby attest that, to the best of my knowledge, information, and belief,

\_\_\_\_\_ obtained \_\_\_\_\_ total hours of clinical experience under  
*Applicant's Name*

my supervision from \_\_\_\_\_ to \_\_\_\_\_ at \_\_\_\_\_  
*(mo./yr.) (mo./yr.) Name of Agency/Org.*

\_\_\_\_\_  
*Address of Agency/Org.*

Of the total number of hours listed above, \_\_\_\_\_ hours consisted of post masters, face to face\* clinical supervision hours.

As the supervisor of this applicant, do you have any reservations about the applicant receiving a license for the independent practice of counseling?

Yes (please use additional sheets to explain)       No

\_\_\_\_\_  
Name (printed)

\_\_\_\_\_  
Lic. Type, Number and State of Issuance

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Business Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

\*"Face-to-face" means in the physical presence of the individuals involved in the supervisory relationship during wither individual or group supervision or using video conferencing which allows individuals to hear and see each other in actual points of time. It does not include telephone supervision; or internet communication that does not involve actual or real time video conferencing such as instant messaging services and social networking sites.

COMAR 10.58.12.02

**PROFESSIONAL REFERENCE ASSESSMENT**

Applicant's Name: \_\_\_\_\_

The above-named individual has applied to the Maryland State Board of Professional Counselors and Therapists to become a licensed professional counselor. Your assessment will help determine the applicant's eligibility for licensure. Please answer all questions to the best of your knowledge, information, and belief.

***PLEASE RETURN THE COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPE.***

Reference's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_

Degree: \_\_\_\_\_ Title: \_\_\_\_\_

Professional Certification/License: \_\_\_\_\_ State/Certifying Org.: \_\_\_\_\_

Relationship to Applicant:  Educator  Prof. Colleague  Supervisor (must sign Supervision Verification form)  Other: \_\_\_\_\_

Length of time you have known Applicant: From (mo./yr.) \_\_\_\_\_ To (mo./yr.) \_\_\_\_\_

Please rate the Applicant on the following skills/characteristics. Place a check $\checkmark$ in each category. (Applicants who are counselor educators should be evaluated on the basis of their ability to train students in counseling skill areas).	<i>Outstanding</i>	<i>Above Avg.</i>	<i>Average</i>	<i>Below Avg.</i>	<i>Poor</i>	<i>Cannot evaluate</i>
<i>Individual counseling skills</i>						
<i>Appropriate referral making skills</i>						
<i>Group counseling skills</i>						
<i>Personal integrity</i>						
<i>Consulting skills</i>						
<i>Insight to client's problems</i>						
<i>Ability to relate to co-workers</i>						
<i>Objectivity on the job</i>						
<i>Ethical conduct</i>						
<i>Concern for welfare of clients</i>						
<i>Sense of responsibility</i>						
<i>Recognition of own limits</i>						
<i>Supervisory ability</i>						
<i>Ability to keep material confidential</i>						

Additional Comments (optional): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I recommend this Applicant for licensure as a clinical professional counselor:  Yes  No

The information provided above is based on my best knowledge, information, and belief. I agree to answer additional questions regarding this evaluation if requested by the Board.

\_\_\_\_\_  
Reference's signature

\_\_\_\_\_  
Date

## PROFESSIONAL REFERENCE ASSESSMENT

Applicant's Name: \_\_\_\_\_

The above-named individual has applied to the Maryland State Board of Professional Counselors and Therapists to become a licensed professional counselor. Your assessment will help determine the applicant's eligibility for licensure. Please answer all questions to the best of your knowledge, information, and belief.

**PLEASE RETURN THE COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPE.**

Reference's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_

Degree: \_\_\_\_\_ Title: \_\_\_\_\_

Professional Certification/License: \_\_\_\_\_ State/Certifying Org.: \_\_\_\_\_

Relationship to Applicant:  Educator  Prof. Colleague  Supervisor (must sign Supervision Verification form)  Other: \_\_\_\_\_

Length of time you have known Applicant: From (mo./yr.) \_\_\_\_\_ To (mo./yr.) \_\_\_\_\_

Please rate the Applicant on the following skills/characteristics. Place a check $\checkmark$ in each category. (Applicants who are counselor educators should be evaluated on the basis of their ability to train students in counseling skill areas).	<i>Outstanding</i>	<i>Above Avg.</i>	<i>Average</i>	<i>Below Avg.</i>	<i>Poor</i>	<i>Cannot evaluate</i>
<i>Individual counseling skills</i>						
<i>Appropriate referral making skills</i>						
<i>Group counseling skills</i>						
<i>Personal integrity</i>						
<i>Consulting skills</i>						
<i>Insight to client's problems</i>						
<i>Ability to relate to co-workers</i>						
<i>Objectivity on the job</i>						
<i>Ethical conduct</i>						
<i>Concern for welfare of clients</i>						
<i>Sense of responsibility</i>						
<i>Recognition of own limits</i>						
<i>Supervisory ability</i>						
<i>Ability to keep material confidential</i>						

Additional Comments (optional): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I recommend this Applicant for licensure as a clinical professional counselor:  Yes  No

The information provided above is based on my best knowledge, information, and belief. I agree to answer additional questions regarding this evaluation if requested by the Board.

\_\_\_\_\_  
Reference's signature

\_\_\_\_\_  
Date

**PROFESSIONAL REFERENCE ASSESSMENT**

Applicant's Name: \_\_\_\_\_

The above-named individual has applied to the Maryland State Board of Professional Counselors and Therapists to become a licensed professional counselor. Your assessment will help determine the applicant's eligibility for licensure. Please answer all questions to the best of your knowledge, information, and belief.

***PLEASE RETURN THE COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPE.***

Reference's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_

Degree: \_\_\_\_\_ Title: \_\_\_\_\_

Professional Certification/License: \_\_\_\_\_ State/Certifying Org.: \_\_\_\_\_

Relationship to Applicant:  Educator  Prof. Colleague  Supervisor (must sign Supervision Verification form)  Other: \_\_\_\_\_

Length of time you have known Applicant: From (mo./yr.) \_\_\_\_\_ To (mo./yr.) \_\_\_\_\_

Please rate the Applicant on the following skills/characteristics. Place a check $\checkmark$ in each category. (Applicants who are counselor educators should be evaluated on the basis of their ability to train students in counseling skill areas).	<i>Outstanding</i>	<i>Above Avg.</i>	<i>Average</i>	<i>Below Avg.</i>	<i>Poor</i>	<i>Cannot evaluate</i>
<i>Individual counseling skills</i>						
<i>Appropriate referral making skills</i>						
<i>Group counseling skills</i>						
<i>Personal integrity</i>						
<i>Consulting skills</i>						
<i>Insight to client's problems</i>						
<i>Ability to relate to co-workers</i>						
<i>Objectivity on the job</i>						
<i>Ethical conduct</i>						
<i>Concern for welfare of clients</i>						
<i>Sense of responsibility</i>						
<i>Recognition of own limits</i>						
<i>Supervisory ability</i>						
<i>Ability to keep material confidential</i>						

Additional Comments (optional): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



I recommend this Applicant for licensure as a clinical professional counselor:  Yes  No

The information provided above is based on my best knowledge, information, and belief. I agree to answer additional questions regarding this evaluation if requested by the Board.

\_\_\_\_\_  
Reference's signature

\_\_\_\_\_  
Date



# MARYLAND Department of Health

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## BOARD OF PROFESSIONAL COUNSELORS AND THERAPISTS

4201 Patterson Avenue, Suite 316, Baltimore, Maryland 21215-2299

### NOTICE OF CRIMINAL HISTORY RECORDS CHECK

Effective January 1, 2014, the Maryland Board of Professional Counselors and Therapists (the "Board") requires that all applicants for licensure, certification, and trainee status complete a criminal history records check in accordance with §§17-501 and 17-501.1 of the Health Occupations Article, Annotated Code of Maryland.

A Criminal History Records Check includes a national and state criminal history background search. The criminal history records check requires you to be fingerprinted. In order to be fingerprinted, you will need to complete and present the LiveScan Pre-Registration Form. (Attached).

You must present this form to the fingerprinting site because it provides the Criminal Justice Information System (CJIS) authorization number **#1300005490** and the FBI ORI number **#MD920512Z** assigned specifically to the Board.

This allows the information to be forwarded directly to the Board.

For additional information contact CJIS at 410-764-4501. For current listings of fingerprinting providers please go to <http://www.dpscs.maryland.gov/publicservs/fingerprint.shtml>.

### FOR FAST AND ACCURATE SERVICE

1. When requesting a criminal history records check for licensing purposes you must have an agency name and authorization number (Listed above).
2. Your background check is being sent to the Board.
3. You must bring a valid form of government identification. (Examples: driver's license, Certificate of Naturalization, passport, Alien Registration Card, or Military Identification).
4. Complete the LiveScan Pre-registration Application and bring it to any fingerprinting center/provider.
5. Bring payment as indicated above. The Board will receive the results from the criminal history records check directly from CJIS within 5-7 business days. The Board will contact you if it has any questions regarding the report. Please do not contact the Board to check if the report has been received.
6. Please do not send the LiveScan Pre-registration Application to the Board. You must present it at the fingerprint center/provider location.



**STATE OF MARYLAND**  
**DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES**  
**CRIMINAL JUSTICE INFORMATION SYSTEMS - CENTRAL REPOSITORY**

**LIVESCAN PRE-REGISTRATION APPLICATION**

**APPLICANT INFORMATION** (PLEASE TYPE OR PRINT CLEARLY)

Name:			
Date of birth:	SSN:	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female (Please check)
Height: ft. inches	Weight: lbs.	Eye Color:	Hair Color:
Race:	<input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Other (Please check)		
Place of Birth:	Citizenship:		
Current address:			
City:	State:	ZIP Code: -	
Daytime Phone:	Evening Phone:	Driver's License #:	

**AGENCY INFORMATION**

Agency Authorization #: 1300005490	
ORI # (if required): MD920512Z	Reason fingerprinted? License/Cert.
Position Applied for: N/A	
Request Type: (Choose one ONLY)	
<input type="checkbox"/> Adult Dependent Care	<input checked="" type="checkbox"/> Government Licensing or Certification
<input type="checkbox"/> Attorney/Client	<input type="checkbox"/> Immigration/VISA
<input type="checkbox"/> Child care	<input type="checkbox"/> Individual Challenge
<input type="checkbox"/> Criminal Justice	<input type="checkbox"/> Individual Review
<input type="checkbox"/> Gold Seal/ Adoption	<input type="checkbox"/> MSP Licensing
<input type="checkbox"/> Gold Seal/Letter/VISA	<input type="checkbox"/> Private Party Petition
<input type="checkbox"/> Government Employment	<input type="checkbox"/> Public Housing

**Mail Response to:**

(Mailing option only available for Visa Gold Seal and/or Individual Review)

Name:	_____
Address:	_____
City, State, Zip code:	_____

### CHECKLIST FOR LCPC APPLICATION

- Official transcript(s) in the sealed envelope sent to you from educational institution.
- NCE and Maryland Law Assessment scores (if applicable).
- Three (3) completed Professional Reference Assessment forms in sealed envelopes to you from each professional reference.
- Supervised clinical experience verification (one form for each clinical experience including internship/practicum and post-degree clinical experience).
- Application is signed and notarized.
- Recent photo (2"x2").
- Copy of receipt from criminal history records check.
- Check or money order in the amount of \$200 payable to the Board of Professional Counselors and Therapists.
- \*\* Remember to make a copy of completed application and attachments for your records.