MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

LICENSED CLINICAL PROFESSIONAL ART THERAPIST (LCPAT)

APPLICATION INSTRUCTIONS

** IMPORTANT **

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: *Board of Professional Counselors and Therapists*. 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: Janice Isaac, Licensing Coordinator
4201 Patterson Avenue, Suite 316
Baltimore, MD 21215

ELIGIBLITY/REQUIREMENTS: *The following is a summary only. For complete requirements and definitions, see Md. Code Ann. Health Occ. II, §17-101, et. seq. which may be found on the Board's website,* 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 an art therapy program accredited by the American Art Therapy Association and approved by the Board.

Documentation of graduate coursework must include training in:

Personality development;

Diagnosis and treatment of mental and emotional disorders;

Psychopathology;

Psychotherapy

Marriage and family therapy;

Addictions; and

Lifestyle and career development.

□ **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 experience in art therapy, two (2) years of which shall have been completed after the award of the master's degree.

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 experience in art therapy, one year of which shall have been completed after the award of the doctoral degree.

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

1) The Art Therapy Credentials Board Exam (ATCBE); ***and***

2) The Maryland law exam.

1) **ATCBE**: Upon review of your application, the Board will determine if you are eligible to take the ATCBE. Once you are deemed eligible, the Board will send you written authorization and instructions on how to register for the exam. If you have already passed the ATCBE, please include a copy of your scores with the application.

2) **Maryland law exam**: To register, please go to: https://www.research.net/r/Md_Jur_Reg .

You may also use the QR code below to register with your mobile device. Within one week of completing your registration, you should receive an 'authorization to test' email from Pearson VUE, indicating you may proceed with scheduling and payment (check your spam and junk folders regularly). You may be required to create a Pearson VUE account using the Client Candidate ID specific to this examination. An exam fee of $100, payable by credit card, is required to schedule your exam. If you have not received the 'authorization to test' email or there is an error, immediately contact our vendor, The Center for Credentialing and Education (336-482-2856) for assistance.

This test is computerized and is administered by Pearson VUE at their testing sites. The exam is composed of 36 multiple choice items, for which 27 items (75%) must be answered correctly to obtain a passing grade. You may access the Maryland law test study guide by visiting http://pearsonvue.com/cce/Law_Test_Study_Guide.pdf.

If you have been approved for special accommodations, you must contact the Center for Credentialing and Education directly for instructions on how to complete your registration process. You are responsible for adhering to Pearson VUE's policies and instructions including those related to no-shows and rescheduling the exam.

You are authorized to take the exam twice within a specified, 60-day window. To retake the exam within your 60-day window, log into your previously created Pearson VUE account, and repeat the initial scheduling and payment process; do not re-register with the links including in this communication. You must pay the examination fee each time the exam is taken. If you require additional opportunities to take the exam, you must obtain approval from the Board.

□ **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.

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LICENSED CLINICAL PROFESSIONAL ART THERAPIST

(LCPAT)

APPLICATION

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: _____ Place 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.

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.***

Topic Area	Course Title and Number (Must appear on transcript)	Credits Earned	College/Univ.	Date	Grade
Personality Development					
Diagnosis and Treatment of Mental and Emotional Disorders					
Psychopathology					
Psychotherapy					
Marriage and Family Therapy					
Addictions					
Lifestyle and Career Development					

VI. EXAMINATIONS

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

B. Have you passed the Maryland law exam? □ Yes □ No Date of exam: _____

VII. SUPERVISED CLINICAL EXPERIENCE (copy and use additional sheets as necessary)

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 (as set forth below) 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) ; **AND**

□ attached completed Supervisor Verification form(s) to this application.

A. Internship/Practicum:

1. Agency/school/org. _____
   Agency/school/org. address: _____
   Name and credential of supervisor: _____
   Inclusive dates of experience: From (mo./yr.) _____ To (mo./yr.) _____
   Total # months worked: _____ Total # hours worked per week: _____
   Total hours worked during internship: total months worked x 4 x total hours per week = _____

2. Agency/school/org. _____
   Agency/school/org. address: _____
   Name and credential of supervisor: _____
   Inclusive dates of experience: From (mo./yr.) _____ To (mo./yr.) _____
   Total # months worked: _____ Total # hours worked per week: _____
   Total hours worked during internship: total months worked x 4 x total hours per week = _____

3. Agency/school/org. _____
   Agency/school/org. address: _____
   Name and credential of supervisor: _____
   Inclusive dates of experience: From (mo./yr.) _____ To (mo./yr.) _____
   Total # months worked: _____ Total # hours worked per week: _____
   Total hours worked during internship: total months worked x 4 x total hours per week = _____

B. Supervised Clinical Work Experience

1. Agency/school/org. _____
   Agency/school/org. address: _____
   Name and credential of supervisor: _____
   Inclusive dates of experience: From (mo./yr.) _____ To (mo./yr.) _____
   Total hours worked _____

2. Agency/school/org. _____
   Agency/school/org. address: _____
   Name and credential of supervisor: _____
   Inclusive dates of experience: From (mo./yr.) _____ To (mo./yr.) _____
   Total hours worked _____

3. Agency/school/org. _____
   Agency/school/org. address: _____
   Name and credential of supervisor: _____

Inclusive dates of experience: From (mo./yr.) _____ To (mo./yr.) _____
Total hours worked _____

VIII. PROFESSIONAL REFERENCES (3): References may include employers, supervisors, and/or colleagues with a mental health license. At least one reference should be a current ATR, ATR-BC, or ATCS who can verify the applicant's competence for licensure.

A. Name of Reference: _____

Degree: _____ Certification/License: _____

Position: _____ Business Name: _____

Business Address: _____

Business Phone: _____

B. Name of Reference: _____

Degree: _____ Certification/License: _____

Position: _____ Business Name: _____

Business Address: _____

Business Phone: _____

C. Name of Reference: _____

Degree: _____ Certification/License: _____

Position: _____ Business Name: _____

Business Address: _____

Business Phone: _____

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 Art Therapist 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 licensure.

_____ _____

Applicant's Signature Date

ATTACH APPLICANT PHOTO

(Recent 2"x2")

NOTARY REQUIRED

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 _____

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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: ☐ Male ☐ Female *(Please check)*	
Height: ft. inches	Weight: lbs.	Eye Color:	Hair Color:
Race: ☐ Black ☐ White ☐ Asian/Pacific Islander ☐ Native American ☐ 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): MD 920512Z	Reason fingerprinted? LICENSURE / REGISTR.
Position Applied for: MDH - MD STATE BOARD OF PROFESSIONAL COUNSELORS	
Request Type: *(Choose one ONLY)* ☐ Adult Dependent Care ☐ Attorney/Client ☐ Child care ☐ Criminal Justice ☐ Gold Seal/ Adoption ☐ Gold Seal/Letter/VISA ☐ Government Employment	☒ Government Licensing or Certification ☐ Immigration/VISA ☐ Individual Challenge ☐ Individual Review ☐ MSP Licensing ☐ Private Party Petition ☐ Public Housing

Mail Response to:
(Mailing option only available for Visa Gold Seal and/or Individual Review)

Name: _____

Address: _____

City, State, Zip code: _____

SUPERVISION VERIFICATION
(copy additional pages as necessary)

The individual listed below has applied to the Maryland Board of Professional Counselors and Therapists to become a licensed clinical professional art therapist.

Your verification of the applicant's supervised art therapy experience will enable the Board to evaluate whether the applicant has met the requirements for licensure.

Please attest to the following statement and return this form to the applicant in a sealed envelope with your signature across the flap.

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

_____ has obtained:
Applicant's Name

□ Three (3) years with a minimum of 3,000 hours of supervised experience in art therapy, two (2) years of which were completed after the award of the applicant's master's degree.

□ Two (2) years with a minimum of 2,000 hours of supervised experience in art therapy, one year of which was completed after the award of the applicant's doctoral degree.

_____ _____
Name (printed) Credential

_____ _____
Signature Date

Relationship to Applicant (supervisor, employer, etc.): _____

Address: _____

Phone: _____ Email: _____