MARYLAND
Department of Health

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

TRANSFER FROM LGPC to LCPC

APPLICATION INSTRUCTIONS

** IMPORTANT **

This form is to be used ONLY if you are a Maryland Licensed Graduate Professional Counselor (LGPC) with an active license, in good standing, and are seeking licensure as a Licensed Clinical Professional Counselor (LCPC).

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. If information and documentation was provided to the Board with your LGPC application, you do not need to provide it again. However, Maryland law requires that you obtain another criminal history record check (CHRC) even though you obtained one when you applied for LGPC. Forms for the CHRC are included with this application.

□ Include a check or money order in the amount of $200 payable to: *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: 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., §17-101, et. seq. which may be found on the Board's website,* www.health.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 a Board 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 a Board approved supervisor. See COMAR 10.58.01.05B(3).

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

1) The National Counselors Exam (NCE); ***and***

2) The Maryland law exam.

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

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.

TRANSFER FROM LGPC TO LCPC

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: _____ LGPC Lic.# _____

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 contender, or been convicted of, received probation before judgment or had a conviction set aside for any criminal act (excluding 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, if applicable. The failure to include this information will result in processing delays.

□ □ 3. 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 graduate colleges or universities attended to satisfy academic requirements for licensure or certification. Do not list degrees unrelated to counseling. 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: _____

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 exam? □ Yes □ No Date of exam: _____

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 at least 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 at least 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 (Clinical counseling hours that were obtained as part of masters/doctoral program. Up to 1000 hours may be applied toward the total 3000 hours required for licensure)

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: _____ ; _____ hours direct clinical counseling services and _____ hours of indirect clinical counseling services.

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: _____ ; _____ hours direct clinical counseling services and _____ hours of indirect clinical counseling services.

□ As further set forth in the attached Supervised Clinical Experience (Internship) Verification(s).

Summary of Internship/Practicum Hours:

Total number of **direct** clinical counseling services accrued during Internship/Practicum to be applied toward licensure: _____ hours.

Total number of **indirect** clinical counseling services accrued during Internship/Practicum to be applied toward licensure: _____ hours.

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): _____ ;
_____ hours direct clinical counseling services and _____ hours of indirect clinical counseling services.

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): _____;
_____ hours direct clinical counseling services and _____ hours of indirect clinical counseling services.

□ As further set forth in the attached Supervised Clinical Experience (Post-Graduate) Verification(s).

□ Summary of Post-Graduate Hours Accrued:

Total number of post-graduate **direct** clinical counseling services to be applied toward licensure: _____ hours.

Total number of post-graduate **indirect** clinical counseling services to be applied toward licensure: _____ hours.

Total number of post-graduate supervision hours by a Board-approved supervisor:
Individual supervision: _____ hours.
Group supervision: _____ hours.

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 my license, 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
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: _____.

CLINICAL SUPERVISION EXPERIENCE VERIFICATION

(Internship/Practicum Supervised Clinical Counseling Experience)

***To Applicant*:** You must submit this form for each clinical counseling experience that you intend to apply toward the hours required for licensure. Please make additional copies as needed.

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

_____ obtained clinical experience under my *Applicant's Name*

supervision, as part of his/her internship/practicum, from _____ to _____
mo./yr. *mo./yr.*

at _____.
Name and Address Agency/Org.

as set forth below:

1. Direct Clinical Counseling Services*: _____ hours.
2. Indirect Clinical Counseling Services**: _____ hours.

As the Board Approved 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: _____

*” Direct ***Clinical Counseling Services”*** means the provision of face to face clinical professional counseling services to clients and their significant others that includes, but is not limited to, the following:

a. Individual counseling;
b. Group counseling;
c. Family counseling;
d. Couples counseling;
e. Evaluation;
f. Intake and assessment;
g. Diagnosis;
h. Treatment planning with client; and
i. Crisis management/intervention.

** ***“Indirect Clinical Counseling Services”*** means all case management and professional development activities related to the provision of clinical professional counseling services to a client that include, but are not limited to, the following:

a. Referral;
b. Intake or assessment by telephone or other means when client is not face to face;
c. Receiving individual or group supervision at site;
d. Consultation with other professionals;
e. Treatment planning with other professionals
f. Case staffing;
g. Staff meetings;
h. Related trainings and seminars;
i. Record keeping;
j. Report writing;
k. Case notes;
l. Telephone triage; and
m. Other clinical counseling administrative duties as required by the setting in which the clinical hours are accrued.

CLINICAL SUPERVISION EXPERIENCE VERIFICATION

(Post-Graduate Supervised Clinical Counseling Experience)

***To Applicant*:** You must submit this form for each clinical counseling experience that you intend to apply toward the hours required for licensure. Please make additional copies as needed.

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

_____ obtained post-graduate clinical counseling experience
Applicant's Name

under my supervision, as a Board-approved Supervisor, from _____ to _____
(mo./yr.) *(mo./yr.)*

at _____,
Name and Address Agency/Org.

as set forth below:

3. Direct Clinical Counseling Services*: _____ hours.
4. Indirect Clinical Counseling Services**: _____ hours.
5. Face to face*** Supervision between Board Approved Supervisor and Supervisee:
   a. Individual face to face supervision: _____ hours.
   b. Group face to face 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: _____

*” Direct ***Clinical Counseling Services”*** means the provision of face to face clinical professional counseling services to clients and their significant others that includes, but is not limited to, the following:

a. Individual counseling;
b. Group counseling;
c. Family counseling;
d. Couples counseling;
e. Evaluation;
f. Intake and assessment;
g. Diagnosis;
h. Treatment planning with client; and
i. Crisis management/intervention.

** ***“Indirect Clinical Counseling Services”*** means all case management and professional development activities related to the provision of clinical professional counseling services to a client that include, but are not limited to, the following:

a. Referral;
b. Intake or assessment by telephone or other means when client is not face to face;
c. Receiving individual or group supervision at site;
d. Consultation with other professionals;
e. Treatment planning with other professionals
f. Case staffing;
g. Staff meetings;
h. Related trainings and seminars;
i. Record keeping;
j. Report writing;
k. Case notes;
l. Telephone triage; and
m. Other clinical counseling administrative duties as required by the setting in which the clinical hours were accrued.

*** ***“Face-to-face”*** means in the physical presence of the individuals involved in the supervisory relationship during either 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 √ in each category. *(Applicants who are counselor educators should be evaluated on the basis of their ability to train students in counseling skill areas).*	***Outstanding***	***Above Avg.***	***Average***	***Below Avg.***	***Poor***	***Cannot evaluate***
Individual counseling skills						
Appropriate referral making skills						
Group counseling skills						
Personal integrity						
Consulting skills						
Insight to client's problems						
Ability to relate to co-workers						
Objectivity on the job						
Ethical conduct						
Concern for welfare of clients						
Sense of responsibility						
Recognition of own limits						
Supervisory ability						
Ability to keep material confidential						

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

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

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

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 Live Scan 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 Live Scan 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 Live Scan 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): MD920512Z — Reason fingerprinted? License/Cert.

Position Applied for: N/A

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: _____