**MARYLAND BOARD OF PROFESSIONAL COUNSELORS AND THERAPISTS**

## Licensed Clinical Professional Art Therapist

# LICENSURE
# APPLICATION INSTRUCTIONS

**The Application must be on a form currently in use by the Board. All supporting documentation must be originals. The application and all supporting documentation must be submitted as a complete packet.*

INSTRUCTIONS TO APPLICANTS:

(1) Carefully read all requirements and instructions on all pages before completing the application form.
(2) Application packets must be complete prior to submission.
(3) Application Fee of $200.00 must be included with the application packet. Check or Money Order only made payable to the Board of Professional Counselors and Therapists.
Please note this fee is non-refundable and nontransferable. *If you are approved for licensure there is a separate license fee of $150.00.*
(4) Type or print all information.
(5) Include your name as you want it to appear on your license. Licenses will not include titles or educational degrees.
(6) Please note that you can attain licensure by meeting either the qualifications for:

** Licensure by Waiver; or
Licensure.

*If you do not meet the qualifications for licensure by waiver you must complete this application for licensure.*

** Licensure Instructions:

(7) You must meet the educational, supervision, and examination requirements for licensure:

**A). Master's Degree from an art therapy program accredited by the American Art Therapy Association and 60 graduate credits** and not less than three (3) years with a minimum of 3,000 hours of supervised experience in art therapy, two (2) years of which shall have been completed after the award of the Master's degree.

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**B). Doctoral Degree from an art therapy program accredited by the American Art Therapy Association** and not less than two (2) years of supervised experience in art therapy, one (1) year of which shall have been completed after the award of the Doctoral degree.

**C).** Pass the Art Therapy Credentials Exam administered by the Art Therapy Credentials Board, Inc.

(9) **Education:** Submit a completed Coursework Outline Form (attached below). Fill out the coursework outline form and submit an official, sealed transcript to the Board documenting completion of at least a Master's degree in an art therapy program accredited by the American Art Therapy Association (AATA) and the completion of **60 graduate credits including the following core courses**:

- Personality Development;
- Diagnosis and Treatment of Mental and Emotional Disorders;
- Psychopathology;
- Psychotherapy;
- Marriage and Family Therapy;
- Addictions; and
- Lifestyle and Career Development

(10) **Examination:** Submit documentation of having taken and passed the ATCBE (Art Therapy Credentials Board Exam) developed by the ATCB (Art Therapy Credentials Board, Inc.). If you have not taken the exam you will be permitted to take it upon approval of the Board.

(11) **Supervised Clinical Experience**: Submit verification of the required supervised experience in art therapy on the "Supervision Verification Form" (attached below). See instructions on the form. Verification of supervision can be from an employer, supervisors, or colleagues. In the case of a colleague, they must have a mental health license.

(12) **ALL APPLICANTS must** take and pass the Maryland Law Test after receiving Board approval. The Maryland Law Test is administered at the Board's office twice monthly.

***Please make sure to sign the affidavit and have it notarized.***

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**Maryland Board of Professional Counselors and Therapists**
**4201 Patterson Avenue, Baltimore, MD 21215**
**410-764-4732 - www.dhmh.maryland.gov/bopc**

# Application For Licensed Clinical Professional Art Therapist

Application Date: _____
(Date)

*Please print or type. Do not use pencil.*
***(Your name must be your legal name and will appear on all documents as noted below.)***

Name:_____
(Last) (First) (Middle)

Home Address: _____
(Number and Street)

_____

_____
(City) (State) (Zip Code)

Business Address:_____

_____
(City) (State) (Zip Code)

Telephone Number: _____ _____
(Home) (Work or Mobile)

E-mail Address:_____

Social Security Number:_____ Date of Birth: _____

Name of School: _____ Degree: _____ Graduation: _____

*Indicate your preference for mail correspondence. (check one) Home:_____ Business: _____*

**Voluntary Equal Opportunity Information:**

To further its commitment to equal opportunity employment, the State of Maryland requests applicants to **VOLUNTARILY** provide the following information. This information will be used for statistical purposes only by authorized personnel.

Race: Are you Hispanic or Latino? _____Yes _____No

If you are not Hispanic or Latino, what is your race? Please select one.

Unknown/Decline: ☐

Race: ☐Caucasian ☐African American ☐Native American ☐Asian ☐Hispanic ☐Other

Asian: *Origins in any of the original peoples of the Far East, Southeast Asia, or the India subcontinent, including for example Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.*

Black or African American: *Origins in any of the black racial groups of Africa.*

American Indian or Alaska Native: *Origins in any of the original peoples of North or South American, including Central America, and who maintains tribal affiliations or community attachment.*

Pacific Islander or native Hawaiian: *Origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.*

White: *Origins in any of the original peoples of Europe, the Middle East, or North Africa*

Gender: ☐Female ☐Male

**********

## SECTION 1. LICENSURE REQUIREMENTS:

**EDUCATION:** ***Master's Degree (60 graduate credits) or Doctorate (90 graduate credits) in an Art Therapy Program accredited by the American Art Therapy Association (AATA).***

*Directions: Please list your relevant educational history below, beginning with your most recent college and graduate education.* **Official Transcripts are required.**

| College or University (include Undergraduate and Graduate) | Date(s) of Attendance | Degree Awarded/Major |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

***You must complete the Course Outline Form on page 12 of this application. Please attach official transcripts.***

**SUPERVISED EXPERIENCE:** *(Please check one)*.

☐ **Master's Degree with 60 graduate credits** and not less than three (3) years with a minimum of 3,000 hours of supervised experience in art therapy, two (2) years of which shall have been completed after the award of the Master's degree.

☐ **Doctoral Degree with 90 graduate credits** and not less than two (2) years of supervised experience in art therapy, one (1) year of which shall have been completed after the award of the Doctoral degree.

*Please make sure to complete the supervision verification form.*

**EXAMINATION REQUIRED:**

Have you successfully passed the following national exam?
Art Therapy Credentials Board Examination (ATCBE) developed by the ATCB (Art therapy Credentials Board, Inc.) ☐ Yes ☐ No

If the answer is yes, please include documentation of passing score with application.

Please provide exam date: _____

If the answer is **no**, you may take the examination upon receiving **Board approval**.

**SECTION 2. ADDITIONAL INFORMATION:**

*For each question answered with a "yes" please attach a detailed explanation. For question (f) also provide a certified copy of the police/court record and final disposition.*

a. Are you credentialed as a licensed professional art therapist in any other state? ☐ Yes ☐ No
If yes, please list the state(s) and the title of the credential:
_____

_____

b. Have you ever been denied an initial application, reinstatement or renewal of a license and /or certificate by any state licensing or disciplinary board? ☐ Yes ☐ No
If "yes" explain reason(s)._____

c. Has any state licensing or disciplinary board ever taken any action against your license and/or certification, including but not limited to limitations of practice, required education, admonishment, reprimand, revocation, suspension? ☐ Yes ☐ No
If yes, explain circumstance(s)._____

d. Have you ever been disciplined by ATCB, AATA or by any other professional association?
☐ Yes ☐ No
If yes, explain circumstance(s)._____

e. Has an investigation or charges ever been brought against you by any licensing or disciplinary board? ☐ Yes ☐ No
If yes, explain circumstance(s)._____

f. Have you pled guilty, nolo contendre, or been convicted of or received probation before judgment or any criminal act (excluding traffic violations)? ☐ Yes ☐ No
If "yes" provide the following information: Date of Conviction:_____

Where convicted _____ Charge _____

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

**SECTION 3. PROFESSIONAL REFERENCES:**

***List below at least three (3) professional references who can attest to your art therapy experience and professional standards of practice. References may include employers, supervisors, and colleagues with a mental health license. At least one reference should be a current ATR, ATR-BC and/or ATCS who can support the applicant's competency for licensure as a Licensed Clinical Professional Art Therapist.***

1) Reference Name:_____

Degree Held: _____ License Held:_____

Position:_____

Business Name and Address:_____

2) Reference Name:_____

Degree Held:_____ License Held:_____

Position:_____

Business Name and Address:_____

3) Reference Name:_____

Degree Held: _____ License Held:_____

Position:_____

Business Name and Address:_____

## AFFIDAVIT

I hereby certify that the information provided in this application is true, accurate and complete to the best of my knowledge and belief.

Signature of Applicant:_____ Date:_____

**The following statement must be executed by a Notary Public.**

State of_____, County of _____

Name_____, being duly sworn, says that he/she is the person who is referred to in the foregoing application for licensure as a Licensed Clinical Professional Art Therapist in Maryland, that the statements herein contained are true in every respect, that he/she has complied with all requirements of the law; and that he/she has read and understands this affidavit.

Subscribed to and sworn to before me this _____day of _____, 20_____.

My commission expires on _____. Signature of Notary:_____

SEAL

Photo Here
(2x2)

## SUPERVISION EXPERIENCE HISTORY

***(Please copy blank page as needed)***

*List all supervised clinical work experience. The supervised clinical work experience may include practicum/internship or professional clinical experience. No more than 1,000 practicum/internship hours may be used toward the overall 3,000 hours required for licensure. 2,000 hours of the overall 3,000 hours of required supervised clinical experience for licensure must be attained* ***after*** *the award of the masters degree.* ***Please indicate if supervised clinical work experience was before or after the award of the degree.***

### Practicum/Internship Supervised Experience(s):

1) Name of agency, school, organization where practicum/internship was obtained.

_____

Name and credential(s) of supervisor: _____

Address of agency, school, or organization:_____

Inclusive dates of experience: From (mo./yr.) To (mo./yr.)

Total number of months worked: Total number of hours worked per week:

***Total number of hours worked during internship/practicum. (Number of months x 4 x number of hours worked each week.)*** _____

2) Name of agency, school, organization where practicum/internship was obtained.

_____

Name and credential(s) of supervisor: _____

Address of agency, school, or organization:_____

Inclusive dates of experience: From (mo./yr.) To (mo. /yr.)

Total number of months worked: Total number of hours worked per week:

***Total number of hours worked during internship/practicum. (Number of months x 4 x number of hours worked each week.)*** _____

3) Name of agency, school, organization where practicum/internship was obtained.

_____

Name and credential(s) of supervisor: _____

Address of agency, school, or organization:_____

Inclusive dates of experience: From (mo./yr.) To (mo. /yr.)

## SUPERVISION EXPERIENCE HISTORY con't:

*List all supervised clinical work experience. The supervised clinical work experience may include practicum/internship or professional work experience. No more than 1,000 practicum/internship hours may be used toward the overall 3,000 hours required for licensure. 2,000 hours of the overall 3,000 hours of required supervised clinical experience for licensure must be attained* ***after*** *the award of the masters degree.* ***Please indicate if supervised clinical work experience was before or after the award of the degree.***

**Supervised Clinical Work Experience(s):**

3) Total number of months worked: Total number of hours worked per week:

***Total number of hours worked during internship/practicum. (Number of months x 4 x number of hours worked each week.)*** _____

4) Name of agency, school or organization where supervised experience was obtained.

_____

Name and credential(s) of supervisor: _____

Address of agency or organization:_____

Inclusive dates of experience: From (mo./yr.) To (mo. /yr.)

Total number of months worked: Total number of hours worked per week:

***Total number of hours worked during internship/practicum. (Number of months x 4 x number of hours worked each week.)*** _____

5) Name of agency, school, or organization where supervised experience was obtained.

_____

Name and credential(s) of supervisor: _____

Address of agency, school, or organization:_____

Inclusive dates of experience: From (mo./yr.) To (mo. /yr.)

Total number of months worked: Total number of hours worked per week:

***Total number of hours worked during supervised experience. (Number of months x 4 x number of hours worked each week.)*** _____

**MARYLAND BOARD OF PROFESSIONAL COUNSELORS AND THERAPISTS**
**4201 Patterson Avenue – Suite 316, Baltimore, MD 21215**
**(410) 764-4732; www.dhmh.maryland.gov/bopc**

## SUPERVISION VERIFICATION FORM

***Please copy blank page as needed.***

The person named below has applied to the Maryland Board of Professional Counselors and Therapists to become a **Licensed Clinical Professional Art Therapist, LCPAT**. Your documentation of the applicant's supervised art therapy experience will enable the Board to evaluate whether this applicant meets the requirements for licensure. ***NOTE: Up to 1,000 hours of practicum/internship hours may be used toward the overall 3,000 hours of required supervised clinical experience for licensure. 2,000 hours of the overall 3,000 hours of required supervised clinical experience for licensure must be attained before or after the award of the masters degree.***

**Please attest to the following statement and return the form to the applicant in a sealed envelope with the sealed flap signed.**

(Print name of applicant)_____ has a (check one)

☐ Has three (3) years with a minimum of 3,000 hours of supervised experience in art therapy, two (2) years of which shall have been completed **after** the award of the Master's degree.

☐ Has two (2) years of supervised experience in art therapy, one (1) year of which shall have been completed **after** the award of the Doctoral degree.

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**I HEREBY AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE FOREGOING INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE INFORMATION AND BELIEF.**

Check one: ☐ Applicant's supervisor ☐ Applicant's employer ☐ Applicant's colleague ***(in the case of colleague, submit documentation of colleague's mental health credential.)***

Your Name: _____

Signature: _____

Date: _____

Your Business Address: _____

_____
(Zip code)

Daytime Contact: _____

Email _____

## MARYLAND BOARD OF PROFESSIONAL COUNSELORS AND THERAPISTS

**Applicant Name:**_____ **Address:** _____

## COURSE OUTLINE FORM

***PLEASE ATTACH OFFICIAL TRANSCRIPTS***

**Complete this form. All required courses must be a 3 semester credit (or 5 quarter credit) graduate courses and from an accredited college or university.**

| *Office Use Only* | *REQUIRED COURSEWORK* | *WRITE IN Credits Earned* | *WRITE IN Course Number(S) & Title(S) Of Required Courses* | *Colleges/University* | *Date and Grade* |
|---|---|---|---|---|---|
| | **Personality Development** | | | | |
| | **Diagnosis and Treatment of Mental And Emotional Disorders** | | | | |
| | **Psychopathology** | | | | |
| | **Psychotherapy** | | | | |
| | **Marriage and Family Therapy** | | | | |
| | **Addictions** | | | | |
| | **Lifestyle and Career Development** | | | | |

# END OF APPLICATION

## APPLICATION PACKET CHECK LIST

**If you are applying for licensure under the licensure requirements provisions make sure the following is included in your application packet:**

**1) Completed application and all supporting documentation.**

**2) Application fee.**

**3) Application – Completed – Section 1**
**- Section 2**
**- Section 3**
**- Affidavit**

**4) Supporting Documentation – Supervised Clinical Experience History**
**- Supervision Verification Form**
**- Course Outline Form**
**- Official Transcripts**