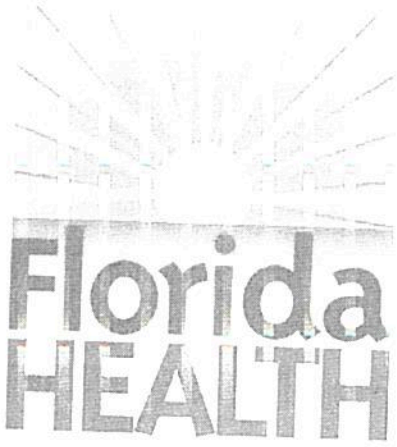

DEPARTMENT OF HEALTH

Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling

PROVISIONAL LICENSE APPLICATION

Department of Health
Florida Board of CSW/MFT/MHC
4052 Bald Cypress Way, C-08
Tallahassee, FL 32399-3258
Telephone: (850) 245-4474
www.floridasmentalhealthprofessions.gov
Email: MQA.491@flhealth.gov

Rule 64B4-3.0075
DH-MQA 1176 (Revised 11/18)

Provisional License Application Instructions

An individual **must** have an application for licensure as a clinical social worker, marriage and family therapist, or mental health counselor on file with the Board office to qualify for a provisional license.

This application is sent to licensure applicants that have submitted an application for licensure and the board has determined they qualify for a provisional license.

STEP 1: COMPLETING THE PROVISIONAL LICENSE APPLICATION

Section I - General Information
List your name as it was listed on your licensure application. Complete all parts by filling in the appropriate information or checking the appropriate box.

If you answer "Yes" to history questions, indicate if all documentation was submitted with your licensure application.

If you answer "Yes" and documentation was not sent with your licensure application, submit appropriate documentation and an explanation with this application.

Section II – Applicant History - Pursuant to Section 456.0635(2), Florida Statutes
Complete questions as indicated.

Section III – Applicant History - General
Answer this question.

Section IV – Applicant History – Professional
Answer all questions.

Section V - Certification
Your signature is required. By signing you are attesting that you have provided true and correct information on the application.

Section VI - Social Security Number - Your Social Security number is required.

Section VII - Applicant History - Health
Answer all questions.

STEP 2: MAILING THE INFORMATION

Mail the completed provisional license application and application fee of $100.00 to the address listed below. Make check or money order payable to the Department of Health.

Any variation or abbreviation of this address may cause a delay in processing.

DEPARTMENT OF HEALTH
BOARD OF CLINICAL SOCIAL WORK, MARRIAGE & FAMILY THERAPY
AND MENTAL HEALTH COUNSELING
PO BOX 6330
TALLAHASSEE, FL 32314-6330

PROVISIONAL LICENSE APPLICATION

DEPARTMENT OF HEALTH

Board of Clinical Social Work, Marriage & Family Therapy, and Mental Health Counseling

$100.00 APPLICATION FEE IS NONREFUNDABLE

For Office Use Only

SECTION I GENERAL INFORMATION *(Type or Print Neatly In Black Ink)*

CHECK ONE

- ☐ Provisional CLINICAL SOCIAL WORKER License (5204)
- ☐ Provisional MARRIAGE & FAMILY THERAPIST License (5205)
- ☐ Provisional MENTAL HEALTH COUNSELOR License (5206)

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

Mailing Address: _____
(Street) (City) (State) (Zip Code)

*** Practice Location Address:** _____
(Street) (City) (State) (Zip Code)

Home Phone: (_____) _____ **Work Phone:** (_____) _____

E-mail Address (Optional: Will be public record if provided.) _____

Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name than the name listed above? ☐ **Yes** ☐ **No** **If "Yes" list name(s).**

Gender:
- ☐ Male
- ☐ Female

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☐ Male ☐ Female U.S. Citizen: ☐ Yes ☐ No RACE: ☐ White ☐ Black ☐ Asian/Pacific ☐ Hispanic ☐ Other

*** <u>Your Practice Location Address Will Show On The Internet License Verification</u>**

Our Internet license verification provides the public with information on licensed health care practitioners in the State of Florida, including an "address of record". The "location address" from the licensure database will show as the "address of record" on the Internet.

If you only provide one address, it will be used for both the mailing address and the practice location address. Please note that the practice location address must be a street address.

Rule 64B4-3.0075
DH-MQA 1176 (Revised 11/18)

Section II. Applicant History - Pursuant to Section 456.0635(2), Florida Statutes

IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation. Supporting documentation includes court dispositions or agency orders where applicable.

1.	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded "no", skip to # 2.)	❑YES ❑NO
a.	If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea or conviction, and completion of any sentence or subsequent period of probation?	❑YES ❑NO
b.	If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).	❑YES ❑NO
c.	If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?	❑YES ❑NO
d.	If "yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation).	❑YES ❑NO
2.	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	❑YES ❑NO
a.	If "yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?	❑YES ❑NO
3.	Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 3a.)	❑YES ❑NO
a.	If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?	❑YES ❑NO
4.	Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If "No", do not answer 4a or 4b.)	❑YES ❑NO
a.	Have you been in good standing with a state Medicaid program for the most recent five years?	❑YES ❑NO
b.	Did the termination occur at least 20 years before the date of this application?	❑YES ❑NO
5.	Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	❑YES ❑NO

Section III. Applicant History - General

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record or conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. ❑ YES ❑ NO

If you answered "Yes" to the question above you are required to send the following items:

☐ **Self Explanation** describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

☐ **Final Dispositions and Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

Section IV. Applicant History - Professional

A.	Have you ever been denied a psychotherapy or counseling-related license or the renewal thereof in any state?	❑ YES ❑ NO
B.	Have you ever been denied the right to take a psychotherapy or counseling-related licensure examination?	❑ YES ❑ NO
C.	Have you ever had a license to practice any profession revoked, suspended, or otherwise acted against in a disciplinary proceeding in any state?	❑ YES ❑ NO
D.	Is there currently pending, in any jurisdiction, a complaint against your professional conduct or competency in a psychotherapy or counseling-related profession?	❑ YES ❑ NO
E.	Have you ever been involved in, reprimanded for or disciplined by an employer or educational institution for misconduct including:	
	1. Acts of dishonesty, fraud, or deceit	1.❑ YES ❑ NO
	2. Lying on a resume or misrepresentation	2.❑ YES ❑ NO
	3. Academic misconduct, including acts such as cheating or plagiarism	3.❑ YES ❑ NO
	4. Theft	4.❑ YES ❑ NO
	5. Sexual harassment	5.❑ YES ❑ NO

Section V. Certification

I understand that by submitting this completed form and fee, I will be provisionally licensed for a period of no longer than 24 months. It is my duty and responsibility as provisional licensee to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for examination or licensure. Such supplement is required by Chapter 456.072, F.S. and Chapter 456.013(1)(a), F.S. Failure to do so may result in disciplinary action by the Board including denial of licensure.

I hereby acknowledge that I have read Chapter 491, F.S., and related rules. I understand that I am under a continuing obligation to keep informed of any changes to Chapter 491, F.S., and related rules.

_____ _____

Applicant Signature Date

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

DEPARTMENT OF HEALTH

Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling

Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 USCA § 666 (a)(13); and Sections 456.013, 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to assure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L 193, Section 317.

Name: _____
Last **First** **Middle**

Section VI. Social Security Number: _____

Section VII. Applicant History - Health

A.	Do you have any condition that currently impairs your ability to practice your profession with reasonable skill and safety?	❑ YES ❑ NO
B.	Are you using medications, other drugs, narcotics, or intoxicating chemicals that impair your ability to practice your profession with reasonable skill and safety?	❑ YES ❑ NO

If you answered "yes" to either of the above questions, please provide a letter from a licensed health care practitioner, who is qualified by skill and training to address your condition, which explains the impact your condition may have on your ability to practice your profession with reasonable skill and safety, and stating either that you are safe to practice your profession without restriction or indicating what restrictions are necessary. If necessary, you may attach additional sheets. Documentation must be current within the last year. If you fail to disclose the information requested in this section, your application may be denied.

Rule 64B4-3.0075
DH-MQA 1176 (Revised 11/18)