Montana Board of Social Work Examiners and Professional Counselors
(Marriage and Family Therapists are also regulated by this Board)
301 South Park, 4th Floor, PO Box 200513
Helena, Montana 59620-0513
Phone (406) 841-2203 Fax (406) 841-2305
Email: dlibsdswp@mt.gov
Website: www.swpc.mt.gov

MONTANA CLINICAL PROFESSIONAL COUNSELOR LICENSE APPLICATION

Applicants may apply for licensure either by examination or by credential.

REQUIREMENTS FOR LICENSURE BY EXAMINATION:

- Academic Requirements: Applicant must have a 60 semester hour or 90 quarter hour graduate degree from a college or university accredited by a regional accrediting entity, that includes a six-semester credit (or nine-quarter credit) advanced counseling practicum course; or a graduate counseling degree with a minimum of 45 semesters (or 67.5 quarter hours), and has obtained graduate level courses to equal the total requirement of a 60-semester credit graduate degree. The classes must be graduate level counseling courses from an accredited institution. A formal transcript is accepted as proof of attendance. Official graduate transcripts should be sent directly to the board office from the college or university.
- Supervision Requirement: Applicant must complete 3,000 supervised experience hours prior to application. A minimum of 1,500 hours may be done pre-degree. A minimum of 1,500 hours **must** be done post-degree. A licensed counselor, social worker, psychologist, psychiatrist, or licensed mental health professional, are qualified to provide supervision. 1,000 of the 1,500 post-degree hours must be in direct client contact. Practice hours are engaging in the practice of counseling as defined in 37-23-102(3), MCA.
- Reference/Nomination Letters: Three (3) letters are required. The letters are to be provided by individuals in the mental health care profession. These individuals should be able to attest to the applicant's aptitude and performance in the profession.
- Application Forms and Fee: Application must be made using official Montana application forms. All forms in the packet must be completed and an application fee must be paid. **No other state's licensing application forms will be accepted as a substitute.** (ARM 24.219.601)
- Fingerprint and Background Check: Applicant is required to obtain a federal fingerprint and background check from Montana Department of Justice. Applicant should contact the board office for a fingerprint packet.

REQUIREMENTS FOR LICENSURE BY CREDENTIAL:

Applicants may apply for licensure by endorsement if they hold a Clinical Professional Counselor License or equivalent license in another state.

- Academic Requirements: Applicant must have official graduate transcripts sent to the board office from the college or university.
- Supervision Requirements: Applicants must either submit completed Supervisory Experience Forms, or proof of previous completion of 3,000 hours of supervised clinical work experience as defined in 37-23-202, MCA. The candidate may verify the experience hours by affidavit, and need not supply a supervisor's signature up on reasonable explanation of why the supervisor's signature is unavailable to the candidate, or the candidate shall submit proof the candidate has been in continuous practice as a clinical counselor in another jurisdiction for the two years immediately preceding the date of application to Montana.
- Reference/Nomination Letters: Three (3) letters are required. The letters are to be provided by individuals in the mental health care profession. These individuals should be able to attest to the applicant's aptitude and performance in the profession.
- Application Forms and Fees: Applicant must submit completed, signed application with application fee payment.
- Fingerprint and Background Check: Applicant is required to obtain a federal fingerprint and background check from Montana Department of Justice. Applicant should contact the board office for a fingerprint packet.

PC_APP
Revised 10/03, 10/10, 11/11, 6/12

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FEES: All fees are non-refundable.
$200.00 Application Fee (must accompany the application).

Any examination fees incurred by an applicant are set by and paid directly to the testing service - National Board of Certified Counselors (www.nbcc.org)

Make check or money order payable to the Board of Social Work Examiners and Professional Counselors. Do not send cash.

APPLICATION DOCUMENTS: A license will not be issued until all materials are received and approved.

1. Application Form: completed and signed.
2. Evaluation of Supervisory Experience Form: Section 1 completed and signed by applicant and Section 2 completed and signed by the supervisor.
3. Academic Summary Sheet: All categories need to be completed with credit hour totals, signed by the academic advisor. Applicant must indicate quarter or semester credits. Official transcripts do not take the place of this form.
4. Official graduate transcripts: sent directly from the school to the board office.
5. Three reference letters: Letters should be from individuals in the mental health profession and sent directly to the board office.
6. Verification of Licensure: Verification should be sent directly to the board office from other state.
7. Fingerprint and background check: obtain a federal fingerprint check from the Montana Department of Justice.

APPLICATION PROCEDURE:

- When the application is complete, it will be processed and considered by board staff for permanent licensure. This may take up to 30 days.
- If the application is considered non-routine there may be a delay in processing of the application. The applicant may be notified to submit additional information as required or may be required to appear before the Board for a personal interview for consideration of the application during a regularly scheduled board meeting The Board meets four times per year.
- If the application is considered incomplete the applicant will be notified in writing of any deficient or missing items from the application file.

For information with regard to the processing of this application or other concerns, please contact the Board of Social Work Examiners and Professional Counselors at 406-841-2391 or 406-841-2392 or email us at dlibsdswp@mt.gov

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APPLICATION FOR LICENSURE AS A CLINICAL PROFESSIONAL COUNSELOR

Application by: ☐ Examination ☐ Credential (licensed in another state)

1. FULL NAME _____
Last First Middle

2. OTHER NAME(S) KNOWN BY _____

3. ORGANIZATION NAME _____

4. ORGANIZATION ADDRESS _____
Street or PO Box # City and State Zip

5. HOME ADDRESS _____
Street or PO Box # City and State Zip

PREFERRED METHOD OF CONTACT

☐ ORGANIZATION ☐ HOME EMAIL ADDRESS _____

6 ORGANIZATION PHONE _____ HOME PHONE _____ FAX _____

7. SOCIAL SECURITY NUMBER _____ FOREIGN ID NUMBER _____

8. DATE OF BIRTH _____ ☐ MALE ☐ FEMALE

Please answer the following questions. If you answer yes, give specific details (names of organizations, dates, reasons, and outcome) on a supplement sheet.

9. If taking an examination, do you have any physical or mental impairment(s) requiring special accommodation(s)? If yes, attach a detailed explanation from your physician. ☐ Yes ☐ No

10. Have you ever taken the licensure examination in Montana or any other state? If yes, give state, date, and results. ☐ Yes ☐ No

_____

11. List all professional/occupational licenses, registrations, or certificates you hold, or have ever held.

State	License #	Issue Date	Expiration Date	License Method	Requested State Verification
				◯ EXAM ◯ ENDORSE ◯ OTHER	◯ YES ◯ NO
				◯ EXAM ◯ ENDORSE ◯ OTHER	◯ YES ◯ NO
				◯ EXAM ◯ ENDORSE ◯ OTHER	◯ YES ◯ NO
				◯ EXAM ◯ ENDORSE ◯ OTHER	◯ YES ◯ NO

Have you ever had an application for a professional or occupational license refused or denied? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ Yes ☐ No

Have you ever withdrawn an application for licensure prior to the licensing agency's decision regarding your application? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ Yes ☐ No

Has a licensing agency initiated or completed disciplinary action against any professional or occupational license you have held? If yes, please provide agency documents including the complaint, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements directly from the source. ☐ Yes ☐ No

Have you ever voluntarily surrendered, cancelled, forfeited, failed to renew a professional or occupation license in anticipation of or during an investigation or disciplinary proceedings or action? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ Yes ☐ No

Has a complaint ever been made against you with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ Yes ☐ No

Have any civil legal proceedings been filed against you by a (patient/client), (former patient/client) or employer/employee? If yes, attach a detailed explanation and documentation from the source including initiating document(s) and documentation of final disposition. ☐ Yes ☐ No

Have you ever been convicted of a misdemeanor or felony crime or do you have a pending criminal charge? "Convicted" for the purposes of this question includes a conviction under appeal, guilty plea, no contest plea, and/or forfeiture of bond. "A pending criminal charge" for the purposes of this question includes a deferred imposition of sentence and/or deferred prosecution. If you answer yes, you must submit a detailed explanation of the events AND the charging documents and final judgments or orders of dismissal. You must report but may omit documentation for: (1) misdemeanor traffic violations older than 10 years ago and that resulted in fines of less than $200; and (2) convictions prior to your 18th birthday unless you were tried as an adult. ☐ Yes ☐ No

Have you ever been diagnosed with chemical dependency or another addiction, or have you participated in a chemical dependency or other addiction treatment program? If yes, please attach a detailed explanation and provide documentation regarding evaluations, diagnosis, treatment recommendations and monitoring from the source. ☐ Yes ☐ No

Have you ever been diagnosed with a physical condition or mental health disorder involving potential health risk to the public? If yes, please provide a detailed explanation. ☐ Yes ☐ No

Have you ever been courts martial or discharged other than honorably from any branch of the armed service? If yes, attach a detailed explanation and documentation from the source. ☐ Yes ☐ No

Have you ever been denied the privilege of taking an examination required for any professional or occupational license? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ Yes ☐ No

Have you ever withdrawn or been suspended, placed on probation, expelled or requested to resign from any postsecondary educational program? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ Yes ☐ No

Have you ever requested temporary or permanent leave of absence, been placed on probation, restricted, suspended, revoked, allowed to resign, or otherwise acted against by any professional or occupational education program (i.e., residency, internship, apprenticeship, etc)? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ Yes ☐ No

Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding hospital, facility or staff privileges; health maintenance organization participation, third party provider or Medicare/Medicaid participation; or any other privileges? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ Yes ☐ No

Have you ever been censured, expelled, denied membership or asked to resign from a professional organization related to your profession or occupation? If yes, please attach a detailed explanation and provide documentation from the source. ☐ Yes ☐ No

Do you have any initiated or completed action against you by any state, federal, tribal, or foreign licensing jurisdiction? (For example: Drug Enforcement Agency; Alcohol, Tobacco and Firearms; Homeland Security; Indian Health Service, etc) If yes, please attach a detailed explanation and provide documentation from the source. ☐ Yes ☐ No

12. **EDUCATION:**
List all colleges, universities, and institutions you have attended.

Name of University or College	City and State/Province/ Territory	Dates Attended	Degree Earned

13. **REFERENCES OF CHARACTER AND QUALIFICATIONS:**
Counselor applicants will give the name address and profession of not less than three (3) reputable citizens, unrelated to the applicant, who can verify the character of the applicant. References may be supervisors or individuals working in the mental health care field.

Name	Profession	Address	Telephone Number

14. **MEMBERSHIPS IN SOCIETIES, ASSOCIATIONS, OR INSTITUTIONS, IF ANY.**

Name of Organization	Location	Grade or Status of Membership	Dates

15. **RESUME OF EXPERIENCE:**

Dates (From - To)	Organization/Business	Exact Title	Hours Per Week	Total Hours (This Job)

Name, Title and License Number of Immediate Supervisor	

DESCRIPTION OF WORK (include only experience relating to the required 3,000 hours of clinical experience.) ☐ Pre-Degree Experience ☐ Post-Degree Experience Graduation Date: __________

Dates (From - To)	Organization/Business	Exact Title	Hours Per Week	Total Hours (This Job)

Name, Title and License Number of Immediate Supervisor	

DESCRIPTION OF WORK (include only experience relating to the required 3,000 hours of clinical experience.) ☐ Pre-Degree Experience ☐ Post-Degree Experience Graduation Date: __________

Dates (From - To)	Organization/Business	Exact Title	Hours Per Week	Total Hours (This Job)

Name, Title and License Number of Immediate Supervisor	

DESCRIPTION OF WORK (include only experience relating to the required 3,000 hours of clinical experience.) ☐ Pre-Degree Experience ☐ Post-Degree Experience Graduation Date: __________

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EVALUATION OF SUPERVISORY EXPERIENCE

Instructions:

The Board of Social Work Examiners and Professional Counselors requires submission of information by the applicant and supervisor to allow the Board to evaluate the extent and quality of the candidate's supervised experience. Section 1 of this form should be completed by the applicant. Section 2 must be completed by the supervisor. A supervisor must be a licensed psychiatrist, psychologist, social worker, professional counselor or other licensed mental health professional.

The applicant must complete 3,000 supervised experience hours. The forms submitted must reflect the required 3,000 hours. This form may be copied as needed

SECTION I: APPLICANT REPORT

I,_____ am applying for a license to practice counseling in the State of Montana.

☐ Pre-Degree Experience ☐ Post-Degree Experience

A. Name of Supervisor _____

B. Address of Supervisor _____

C. Name and nature of setting in which the supervised practice took place

D. Dates of practice at this setting _____

E. Total number of supervised practice hours during this period _____
(the number of hours you worked)

F. Number of supervisory hours during this period _____
(The hours spent face-to-face with your supervisor)

G. **Post-degree** direct client contact hours (ARM 24.219.604(3)(b)(i)) _____

No more than 250 client contact hours may be in a group or co-facilitative counseling situation. 1,000 hours must be direct client contact. The applicant must receive a minimum of one hour of face-to-face supervision and consultation for every 20 hours of work experience. No more than 80 hours of work experience may transpire without receiving the required hours of supervision and/or consultation. Less frequent supervision may take place only with prior approval of the licensure board. Any hours earned without appropriate supervision will not be counted towards licensure.

H. Describe the nature of applicant's duties

I. Describe the nature of supervision provided

_____ _____
Signature of Applicant Date

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EVALUATION OF SUPERVISORY EXPERIENCE

SECTION 2: SUPERVISOR REPORT

Section 2 must be completed by the supervisor:

Name of Applicant _____

☐ Pre-Degree Experience ☐ Post-Degree Experience

Name of Supervisor: _____ Phone number: _____

J. Please state the quality of the applicant's performance during the supervised practice period.

K. I have reviewed the applicant's statements. They are ☐ are not ☐ substantially correct.

Title at time of supervision _____

Type of professional license _____ Professional License Number _____

State of licensure _____

Note: Supervisor must hold a state license in the mental health care field (social worker counselor, psychologist, psychiatrist or other licensed mental health care professional) to insure acceptance of your supervisory hours.

I hereby declare under penalty of law that the above information is true and complete to the best of my knowledge. In signing this page, Section 2 of Evaluation of Supervisory Experience, I am aware that a false statement or misrepresentation may be considered a violation of professional ethics, which may result in discipline of my license.

_____ _____
Signature of Supervisor Date

Please return both Section 1 and Section 2 of the Evaluation of Supervisory Experience to the board address listed above.

Supervisor must attest to the above under penalty of law. Falsification or misrepresentation of any of the above may be considered misrepresentation and a violation of professional ethics, which may result in discipline of the supervisor's license. ARM 24.219.604(3)(g)(ii)(C)(v)

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ACADEMIC SUMMARY SHEET

Transcripts will not be accepted in lieu of this form. Both this form and official transcripts must accompany the application - otherwise the application will be considered incomplete and will not be reviewed.

Instructions:

1. All applications must comply with 37-23-202, MCA, ARM 24.219.604, and all other applicable statutes/rules.
2. The planned graduate program course list will be used by the Board to cross-reference those courses being submitted with your application.
3. All courses must be graduate level from a college or university accredited to offer a graduate program in counseling by various associations of colleges and secondary schools.
4. If a course title is not clearly indicative of Board content areas, attach the college catalog description or course syllabi indicating that specific material was included.
5. If a course is utilized for more than one content area, do not duplicate credit hours. Place an asterisk * in the credit hours column for the second listing of the course.
6. Applicant shall submit written verification (transcripts) from the registrar of the school or other person deemed satisfactory by the board that the applicant has completed courses in the required subjects.
7. Date student was admitted to the graduate program and graduation date: _____

Applicant's Name _____ Applicant's Signature _____

Advisor's Name _____ Advisor's Signature _____

Content Areas	**Course Number**	**Title**	**College/University**	Credit Hours **sem or qtr.**
Counseling Theory				
Counseling Techniques				
Supervised Experience				
Human Growth & Development				
Social & Cultural Foundations				
The Helping Relationship				
Groups				
Life-Style & Career Development				
Appraisal				
Research & Evaluation				
Professional Orientation				
Advanced Counseling Practicum				

TOTAL CREDITS (Please indicate SEMESTER OR QUARTER hours)
You can list other courses on the back of this form.

_____ Please Total

☐ Sem ☐ Qtr
PLEASE CHECK

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PROFESSIONAL COUNSELOR SUPERVISORY AGREEMENT

1. Supervisor Name _____ License Number _____

2. Applicant Name _____

3. Duration and termination of supervision: Beginning date _____ Ending date: _____

4. Financial compensation (if any) _____

5. Frequency and method of supervision: (hours per week or month; where the supervision takes place; how the supervision was delivered, etc.).

Hours per week or month _____ Location of Supervision _____

Method of delivery of supervision _____

Other _____

Statement of confidentiality: This form is to be reviewed by the Board only for the purpose of meeting the Montana professional counselor licensure requirements and is not public information.

The Supervisor shall:

1. Be a qualified supervisor as determined by the Board and provide verification of this qualification to the supervisee. The supervisor shall maintain this credential for the duration of the supervision.
2. Provide supervision on the agreed-upon basis.
3. Provide a reference letter as specified in 37-23-202(1)(d), MCA.
4. Conduct supervision with a focus on the supervisee's clinical work and professional development.
5. Conduct supervision as a professional endeavor, making a reasonable effort to ensure the supervisee's competence in practice.
6. Conduct supervision according to the Code of Ethics. (ARM 24.219.804)
7. Complete the supervisor's portion of the Evaluation and Verification of Supervised Experience form.

The Applicant shall:

1. Attend supervision on the agreed-upon basis.
2. Keep a Counselor Supervision Log for reference.
3. Provide appropriate clinical material for supervision, which is representative of the supervisee's practice or of the specialty where more guidance and direction is needed.
4. Participate in supervision with a goal of increasing competency in clinical counseling practice and in accordance with the Code of Ethics. (ARM 24.219.804)
5. Request an on-going and final evaluation of clinical counseling skills from the supervisor.

_____ _____
Applicant's Signature and Date Supervisor's Signature and Date

_____ _____
Please print name Please print name

DECLARATION

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Social Work Examiners and Professional Counselors.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

_____ _____

Signature of Applicant Date

VERIFICATION OF MORAL/PROFESSIONAL CHARACTER

APPLICANT: Complete the upper portion of this form and mail to each of the character references you have listed in your application.

_____ _____
Legal Signature of Applicant Date

(Please Type or Print)
Name of Applicant: _____

Address: _____

This verification sent to: _____
(Name of Reference)

CHARACTER REFERENCE: Please answer the following questions concerning the applicant's moral and professional character. This document is your authorization to release any and all information and opinions you have, favorable or otherwise, directly to the Montana Board of Social Work Examiners and Professional Counselors. Your response will be kept confidential.

Name of reference: _____ Daytime phone: _____

Address: _____

_____
Type of License/License Number/Profession/Position

How long have you known the applicant? _____ In what capacity? _____

To your knowledge, does the applicant have any habits or practices that would adversely affect his/her professional activities? If your answer is "yes", please explain: ☐ Yes ☐ No

Do you consider this applicant worthy of approval to practice as a Clinical Professional Counselor in Montana? ☐ Yes ☐ No

Please comment on the applicant's professional character, morals and ethics (attach additional sheet as needed):

_____ _____
Signature of Reference Date

Please use additional sheets, if necessary.
The applicant and the Board thank you for your assistance.

VERIFICATION OF LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

Applicant Instructions:
Please complete the top section and mail to each state board in which you are now or have ever been licensed to practice as a clinical professional counselor. You may copy this form as many times as needed. Some boards require a fee for this service.

STATE BOARD:

I am applying for a license to practice as a clinical professional counselor in the State of Montana and the Board of Social Work Examiners and Professional Counselors requires this form to be completed by each state wherein I hold or have ever held licensure. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **BOARD OF SOCIAL WORK EXAMINERS AND PROFESSIONAL COUNSELORS, PO BOX 200513, HELENA, MT 59620-0513.**
Your early response is appreciated.

_____ _____
(Signature) Name (Please Print)

Address _____ My License Number is _____

DO NOT DETACH - - THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF SOCIAL WORK EXAMINERS & PROFESSIONAL COUNSELORS.

State of: _____

Full Name of Licensee: _____

License No. _____ Issue Date: _____

Licensed by Examination _____ Endorsement (List State) _____ Other (Please List) _____

Type of Examination
NBCC- NCE or NCMHCE _____ Is License current ☐ Yes ☐ No

License Status: ☐ Active ☐ Inactive ☐ Other If NO, explain _____

Has License been suspended, revoked, on probation or otherwise disciplined? ☐ Yes ☐ No
If YES, explain and attach documentation.

Has licensee ever been requested to appear before your Board? ☐ Yes ☐ No
If YES, explain.

Derogatory information, if any _____

Comments, if any _____

Signed: _____

Title: _____

BOARD SEAL

State Board: _____

Date: _____

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FINGERPRINT AND BACKGROUND CHECKS FOR ALL CLINICAL COUNSELOR APPLICANTS

The 2007 Legislative Session passed Senate Bill 342 which requires applicants for licensure as Social Workers or Professional Counselors to submit fingerprints for criminal background checks. This amended statute 37-23-202, MCA for Licensed Clinical Professional Counselors as follows:

37-23-202. Licensure requirements (3) As a prerequisite to the issuance of a license, the board shall require the applicant to submit fingerprints for the purpose of fingerprint checks by the Montana Department of Justice and the Federal Bureau of Investigation as provided in 37-1-307.

(4) If an applicant has a history of criminal convictions, then pursuant to 37-1-203, the applicant has the opportunity to demonstrate to the board that the applicant is sufficiently rehabilitated to warrant the public trust, and if the board determines that the applicant is not, the license may be denied. **Full text of the initiating statute can be found at 37-23-101.**

Applicants must contact the board office and request a fingerprint packet be mailed to them. Instructions for completing the fingerprint/background process will be included in the packet.

Obtaining prints sometimes results in errors; in the event that this occurs, this office will contact you and send a new fingerprint card. You will need to get a second set of prints done. Please consider using a facility which offers digital fingerprinting if the ink prints are rejected due to smudging.
If your first finger print card is rejected you are not required to pay a second fee to the Department of Justice, Montana Criminal Records. Simply attach your new fingerprint card to the dated request form and mail to the Department of Justice. The dated request form will be returned to you by this office when we notify you that your fingerprints were rejected. We cannot guarantee that the agency taking your fingerprints will not charge a second fee.

Information from the Department of Justice is only released to the Montana Board of Social Work Examiners & Professional Counselors. A representative from the agency that you choose to collect your fingerprints must enclose the request form and the fingerprint card with your check or money order for $29.25 made payable to the Department of Justice in the pre-addressed envelope provided and mail it to **the Department of Justice, Montana Criminal Records, 303 North Roberts, P.O. Box 201403, Helena, MT 59620-1403**. *The envelope is addressed but it is **not** postage paid so you will be required to add a minimum of $1.20 postage to the envelope. Please check with your local post office and add the accurate postage **PRIOR** to going to the agency that is collecting your fingerprints. The envelope will be mailed directly from the agency to the Department of Justice.*

As a licensure applicant your application will not be considered complete until the information is received from the Department of Justice and processed by the board office. Results of the background check will be sent directly to the board office by the State of Montana Department of Justice. You will only be contacted by this office **if** a disqualifying event is identified on the report.

Please contact the board office at 406-841-2203 if you have any questions.