



INSTRUCTIONS FOR COMPLETION OF

LICENSED PROFESSIONAL COUNSELOR OF MENTAL HEALTH (LPCMH) APPLICATION

A Summary for New Applicants

In summary, a successful applicant must provide the following items to the Board:

1. A completed application with the appropriate fee
2. An earned graduate degree transcript acceptable to the Board
3. A signed affidavit acceptable to the Board
4. Certification that you have passed an acceptable examination
5. Documentation of post master's degree experience and supervision acceptable to the Board

The post master's degree experience and supervision can be summarized as follows:

1. Complete 3,200 hours of acceptable clinical experience providing mental health counseling services within a 4 year span of time.
2. A minimum of 1,600 of these hours must be under the direct supervision of an approved supervisor. Approved supervisors are individuals who preferably hold the LPCMH. If one is not available, a licensed marriage and family therapist, a licensed clinical social worker, a licensed clinical psychologist, or licensed psychiatrist can provide supervision.
3. 100 of these hours must consist of face to face supervisory sessions. A minimum of 60 of these hours must be individual sessions. Up to 40 of these hours may be in a group supervisory setting.
4. The remaining hours of clinical experience must be listed on the Professional Counseling Experience Form and be signed by either your administrative or clinical supervisor(s).

This description is intended to be a summary. The specific requirements are presented below.

1. **LPCMH Application** – Submit a completed application, which must be signed and notarized, along with the pro-rated processing fee. Make your check or money order payable to the “State of Delaware”.
2. **Direct Supervision Reference Form** - Your clinical supervisor(s) must complete this form and mail it directly to the Board. The forms must clearly indicate the number of hours the applicant has completed providing mental health counseling services. The supervisor(s) must be a licensed professional counselor of mental health, licensed marriage and family therapist, licensed clinical social worker, licensed clinical psychologist, or licensed physician specializing in psychiatry. ***Certified School Counselors and Certified School Psychologists are not Board approved supervisors.*** The Board's rules define the supervisory experience as:

2.5 Supervised Professional Counseling Experience - Supervised professional counseling experience shall be the accumulation of hours spent providing mental health counseling services while under the supervision of an approved clinical supervisor. Supervised professional counseling experience acceptable to the Board shall be defined as follows:

2.5.1 Supervised professional counseling experience shall consist of 1,600 hours of clinical experience, directly supervised by a LPCMH. Where direct supervision by a LPCMH is not available, a licensed clinical social worker, licensed psychologist or licensed physician specializing in psychiatry may supervise the applicant.

2.5.2 Direct Supervision - 1600 hours of direct supervision acceptable to the Board, for purposes of §3008(a)(2) shall mean supervision overseeing the supervisee's application of clinical counseling principles, methods or procedures to assist individuals in achieving more effective personal and social adjustment. At least 100 of the 1600 hours of supervision shall consist of face to face consultation between the supervisor and the supervisee. Direct supervision may take place in individual and/or group settings, defined as follows:

2.5.2.1 Individual Supervision - Individual supervision shall consist of one-to-one, face-to-face meetings between supervisor and supervisee.

2.5.2.2 Group Supervision - Group supervision shall consist of face-to-face meetings between supervisor and no more than six (6) supervisees.

2.5.2.3 Supervisory Setting - No more than forty (40) hours of group supervision shall be acceptable toward the 100-hour requirement. The entire 100-hour requirement may be fulfilled by individual supervision.

2.5.3 Supervision shall be verified by the "Direct Supervision Reference Form," submitted directly to the Board by the approved clinical supervisor.

- 3. Professional Counseling Experience Form** – Your administrative or clinical supervisor(s) must complete this form and mail it directly to the Board. The forms must clearly indicate the total number of post-Master's mental health counseling hours in addition to your dates of employment. The Board's rules define Professional Counseling Experience as:

2.4 Professional Counseling Experience - Professional Counseling experience shall be defined as the accumulation of hours spent providing mental health counseling services in a professional mental health clinical counseling setting, including face-to-face interaction with clients and other matters directly related to the treatment of clients.

- 4. National Certifying Organization Certification Form** – If your national certifying organization is other than the NBCC, you will need to complete part 1 of this form and mail it to your national certifying organization. They will complete the form and forward it to the Board.
- 5. NBCC Certification** – If your certifying organization is the NBCC you will need to request in writing a Verification of Certification and Examination Scores. Send a letter of request along with a \$15.00 processing fee for each verification request. Make checks payable to "NBCC". Send your request to:

**NBCC Examinations Department
PO Box 7407
Greensboro, NC 27417-0407**

- 6. Verification of Licensure Form** – If you hold or have ever held any license in another state, you will need to contact them and request that they send the Delaware Board a verification of your licensure in good standing.
- 7. Official Transcript** – Submit an official transcript of your completed Master's degree. The transcript must be sent directly to the Board from your college or university.

If you have any questions, please contact the board's Administrative Specialist at (302) 744-4500.

7. Professional Clinical Experience: List your post-Master's professional clinical counseling experiences beginning with the latest one first. If needed, use this same format on additional sheets. Do not submit resumes.

a. Dates of employment: From _____ To _____ Total Number of Hours: _____

Employer

Address

Supervisor's Name

Title/Professional Status

Telephone

Your Position/Title: _____

Job Responsibilities and Activities (use additional page if needed): _____

b. Dates of employment: From _____ To _____ Total Number of Hours: _____

Employer

Address

Supervisor's Name

Title/Professional Status

Telephone

Your Position/Title: _____

Job Responsibilities and Activities (use additional page if needed): _____

8. National Certifying Organization:

Name of Certifying Organization	Certification Number	Date Certified	Expiration Date
NBCC			
ACMHC			
Other Certifying Organization	<i>Requires completion of "Certifying Organization Certification Form"</i>		

9. Clinical Supervision: List present or former clinical supervisor(s) who is/are able to verify your required post-Master's degree supervision:

Name	Address	Telephone	License #

10. Graduate Credit Alternative: If you wish to substitute 30 post-Masters credit hours in the field of counseling for 1,600 hours of Professional Counseling Experience, please answer the following:

Educational Institution: _____

Dates: _____ Number of Credits Earned: _____

Please Note: *If you use this option, you must have the educational institution send a transcript showing graduate credits directly to the Board office.*

11. Have you ever been convicted of or entered a plea of guilty or nolo contendere (no contest) to any felony, misdemeanor, or any other criminal offense, for which you have not received a pardon, in any jurisdiction? **If yes, submit a certified copy of your criminal history record.** Yes No

12. Have there ever been, or are there now any pending professional disciplinary actions against you? **If yes, attach an explanation in full detail by giving all particulars of such action(s).** Yes No

13. Have you ever had a professional license suspended or revoked? **If yes, attach an explanation in full detail by giving all particulars of such action(s).** Yes No

14. Are you presently in violation of any Rule and Regulation set forth by the Delaware Board of Mental Health and Chemical Dependency Professionals? **If yes, attach an explanation in full detail by giving all particulars of such action(s).** Yes No

15. Are you in violation of any grounds for disciplinary actions, as set forth in 24 Del. C., Subchapter I, Section 3009? **If yes, attach an explanation in full detail by giving all particulars of such action(s).** Yes No

16. Have you ever been denied licensure in any other jurisdiction? **If yes, attach an explanation in full detail by giving all particulars of such action(s).** Yes No

To assure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- Completed, signed and notarized application form
- Fee payment
- All required supporting documentation.

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is complete, please allow 4-8 weeks to receive your license.

Delaware Board of Mental Health and Chemical Dependency Professionals

AFFIDAVIT

The undersigned applicant for Licensed Professional Counselor of Mental Health or Licensed Associate Counselor of Mental Health, being sworn, deposes and affirms that he/she meets the following Qualifications for Licensure as stated in Title 24, *Delaware Code*, Chapter 30:

The applicant is not the recipient of any administrative penalties regarding his/her actions as a licensed, registered or certified mental health provider, and has not entered into any "consent agreements" containing conditions placed upon his/her professional conduct, including voluntary surrender of license.

The applicant does not have any impairment related to drugs, alcohol, or a finding of mental incompetence by a physician that would limit the applicant's ability to safely act as a licensed professional counselor of mental health.

The applicant does not have a criminal conviction nor pending criminal charge relating to an offense, the circumstances of which substantially relate to actions as a licensed professional counselor of mental health.

The applicant has not been penalized for any willful violation of any code of ethics or professional mental health or chemical dependency counseling standard.

The applicant further states that he/she has not violated any rule or regulation set forth by the Delaware Board of Mental Health and Chemical Dependency Professionals.

Signature of Applicant

State of _____

City of _____ County of _____

Sworn before me this _____ day of _____, 20____.

My commission expires on _____.

(Notary Signature)

Notary Seal



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

Licensed Professional Counselor of Mental Health
SUPERVISORY REFERENCE FORM

APPLICANT: DO NOT COMPLETE ANY SECTION OF THIS FORM. This form must be completed by the applicant's board approved supervisor who is then to mail it directly to the Board of Mental Health and Chemical Dependency Professionals at the address listed above.

Chapter 39, Title 24 of the Delaware Code states that individuals seeking licensure to practice professional counseling in the State of Delaware must submit satisfactory proof to the Board of Mental Health and Chemical Dependency Professionals that they have acquired two (2) years of post-master's clinical counseling experience. This experience shall consist of not less than 3,200 hours, at least 1,600 hours of which shall have been under the supervision of a licensed marriage and family therapist (LMFT), licensed professional counselor of mental health (LPCMH), licensed clinical social worker (LCSW), licensed psychologist or licensed physician specializing in psychiatry. **At least 100 of the 1600 hours of supervision shall consist of face to face consultation between the supervisor and the supervisee (up to 40 hours may be group supervision). Certified School Counselors and Certified School Psychologists are not Board approved supervisors.**

1. I, _____, attest that _____ worked under my clinical supervision.
(Name of Supervisor) (Name of Applicant)
2. Total Clinical Supervised Hours: _____ Total Hours of Individual Face-to-Face Supervision: _____
Total Hours of Group Supervision: _____ (no more than 40 group hours can be counted toward the 100 hour requirement)
3. Dates of Post Master's Supervised Clinical Experience: From _____ to _____
Month/Year Month/Year

✓	Supervisor: Check all that apply	State	License #	Date Issued
	I am a licensed professional counselor of mental health			
	I am a licensed clinical social worker			
	I am a licensed marriage and family therapist			
	I am a licensed clinical psychologist or licensed psychiatrist			

4. Supervisor's Agency's Name (if applicable): _____
Address: _____ Phone: _____
_____ Zip Code: _____

5. I certify that I have personally completed all sections of this form and that the information provided herein is accurate and complete to the best of my knowledge and belief.

Signature of Supervisor

Date



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Licensed Professional Counselor of Mental Health

PROFESSIONAL COUNSELING EXPERIENCE FORM

APPLICANT: DO NOT COMPLETE ANY SECTION OF THIS FORM. This form must be completed by the applicant's administrative or clinical supervisor who is then to mail it directly to the Board of Mental Health and Chemical Dependency Professionals at the above address

2.4 Professional Counseling Experience - Professional Counseling experience shall be defined as the accumulation of hours spent providing mental health counseling services in a professional mental health clinical counseling setting, including face-to-face interaction with clients and other matters directly related to the treatment of clients.

1. Name of Applicant: _____

2. Name of Administrative or Clinical Supervisor: _____

Title: _____ Phone: _____ - _____ - _____

Setting/Location Name: _____

Address: _____

_____ Zip Code: _____

3. Dates of Employment: From _____ to _____

Total Number of Hours of Professional Counseling Experience: _____

4. Description of Agency/Work Setting (for example, group practice, community mental health agency, elementary school, etc.)

I certify that I have personally completed all sections of this form and that the information provided herein is accurate and complete to the best of my knowledge and belief and that this applicant competently and satisfactorily performed his/her counseling duties pursuant to board rule 2.4.

Signature of Administrative or Clinical Supervisor

Date



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DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
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Board of Mental Health and Chemical Dependency Professionals

VERIFICATION OF LICENSURE FORM

Section I – To be completed by applicant and sent to those states where applicant is currently licensed or was previously licensed. You may duplicate this form.

Name	
License Type	
License #	
Phone #	

I hereby authorize _____ to release information regarding my licensure,
Name of state licensing Board/Authority
certification, or registration to the Delaware Board of Mental Health and Chemical Dependency Professionals.

Signature of Applicant

Date

Section II - To be completed by State Licensure Board/Authority and returned to the address above:

Date of Original Registration/Licensure: _____

Registration/License No: _____ Expiration Date: _____

Has the licensee ever been subject to any disciplinary action, or had his/her license suspended or revoked? ***If yes, enclose a certified copy of the board's final order.*** Yes No

Are there any current or pending disciplinary proceedings or unresolved complaints against the applicant? Yes No

I certify the statements contained herein are true and correct.

Name of Official: _____ Title: _____

Name of Licensure Authority: _____

Address: _____ Phone: _____

_____ Zip Code: _____

AFFIX BOARD SEAL

Signature and title of official for state licensing authority

Date



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Licensed Professional Counselor of Mental Health

CERTIFYING ORGANIZATION CERTIFICATION FORM

To: _____

The applicant named below has applied for licensure as a Licensed Professional Counselor of Mental Health in the State of Delaware. In order to properly evaluate his/her application, the Board of Mental Health and Chemical Dependency Professionals need the following information about your organization:

1. Verification of applicant's current certification in good standing;
2. Statement of Mission and Scope of Membership;
3. Membership Requirements;
4. Description of Standardized Examination required for membership; and
5. Code of Ethics for members.

Please verify the applicant's standing by completing Part 2 of this form and return it with the additional information listed above to the Delaware Board of Mental Health and Chemical Dependency Professionals at the address above. Thank you in advance for your assistance.

Part 1 - To be completed by Applicant:

Name: _____ Phone: _____

Address: _____
_____ Zip Code: _____

Certified as: _____

Certification No. _____ Date Certified: _____ Expiration Date: _____

I hereby authorize _____ to release information regarding my certification to the Delaware Board of Mental Health and Chemical Dependency Professionals.

Signature of Applicant

Date

Part 2 - To be completed by Official of Certifying Organization:

Is the applicant currently certified as represented on this form? Yes No

Is the applicant currently in good standing? Yes No

If the answer to either of the above is "no" please give full particulars: _____

Enclosed are the following:

Statement of Mission and Scope of Membership Yes No

Membership Requirements Yes No

Description of Examination required for membership Yes No

Code of Ethics for Members Yes No

Name of Official: _____ Title: _____

Name of Certifying Organization: _____

Address: _____ Phone: _____

_____ Zip Code: _____

Signature of Official: _____ Date: _____

Revised 04/30/2008