



## INSTRUCTIONS FOR COMPLETION OF

### LICENSED ASSOCIATE COUNSELOR OF MENTAL HEALTH (LACMH) APPLICATION

1. **LACMH 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. **Completed Professional Counseling Experience Form** - Your administrative and clinical supervisors must complete this form and sign it. The form must clearly indicate the dates and number of hours the applicant has already obtained after having received his/her master’s degree. 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.
3. **Written Plan for Professional Counseling Experience and Supervision Form** - Your administrative and clinical supervisors must complete this form and sign it. The form must clearly indicate the dates and number of hours the applicant plans to complete the remaining professional counseling experience and supervision requirements. 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.
4. **National Certifying Organization Certification Form** – If your national certifying organization is other than the NBCC, 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, request 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.



**COMPLETED PROFESSIONAL COUNSELING EXPERIENCE AND SUPERVISION**

**7. Completed Professional Clinical Experience:** List your completed post-Master's professional clinical counseling experiences. If needed, use this same format on additional sheets.

a. Dates of completed 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): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Administrative or Clinical Supervisor

\_\_\_\_\_  
Date

**8. Completed Direct Supervision:** List your planned post-Master's professional clinical counseling experiences. If needed, use this same format on additional sheets.

a. Dates of completed supervision: From \_\_\_\_\_ to \_\_\_\_\_ Total Number of Hours \_\_\_\_\_

b. Number of Hours of completed Individual Face-to-Face Supervision \_\_\_\_\_

c. Number of Hours of completed Group Face-to-Face Supervision \_\_\_\_\_

d. Total Number of Hours of completed Individual/Group Supervision \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Supervisor's Name \_\_\_\_\_ Title/Professional Status \_\_\_\_\_ Telephone \_\_\_\_\_

Your Position/Title: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Clinical Supervisor

\_\_\_\_\_  
Date

**WRITTEN PLAN FOR PROFESSIONAL COUNSELING EXPERIENCE AND SUPERVISION**

**9. Planned Professional Clinical Experience:** List your planned post-Master's professional clinical counseling experiences. If needed, use this same format on additional sheets.

a. Dates of planned 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): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Administrative or Clinical Supervisor

\_\_\_\_\_  
Date

**10. Planned Direct Supervision:** List your planned post-Master's professional clinical counseling experiences. If needed, use this same format on additional sheets.

e. Dates of planned supervision: From \_\_\_\_\_ to \_\_\_\_\_ Total Number of Hours \_\_\_\_\_

f. Number of Hours of Planned Individual Face-to-Face Supervision \_\_\_\_\_

g. Number of Hours of Planned Group Face-to-Face Supervision \_\_\_\_\_

h. Total Number of Hours of Planned Individual/Group Supervision \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Supervisor's Name \_\_\_\_\_

Title/Professional Status \_\_\_\_\_

Telephone \_\_\_\_\_

Your Position/Title: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Clinical Supervisor

\_\_\_\_\_  
Date

11. 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>		

12. **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 #

13. **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.*

	YES	NO
Have you ever been convicted of or entered a plea of guilty or <i>nolo contendere</i> (no contest) to any felony, misdemeanor, or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon, in any jurisdiction? <b><i>If yes, submit a certified copy of your criminal history record.</i></b>		
Have there ever been, or are there now any pending professional disciplinary actions against you? <b><i>If yes, attach an explanation in full detail by giving all particulars of such action(s).</i></b>		
Have you ever had a professional license suspended or revoked? <b><i>If yes, attach an explanation in full detail by giving all particulars of such action(s).</i></b>		
Are you presently in violation of any Rule and Regulation set forth by the Delaware Board of Mental Health and Chemical Dependency Professionals? <b><i>If yes, attach an explanation in full detail by giving all particulars of such action(s).</i></b>		
Are you in violation of any grounds for disciplinary actions, as set forth in 24 Del. C., Subchapter I, Section 3009? <b><i>If yes, attach an explanation in full detail by giving all particulars of such action(s).</i></b>		
Have you ever been denied licensure in any other jurisdiction? <b><i>If yes, attach an explanation in full detail by giving all particulars of such action(s).</i></b>		

The Board office must receive items submitted for the Board to consider at its meeting no later than two full business days before the meeting. In order to be considered at a Board meeting, license applications must be complete two full business days before the meeting. A complete application is one that includes all required documentation and correct payment.

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 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 associate 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 associate counselor of mental health.

The applicant has not been penalized for any willful violation of any code of ethics or professional mental health 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**

Approved 4/28/2008



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

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.**

<b>Name</b>	
<b>License Type</b>	
<b>License #</b>	
<b>Phone #</b>	

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



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 Associate Counselor of Mental Health

**CERTIFYING ORGANIZATION CERTIFICATION FORM**

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The applicant named below has applied for licensure as a Licensed Associate 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: \_\_\_\_\_