Behavioral Sciences Regulatory Board
700 SW Harrison St. Suite 420
Topeka, KS 66603-3929
Max L. Foster, Jr., Executive Director

Kansas
Behavioral Sciences
Regulatory Board

Phone: 785-296-3240
Fax: 785-296-3112
www.ksbsrb.ks.gov
Laura Kelly, Governor

INSTRUCTIONS FOR CLINICAL PROFESSIONAL COUNSELING LICENSURE
LCPC

1. Before you begin to complete the application materials, please read all instructions and review the statutes and regulations so that you will understand exactly what information is being requested. The statutes and regulations can be found either in the rules and regulations handbook or from our website, www.ksbsrb.org.
2. Your completed application packet shall be submitted to the BSRB and should include the following:
   If you are currently an LPC in Kansas, you will need to submit the following documentation:
   - ☐ The completed application form (pages 1 -4);
   - ☐ The correct application fee made payable to the BSRB by check, money order, or credit card;
   - ☐ Post Graduate Supervisor Attestation(s).

   If you are not currently an LPC in Kansas, you will also need to additionally submit the following:
   - ☐ Your official transcript;
   - ☐ The three (3) completed Professional Reference Forms;
   - ☐ The Out-of-State Clearance Form, if you are or have been licensed in another state;
   - ☐ The Graduate Practicum Review Form;
   - ☐ The Academic Background Form;
   - ☐ Exam scores, if applicable.

3. Answer all questions completely and accurately. The burden of proof in satisfying to the Board that you are eligible for licensure is upon you. If you have been convicted of a felony or if there have been other past or current events that potentially raise questions about your ability to merit the public trust, you may be required to appear before the Board to explain these matters.
4. Type or print your responses in ink.
5. The correct application fee must accompany your application. Your check or money order should be made payable to the "Behavioral Sciences Regulatory Board" or "BSRB". **ALL FEES ARE NON-REFUNDABLE**. The application fee is $50.00.
6. As part of the application process, each applicant is required to provide an official transcript (if we don't already have one) from the Registrar's office of the college or university where your degree was granted. Please have the school send the transcript directly to the Board office. **We will not accept transcripts sent directly from the applicant.**
7. **If you are currently an LPC in Kansas, skip to #8. If not, you need to review the following:**
   a) As part of your completed application packet, you are required to submit three (3) completed Professional Reference Forms. After completing Section 1, mail these forms directly to each of the three individuals that will serve as your professional references. Each of your references should complete the reference form and return it to you. You will then include these reference forms with your application and any other required material to the BSRB. NOTE: The individuals providing a reference should seal the envelopes and then sign the back of the sealed envelopes so that the Board is assured of the confidentiality and integrity of the referencing process. **The Board will NOT accept references that are not in sealed, signed envelopes.**
   b) By regulation, one of your references must be from a Licensed Clinical Professional Counselor (LCPC).
   c) One of the references must be from the individual(s) who provided the direct clinical supervision of your on-site graduate program practicum or internship. If this person is unavailable, the graduate program director or any person with knowledge of the applicant's practicum shall submit the reference.
   d) Tthe professional references shall be familiar with your work as a counselor and must be able to address the applicant's professional conduct, competence, and merit of the public trust. They cannot be related to you.
8. You will need to have your clinical supervisor(s) complete the post-graduate attestation form(s).
9. The Board cannot determine whether you are eligible to sit for the examination until all the application materials have been received and approved by the BSRB.
10. If you have not already passed the National Counselor's Exam (NCE) and the National Clinical Mental Health Counselor's Exam (NCMHCE), upon eligibility, you will receive information for scheduling/contacting the exam center.
11. If you are or have ever been licensed, registered, or certified as a professional counselor in another state, please have the Out-of-State Clearance Form completed by your former state board. You will need to send the Out-of-State Clearance Form to the state(s) where you were licensed, registered, or certified as a professional counselor. They should return this form directly to us.

Please allow 30 days for review of your application. You may now **check the status of your application on our website** www.ksbsrb.ks.gov, under *"Services."*

Behavioral Sciences Regulatory Board
700 SW Harrison St. Suite 420
Topeka, KS 66603-3929
Max L. Foster, Jr., Executive Director

Kansas
Behavioral Sciences
Regulatory Board

Phone: 785-296-3240
Fax: 785-296-3112
www.ksbsrb.ks.gov
Laura Kelly, Governor

APPLICATION FOR LICENSURE AS A LICENSED CLINICAL PROFESSIONAL COUNSELOR: LCPC

Application Fee: $50.00 check, money order, or credit card made payable to BSRB

I. Identifying information: (Please type or print clearly in ink)

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

Maiden/Other names used: _____ **Gender**: _____

Date of Birth: _____ **Social Security Number:** _____ (**Note:** Your social security number is required pursuant to 42 U.S.C.S. § 666(a)(13), K.S.A. 74-148 and K.S.A. 74-139, and may be used for child support enforcement purposes or provided to the Kansas director of taxation upon request.)

Ethnic Information: (Optional) African American _____ Native American _____ Asian Indian _____ Asian-Other _____
Hispanic _____ Pacific Islander _____ White – Non Hispanic _____ Other _____
(Please Specify)

Languages that you speak: (Optional) English _____ Spanish _____ Sign _____ Other _____
(Please Specify)

Preferred E-Mail Address: _____ **Preferred Mailing:** Home____ Business____

Home Phone: _____ **Cell Phone (optional):** _____

Home Address:_____ **Apartment Number:**_____

City: _____ **State:** _____ **Zip+4:**_____

Business Name: _____ **Business Phone:** _____

Business Address: _____ **Suite Number:** _____

City: _____ **State:** _____ **Zip+4:**_____

Address of Record: (**Note:** The address of record is not required. It is a separate address that will be kept on file to be given out when requested by the public through the Kansas Open Records Act. If you do not indicate an address of record, your preferred mailing address will be used.)

Street Address: _____

City: _____ **State:** _____ **Zip+4:**_____

II. General Background Information:

A. Have you ever filed any application for licensure or registration in Kansas? Yes____No____
If "yes", please answer the following questions:

1. When:_____For which credential:_____
2. Under what name:_____

B. Do you currently hold, or have you ever held a certificate, registration or license to practice in the behavioral or health sciences in another state or jurisdiction? Yes____No____
If "yes", please answer the following questions:

1. When:_____ For which credential:_____
2. Under what name:_____
3. In which state or jurisdiction:_____

If you currently hold, or have ever held a certificate, registration, or license to practice in one of the behavioral or health sciences in another state or jurisdiction, you will need to have the former state Board(s) complete an Out-of-State Clearance Form. They should send the completed form directly to us.

III. Merit of the Public Trust:

A. Please answer the following questions. **Note: If the answer to any of the items 1 through 9 in this section is "Yes", submit as part of your application a signed, dated type-written explanation that gives specific details including disposition of the matter.**

1. Have you ever been charged with or convicted of a felony or misdemeanor other than a traffic violation? Yes____No____
2. Have you ever had a complaint filed with a professional association or a counselor certifying, licensing, or registering body against you for alleged unethical behavior or unprofessional conduct? Yes____No____
3. Have you used any alcohol, narcotic, barbiturate other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent within the last 2 years? Yes____No____
4. Have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice behavioral sciences with reasonable skill and safety within the past 2 years? Yes____No____
5. Have you used controlled substances which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the direction of a licensed health care provider within the past 2 years? Yes____No____
6. Have you ever had disciplinary action taken against you for unethical behavior, unprofessional conduct or any other grounds? Yes____No____
7. Has any state, jurisdiction, providence, or professional organization denied your application for credentials or professional membership? Yes____No____
8. Have you ever been sued for malpractice, or agreed to pay a settlement in a malpractice suit? Yes____No____
9. Has any governmental agency ever substantiated allegations made against you for physical, mental or emotional abuse or neglect, sexual abuse, or exploitation of (1) a child, (2) a resident of an adult care home, medical care facility, psychiatric hospital or state institution for the mentally retarded, or (3) an adult? Yes____No____

If you are currently licensed as an LPC in Kansas, you may skip over Section IV and proceed to Section V--Supervised Post Graduate Experience.

IV. Educational Background:

A. **Transcript(s):** As part of the application process, each applicant is required to provide an official transcript from the Registrar's office of the college or university where your degree was granted. Please direct the school to send the transcript directly to the Board office. We will not accept transcripts sent directly from the applicant.

B. List all accredited colleges or universities you have attended at the graduate level:

INSTITUTION	DATES OF ATTENDANCE		MAJOR AND/OR CONCENTRATION	DEGREE RECEIVED	DATE DEGREE CONFERRED
	FROM	TO			

C. Give other name(s) under which your coursework was taken or your degree was conferred, if different from the name you use now:

_____

D. Submit at the time of application, the completed Academic Background Form

E. At the time of application, submit in the unopened envelope that has been signed or stamped by the graduate program director, the completed Graduate Practicum Review Form. Note: This form must be completed by the counseling program director from the college or university that academically supervised the masters degree counseling practicum experience.

F. INFORMATION REGARDING YOUR CLINICALLY ORIENTED PRACTICUM EXPERIENCE:

1. Name of Agency:_____
2. Address of Agency:_____
3. Name of Practicum Supervisor:_____
4. Total Number of Hours in Practicum experience:_____
5. Briefly describe your responsibilities in the practicum experience:

_____

_____

_____

G. At the time of application, submit 3 professional references in the unopened envelopes that have been signed across the seal by each reference, including the reference from the individual who provided the direct clinical supervision of your on-site graduate program practicum or internship. It this person is not available, the graduate program director, or anyone with knowledge of the practicum shall submit the reference. One of these references must be from a Licensed Clinical Professional Counselor (LCPC). All of the references cannot be related to you, and they must be able to attest to your professional competency and character.

H. Provide the names and mailing addresses of the three individuals that completed the Professional Reference Forms on your behalf. **Please place an asterisk/star (*) next to the person(s) who provided the direct supervision of your on-site graduate program practicum or internship.**

Name:_____

Address:_____

Name:_____

Address:_____

Name:_____

Address:_____

V. Supervised Post-Graduate Work Experience:

A. List the name and current address of the supervisors that have submitted post-graduate supervisors' attestations in support of your application for licensure, the settings where the experience was gained, and the dates of the experience:

Name of Supervisor Current Address Setting Experience Dates of Employment

_____

_____

_____

VI. Examination:

A. If you have not previously taken the National Counselor's Exam (NCE) developed by the National Board for Certified Counselors (NBCC) and achieved a passing score(s), you will be notified in writing if you are eligible to register and sit for the examination. Applicants must first satisfy the educational requirements in order to be authorized by the Behavioral Sciences Regulatory Board (BSRB) to register for the exam.

1. Have you previously passed the NCE exam? Yes____No____ **If "yes", answer the following question:**

   a) Location and date exam was taken:_____

B. If you have not previously taken the National Clinical Mental Health Counselors Exam (NCMHCE) developed by the National Board for Certified Counselors (NBCC) and achieved a passing score, you will be notified in writing if you are eligible to register and sit for the exam. Applicants must first satisfy the educational requirements in order to be authorized by BSRB to register for the exam.

1. Have you passed the NCMHCE exam? Yes____No____**If "yes", answer the following question:**

a) Location and date exam was taken:_____

C. Arrange for the Board's receipt of the official test scores by requesting that the National Board of Certified Counselors (or the out-of-state credentialing board) send the scores directly to you in an envelope that is signed (or officially stamped) across the sealed envelope. At the time of making application, submit the test scores in the unopened, sealed, signed envelope.

VII. Applicant's Attestation:

A. I have reviewed the licensure eligibility requirements prior to submitting this application. Yes____No____
B. I have completed the application materials and procedures honestly and in good faith. Yes____No____
C. I understand that the members and staff of BSRB are compelled by law to uphold, implement and enforce the licensure statutes and regulations as written. Yes____No____
D. I understand that all state records pertaining to application and licensure may be used to conduct research or program evaluation, but any such research will not personally identify the applicants or licensees, either directly or indirectly. Yes____No____
E. I understand that the Board has the statutory authority to refuse to grant licensure to, or may suspend, revoke, condition, limit, qualify, or restrict the license of any individual who has knowingly made a false statement on a BSRB form required for licensure or licensure renewal. Yes____No____
F. I **have read** and am familiar with the statutes and regulations governing the practice of clinical professional counseling in Kansas. Yes____No____
G. I understand that **once the Board receives my application I am bound by, and will abide by the statutes and regulations** governing the practice of clinical professional counseling in Kansas. Yes____No____

Signature:_____Date:_____

NAME or ADDRESS CHANGE: It is the applicant's responsibility to notify the Board in writing of any name or address change that might occur during the application process.

Kansas
Behavioral Sciences
Regulatory Board

APPLICATION FOR LICENSURE AS A LICENSED CLINICAL PROFESSIONAL COUNSELOR: LCPC

Graduate Practicum Review

Instructions for Applicant: Complete section 1 and send to the Graduate Program Director of the counseling program for completion. Graduate Practicum Review forms **shall be submitted in the unopened signed and sealed envelopes by the applicant at the time of application**.

I. Section A: To be completed by the Applicant:

A. Applicant's Name:_____ Social Security #: _____

B. Date of Birth:_____ Degree and Graduation Date:_____

C. Educational Institution:_____ Graduate Program Director:_____

II. Section 2: To be completed by the Graduate Program Director and returned to the applicant in a sealed envelope signed across the seal:

Instructions for the Graduate Program Director:
The above named applicant has applied to the Kansas Behavioral Sciences Regulatory Board (BSRB) for licensure as a clinical professional counselor. In order for the Board to make a determination as to whether the applicant meets educational qualifications pursuant to K.S.A. 65-5804 as defined in K.A.R. 102-3-3a, the items listed below need to be completed by the graduate program director and ***returned to the applicant in a sealed envelope with your signature across the seal.***

A. What regional accreditation is held by your university that awarded the applicants masters or doctoral degree?

_____

B. What professional accreditation (if any) is held by the graduate program completed by the applicant?

_____

C. Please complete the following questions regarding the above listed applicant's practicum.

1. As part of the applicant's graduate program did the applicant satisfactorily complete a graduate level supervised clinical practicum? Yes____ No____

2. Was this a clinical experience which included studies in the application and practice of the theories and concepts presented in formal study? Yes____ No____

3. Did the applicant receive supervision during their practicum experience: Yes____ No____

If you answered "NO" to any of these questions please explain on a separate sheet of paper.

4. How many hours of face-to-face client contact, conducting psychotherapy and assessment, with individuals, couples, families, and/or groups did the applicant complete during this practicum? _____

I hereby affirm that to the best of my knowledge all answers to the above items are true and correct.

Print:_____Date:_____
Graduate Program Dean or Director

Signature:_____
(No Stamps Please)

Kansas
Behavioral Sciences
Regulatory Board

APPLICATION FOR LICENSURE AS A CLINICAL LICENSED PROFESSIONAL COUNSELOR: LCPC

Academic Background Form

Name:_____Date:_____

Social Security Number:_____Date of Birth:_____

Date of Conferral of Graduate Degree(s):_____

List level of degree(s) conferred and field/department of study:_____

University:_____City/State:_____

INSTRUCTIONS: This form is to be completed by the applicant and submitted at the time of application. To be considered toward the educational requirements, the applicant's reported coursework must be graduate level academic coursework that has been taken for graduate level academic credit.

A total of 60 semester hours of graduate coursework is required. Forty-five semester hours of graduate counseling coursework must be distributed across the following ten categories. It should be noted that there should be a minimum of at least two discrete and unduplicated semester hours or their academic equivalent, neither of which may be taken by independent study, reported in each area.

Each course may be reported in only one category, where it most accurately fits by course content. If the course title does not clearly reflect the category where you are reporting a particular course, submit at the time of application copies of the course catalog description and syllabus for any such course(s).

The following activities shall **NOT** be reported, substituted for or counted toward the coursework requirements:
1. coursework taken for undergraduate credit; 2. academic coursework that was audited;
3. academic coursework that has a failing grade or that is incomplete;
4. nonacademic or correspondence coursework or training; 5. continuing education, in-service, or on-the-job training;
6. coursework that the board determines is not closely related to the field or practice of counseling.

Please remember that fifteen (15) graduate credit hours supporting diagnosis or treatment of mental disorders is required for the LCPC license. Please indicate in the far right column which hours you will be claiming to meet the 15 hour requirement.

Please see K.S.A. 65-5804a and K.A.R. 102-3-3a for more detail.

Note: If your college or university awarded quarter or trimester credit hours rather than semester hours, please indicate by putting a Q (for quarter hours) or a T (for trimester hours) adjacent to the reported number of credit hours throughout the form.

1. Counseling Theory and Practice includes courses in basic theories, principles and techniques of counseling and their applications to professional counseling settings.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

2. The Helping Relationship includes courses in philosophic basis of helping relationships; application of the helping relationship to counseling practice: and an emphasis on development of counselor and client self-awareness.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

3. Group Dynamics, Processes and Counseling Approaches and Techniques including courses in theories and types of groups, as well as descriptions of group practices, methods, dynamics and facilitative skills.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

4. Human Growth and Development includes courses that provide a broad understanding of the nature and needs of individuals at all developmental levels. Emphasis is placed on psychological, sociological, and physiological approaches. Also included are such areas as human behavior (normal and abnormal), personality theory and learning theory.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

5. Career Development and Lifestyle Foundations includes courses in vocational theory, the relationship between career choice and lifestyle, sources of occupational and educational information, approaches to career decision-making processes and career development exploration techniques.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

6. Appraisal of Individuals includes courses and training in the development of a framework for understanding the individual including methods of data gathering and interpretation, individual and group testing, and the study of individual differences.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

7. Social and Cultural Foundations includes courses in change-processes, ethnicity subcultures, families, gender issues, changing roles of women, sexism, racism, urban and rural societies, population patterns, cultural mores, use of leisure time and differing life patterns. These courses may come from such disciplines as the behavioral sciences, economics and political science.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

8. Research and Evaluation includes courses in statistics, research design, and development; development of program goals and objectives; evaluation of program goals and objectives; and, thesis preparation. A maximum of four hours may be counted for thesis.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

9. Professional Orientation includes courses in goals and objectives of professional organizations, codes of ethics, legal considerations, standards of preparation and practice, certification, licensing, and role identities of counselors and others in the helping professions.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

10. Supervised Practical Experience includes supervised practical experience that includes studies in the application and practice of the theories and concepts presented in formal study. Such experiential practice shall be completed under the close supervision of the instructor with the use of direct observation through one-way mirrors in a counseling laboratory through the use of video taped sessions, with audio tapes and written case notes.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

11. List below the additional fifteen (15) semester hours of credit to complete the sixty (60) semester hours of required graduate credit in counseling. You may include (in this category only) up to 6 hours of graduate semester hours of independent study that is related to the field or practice of counseling. You may also include, if not used in category 8, no more than 4 graduate semester hours for thesis research and writing.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

Kansas
Behavioral Sciences
Regulatory Board

APPLICATION FOR LICENSURE AS A LICENSED CLINICAL PROFESSIONAL COUNSELOR: LCPC

Professional Reference Form

Instructions: Section 1 is to be completed by the applicant and then sent to the referencing individuals for completion. Additional copies of this form may be made and used as needed by the applicant. **Completed Professional Reference forms shall be submitted in the unopened sealed envelopes by the applicant at the time of application**.
Section 2 is to be completed by the referencing individual who needs to seal the envelope and sign across the seal, and then returned to the applicant.

SECTION 1: This section is to be completed by the applicant.

To: (Name of reference-please print): _____

From: (Name of Applicant-please print):_____

I am applying for licensure as a clinical professional counselor in the State of Kansas and I am required to provide information to support that application. This form, bearing my signature, gives my consent and authorization to release any and all information and/or documents that may be material to an evaluation of my merit of the public trust. I authorize the Behavioral Sciences Regulatory Board (BSRB) and its representatives to consult with you regarding my professional competence, character, ethical qualifications, health status, ability to work cooperatively with others and other qualifications for licensure.

I release from liability any and all individuals, institutions and organizations that provided information to the BSRB or its representatives, in substantial good faith and without malice, concerning my merit of the public trust and my qualifications for licensure. I consent to the inspection by the BSRB and its representatives of all documents that may be material to an evaluation of my qualifications and competence. I understand that this consent for release of information will be in effect for a period of one year from the date of consent.

Please mail this completed form directly to me in a sealed envelope with your signature across the seal. **Please be certain to seal the envelope and sign over the seal.** I am responsible for submitting to BSRB the completed form in its sealed envelope as part of my application packet.

Signature of Applicant: _____ Date:_____

SECTION 2: The qualified referencing individual should answer all of the following questions to the best of their knowledge. The reference should then return this completed form to the applicant in a sealed envelope. The reference should sign his/her name over/across the seal on the envelope to insure confidentiality.

To qualify to serve as a professional reference, the referencing individual must be:

1. unrelated to the applicant;
2. able to address the applicant's professional conduct, competence and merit of the public trust;
3. one of the references must be from the individual who provided direct clinical supervision of the applicant's graduate practicum or internship; If this person is unavailable the graduate program director, or any person with knowledge of the applicant's practicum or internship on the basis of the student records may complete the form.
4. one of the references must be from a Licensed Clinical Professional Counselor (LCPC), or the equivalent if in another state.

Note: If you do not qualify to serve as a professional reference, please alert the applicant. If you do qualify to serve as a professional reference, please complete the form and return it, at your earliest convenience, to the applicant as indicated above. Please be sure to sign over the seal on the back of the sealed envelope before returning it to the applicant. Thank you.

I. Professional Reference's Qualifications:

A. Professional Reference's Name:_____

B. Do you hold a professional license? Yes____No____ **If "yes", please answer the following questions:**

1. Professional Licenses held:_____License #:_____

2. State of Issuance:_____Issuance Date:_____Expiration Date:_____

C. Agency:_____

D. Agency Address:_____

E. Phone:_____Fax:_____

F. Professional Reference's Educational Background:_____

G. Professional Title:_____

H. Were you the applicant's graduate program on-site practicum supervisor? Yes____No____

I. Are you related by blood or marriage to the applicant? Yes____No____
If "yes", state relationship:

_____

J. How long have you known the applicant? _____

K. What relationship (such as employer, supervisor, co-worker, instructor and the like) have you had with the applicant that has aided you in forming any opinion of his/her character:

_____

II. Professional Reference's Knowledge of Applicant:

A. Please consider the candidate's behavior in the following areas: good judgement, integrity, honesty, fairness, credibility, reliability, respect for others, respect for the laws of the state and nation, self-discipline, self-evaluation, initiative, and commitment to the profession of professional counseling and its values and ethics. Does the candidate, in your opinion, possess the moral standards and fitness required for working as a professional counselor? Yes____No____
If your answer is "no", please elaborate in detail on attached sheet.

B. Are you aware of any significant facts concerning the applicant's background that would reflect unfavorably on the applicant's character and fitness to practice clinical professional counseling? Yes____No____
If your answer is "yes", please state these facts in detail on an attached sheet.

C. Do you recommend the applicant for licensure to practice clinical professional counseling in Kansas?
If not, please elaborate in detail in an attached statement. Yes___No____

D. If you desire, please expand upon any of the foregoing answers or add any comments or information that you believe will aid the Behavioral Sciences Regulatory Board (BSRB) in evaluating the applicant's merit of public trust for licensure as a clinical professional counselor in Kansas. For such purpose you may supplement this Professional Reference Form by typewritten letter addressed to the Board and attached hereto.

III. Professional Reference's Attestation:

Reference's Attestation: I certify the foregoing answers and information furnished above are given in good faith with the understanding that it will be utilized for purposes of determining the applicant's merit of the public trust to be licensed and to practice as a professional clinical professional counselor in the State of Kansas. Any response or information I have provided is true and correct to the best of my knowledge and belief. Where I have relied upon other sources of information, they are only those which I believe to be accurate and reliable.

Printed Name:_____

Signature:_____Date:_____

Behavioral Sciences Regulatory Board
700 SW Harrison St. Suite 420
Topeka, KS 66603-3929
Max L. Foster, Jr., Executive Director

Kansas
Behavioral Sciences
Regulatory Board

Phone: 785-296-3240
Fax: 785-296-3112
www.ksbsrb.ks.gov
Laura Kelly, Governor

APPLICATION FOR LICENSURE AS A LICENSED CLINICAL PROFESSIONAL COUNSELOR: LCPC

Out-of-State Clearance Form

Instructions: Section 1 is to be completed by the applicant and then sent to the out-of-state board for completion. Additional copies of this form may be made and used as needed by the applicant.
Section 2 is to be completed by a representative of the out-of-state board, and then returned directly to us.

I. SECTION 1: This section is to be completed by the applicant.

A. Name:_____

B. Social Security #:_____Date of Birth:_____

C. Maiden or other name in which license was issued:_____

D. Type of Credential held in the other state:_____

E. Type or Field of Practice:_____

F. License Number:_____

G. Date of Issuance:_____Date of Expiration:_____

H. Level of Licensure (Baccalaureate, Masters, Doctorate):_____

II. SECTION 2: This section is to be completed by the State Board. Upon completion, please return this form to: BSRB, 700 S.W. Harrison St., Ste. 420, Topeka, KS 66603-3929.

A. Type of Credential (please circle applicable designation): Licensure____ Registration____ Certification____

B. Type or Field of Practice:_____

C. Lic/Reg/Cert Number:_____

D. Date Issued:_____Date of Expiration:_____

E. Level of Lic/Reg/Cert (Baccalaureate, Masters, Doctorate): _____

F. Is Lic/Reg/Cert in Good Standing? Yes____No____ **If "no", please state reason(s):**

_____

_____

G. Has the Lic/Reg/Cert ever been suspended or revoked? Yes____No____ **If "yes", please state reason(s):**

_____

_____

G. Does this license allow them to practice independently? Yes____No____

H. Education: Degree:_____Date Conferred:_____

University:_____Major/Concentration:_____

I. Did the applicant take the National Counselor's Examination (NCE) developed by the National Board for Certified Counselors (NBCC) to qualify for the Lic/Reg/Cert? Yes____No____ **If "yes", please complete the following:**

1. Date of Exam:_____ Passed ☐ Failed ☐
2. Exam Form #:_____Applicant's Exam ID#:_____

3. Applicant's Score: Raw:_____Scaled:_____

   Percent:_____Exam Mean:_____

   Standard Deviation:_____State Cutoff Score:_____

J. Did the applicant take the National Clinical Mental Health Counselor's Examination (NCMHCE) developed by the National Board for Certified Counselors (NBCC) to qualify for the Lic/Reg/Cert? Yes____No____ **If "yes", please complete the following:**

1. Date of Exam:_____Pass ☐ Failed ☐
2. Exam Form #:_____Applicant's Exam ID#:_____
4. Applicant's Score: Raw:_____Scaled:_____

   Percent:_____Exam Mean:_____

   Standard Deviation:_____State Cutoff Score:_____

K. Additional Comments:

Signature of State Board Representative:_____

Printed Name:_____

Official Title/Position:_____

Agency:_____

Mailing Address:_____
State City State Zip

Phone Number:_____Fax Number:_____

Date:_____

STATE SEAL

Kansas
Behavioral Sciences
Regulatory Board

APPLICATION FOR LICENSURE AS A CLINICAL PROFESSIONAL COUNSELOR: LCPC

Post-graduate Supervised Clinical Work Experience Supervisor's Attestation

Consent and Authorization to Release Information

Applicant's Name (Please print):_____

Supervisor's name (Please print):_____

Supervisor's Contact information (email and phone) _____

To my supervisor:

I am applying for license as a clinical professional counselor in the state of Kansas, and I am required to provide information in support of that application. This form bearing my signature, gives my consent and authorization to release any and all information and documents that may be material to an evaluation of my qualifications and competence.

I authorize the Behavioral Sciences Regulatory Board (BSRB) and its representatives to consult with you regarding my professional competence, character, ethical qualifications, ability to work with others, and any other qualifications for licensure.

I release from liability any and all individuals, institutions, and organizations that provided information to the BSRB or its representatives, in substantial good faith and without malice, concerning my professional conduct, ethics, character and other qualifications for licensure. I consent to the inspection by the BSRB of all documents that may be material to an evaluation of my qualifications and competence. I understand that this consent for release of information will be in effect for a period of one year from the date of consent.

Please return this completed attestation to me IN A SEALED ENVELOPE, WITH YOUR SIGNATURE OVER THE SEAL. I am responsible for submitting this completed reference, in the unopened sealed envelope as part of my application packet.

_____

Signature of Applicant Date

I. Post Graduate Clinical Supervisor's Attestation:

A. Setting where supervised postgraduate experience occurred:

1. Work site name:_____

2. Agency Address:_____

B. Dates of supervision provide by you: From_____ to _____
(provide a date. Do not write present/current)

II. Supervised hours while under your supervision:

A. Total number of post graduate clinical experience hours that involved direct, face to face clinical contact with clients providing psychotherapy and evaluation: _____
B. Total number of post graduate clinical experience hours that applicant completed including those hours reported in "A": _____
C. Average number of hours that applicant worked per week:_____
D. Total number of supervision hours provided to the applicant _____
E. Total number of supervision sessions provided to the applicant:_____
F. Total number of clinical hours of supervision provided individually to the applicant: _____
G. Total number of clinical hours of supervision provided in a group setting: _____
H. If clinical training was provided before July 1, 2000, did you provide at least 100 hours of administrative supervision? Yes___No____ **If "no", then how many administrative hours did you provide?_____**

III. Supervisor's Qualifications at the time supervision was provided:

A. Masters degree in: _____Year conferred: _____
B. License type and number:_____
C. Original date of issue:_____State:_____
D. If licensed in a state other than Kansas at the time supervision was provided, was this license the independent, clinical of licensure? Yes____No____
E. Were you under any disciplinary sanction, restriction or have any disciplinary action pending by a professional licensing or credentialing board at the time you provided supervision? Yes____No____
F. Did you have, at least in part, clinical responsibility for the supervisee's practice of professional counseling? Yes____No____
G. Did you have knowledge and experience with the supervisee's client population? Yes____No____
H. Did you have knowledge and experience with the methods of practice that the supervisee employs? Yes____No____
I. Were you a member of the staff in the supervisee's practice setting? Yes____No____
If "no", please answer the following questions:
   1. Did you have an understanding of the organization and administrative policies and procedures of the practice setting? Yes____No____
   2. Did you have an understanding of the mission of the practice setting? Yes____No____
   3. Was the extent of your of your responsibilities clearly defined with respect to the client cases to be supervised and your role, if any, in the personnel evaluation within the practice setting? Yes____No____
   4. Was the responsibility for payment for supervision clearly defined? Yes____No____
   5. If the supervisee paid you directly for supervision, did you maintain your responsibility to the client and the practice setting? Yes____No____
   6. Were the parameters of client confidentiality defined and agreed to by the client? Yes____No____

IV. Supervisor's requirements within the supervision process:

A. Did you meet in person with the supervisee to provide at least 1 hour of supervision session for every 15 hours of direct clinical client contact? Yes____No____
B. Did you provide at least 2 separate supervisory sessions per month? Yes____No____
C. If you provided supervision in a group format, how many supervisees were in those groups? _____
D. Did you provide oversight, guidance and direction of the supervisee's practice by assessing and evaluating the supervisee's performance? Yes____No____
E. Did you provide supervision in a process distinct from personal therapy, didactic instruction, or professional counseling consultation? Yes____No____
F. Did you ensure that your scope of responsibility and authority in the supervisee's practice setting was clearly defined? Yes____No____
G. Did you periodically evaluate the supervisee's role and their use of a theoretical base, and their use of professional counseling principles? Yes____No____
H. Did you provide supervision consistent with the education, training, experience, and ability of the supervisee? Yes____No____

V. Evaluation of the Applicant's supervised experience:

A. Please summarize the types of clients and client situations dealt with during the supervised experience:

_____

_____

_____

_____

B. Did the applicant complete all supervision goals and objectives? Yes____No____
If "no", please explain the reasons why all supervision goals and objectives were not met.

C. Please assess the applicant's performance in regard to the following components of the clinical professional counseling practice. **NOTE: If any of the following areas are rated as "unacceptable", please attach a statement outlining the basis for those ratings or for your reservations concerning licensing this applicant for independent clinical professional counseling.**

	Acceptable	Unacceptable
1. Assessment	_____	_____
2. Diagnosis	_____	_____
3. Treatment (psychotherapy)	_____	_____
4. Client centered advocacy	_____	_____
5. Consultation	_____	_____
6. Evaluation	_____	_____

D. Was the applicant's performance throughout the period of supervision consistently acceptable? Yes____No____

E. Please evaluate the applicant's merit of public trust in regard to the following qualities:

	Acceptable	Unacceptable
1. Good judgment:	_____	_____
2. Integrity:	_____	_____
3. Honesty:	_____	_____
4. Fairness:	_____	_____
5. Credibility:	_____	_____
6. Reliability:	_____	_____
7. Respect for others:	_____	_____
8. Respect for state and federal laws:	_____	_____
9. Self discipline:	_____	_____
10. Self-evaluation:	_____	_____
11. Initiative:	_____	_____
12. Commitment to professional counseling values/ethics:	_____	_____

F. Do you recommend this applicant for licensure at the independent, clinical level in professional counseling? Yes____No____ **If your response is "no", attach a statement that describes the basis for your denial.**

VI. Attestation of the Supervisor:

I have personally known the above applicant who has made application to the Behavioral Science Regulatory Board (BSRB) for licensure as a clinical professional counselor, and attest that said applicant has been practicing in the clinical setting as indicated and has been supervised by me in that specialty.

In signing this form, I understand that I am attesting that all the information provided in this attestation form is true, accurate, and submitted in good faith. I understand that in accordance with Kansas statutes, anyone knowingly making a false statement on any form of the BSRB shall be guilty of a Class B misdemeanor.

_____

Printed Name

_____

Signature

_____

Date

Behavioral Sciences Regulatory Board
700 SW Harrison St. Suite 420
Topeka, KS 66603-3929
Max L. Foster, Jr., Executive Director

Kansas
Behavioral Sciences
Regulatory Board

Phone: 785-296-3240
Fax: 785-296-3112
www.ksbsrb.ks.gov
Laura Kelly, Governor

Credit Card Payment Form

Only complete when paying by credit card.

The credit cards accepted are American Express, Discover, MasterCard and Visa.

Amount of Purchase: $_____

Credit Card: American Express _____ Discover _____
MasterCard _____ Visa _____

Credit Card Acct. # __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Credit Card Expiration Date ___ ___ / ___ ___

Name as it appears on the card _____

Signature: _____ Date_____

For Office Use Only:

Approval Number _____ **Date** _____