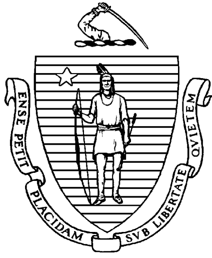


The Commonwealth of Massachusetts
**Division of Professional Licensure**
Board of Allied Mental Health and Human Services Professions
1000 Washington Street, Suite 710
Boston, MA 02118-6100

## APPLICATION INFORMATION FOR LICENSURE AS A MENTAL HEALTH COUNSELOR

Prior to completing the application, it is strongly recommended that all applicants obtain a copy of 262 CMR from the State Bookstore, Room 116, State House, Boston, MA 02133, (617) 727-2834, or online at www.mass.gov/dpl/boards/mh, to verify that all educational, exam, experience and supervision requirements are met. It is also recommended that applicants maintain a copy of their application for their records.

All applicants must pass the National Clinical Mental Health Examination (NCMHCE) in order to become licensed. You may obtain exam registration materials from the above website. If you have already passed the exam, submit an official score report (copy of your report is acceptable) with your application. Exam scores expire after 5 years, unless you currently hold a license in another state.

There is a non-refundable application fee of **$117.00**, which must be submitted in the form of a check or money order payable to the Commonwealth of Massachusetts. The application fee must accompany the completed application.

Application processing generally takes 4-6 weeks. If all licensure requirements have been met, notification will be sent, and the initial licensure fee will be assessed. If it is determined that your application does not meet the requirements, you will be notified in writing.

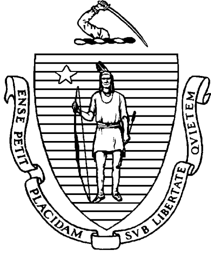
**As of January 1, 2010 all applicants must include two professional reference forms (provided in this application) completed by your two most recent supervisors.**

All application materials should be submitted to:

**Board of Allied Mental Health and Human Services Professions**
**1000 Washington Street, Suite 710**
**Boston, MA 02118-6100**

Should you have any questions about the application process, please contact Board staff at 617-727-3080 or via email at leija.t.meadows@state.ma.us.

**ALL APPLICANTS MUST COMPLETE AND INCLUDE THE CHECKLIST PROVIDED AT THE END OF THIS APPLICATION**



The Commonwealth of Massachusetts
**Division of Professional Licensure**
Board of Allied Mental Health and Human Service Professionals
1000 Washington Street, Suite 710
Boston, MA 02118-6100

# MENTAL HEALTH COUNSELOR LICENSURE APPLICATION

Please attach recent

2” x 2”

Head and shoulder photograph

NON-REFUNDABLE APPLICATION FEE:
**$117.00**

1. **Name:** ____________________________________________
Last First Middle Maiden

2. **Mailing Address:** ____________________________________________
No. Street Apt. No.

____________________________________________
City/Town State Zip Code

*NOTE: The mailing address above will be a matter of public record. It will appear on your license and will be used for all board correspondence. The mailing address and the business address provided below may be the same.*

3. **Business:** ____________________________________________
Company Name

____________________________________________
Street .

____________________________________________
City/Town State Zip Code

4. **Date of Birth** ________________

5. **Telephone No: Day** ___________________**Evening** ___________________

6. **Email:** ____________________________________________

7. **Pursuant to G.L c. 62, s. 49A, I have filed all state tax returns and paid all state taxes required under law: ☐ Yes ☐ No If no, please explain ________________________**

**________________________________________________________________________**

| **If you have ever held a license in another state, please complete the information below.** | | | | |
|---|---|---|---|---|
| **State** | **License Number** | **Issue Date** | **Current** | **Lapsed** |
| | | | | |
| | | | | |
| | | | | |
| **A letter of standing from each state listed must be sent to the Board separately.** | | | | |

## DISCIPLINARY HISTORY

***If you answer "Yes" to any of the following questions, please attach a full explanation.***

**A. Has any disciplinary action been taken against you by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes __ No __**

**B. Are you the subject of pending disciplinary action by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes __ No __**

**C. Have you voluntarily surrendered or resigned a professional license to a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes __ No __**

**D. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction? Yes ___ No ___**

**E. Have you ever been convicted of a felony or misdemeanor in the United States or any country or foreign jurisdiction, other than a traffic violation for which a fine of less than $200 was assessed? Yes ___ No ___**

**The Board is certified by the Criminal History Systems Board [ID# MAREG G] to access data about convictions and pending criminal cases. Those records-and other Federal and professional records-may be checked as part of your licensing process. No records are automatic disqualifiers; you will be given an opportunity to discuss any issues with the Board.**

| EDUCATION | | | | |
|---|---|---|---|---|
| **College or University** | **Degree** | **Year** | **Major** | **Credits** |
| **A. Masters** | | | | |
| **B. Post-Master's Credits (non-CAGS)** | | | | |
| **C. Second Master's Degree** | | | | |
| **D. CAGS or other post-master's certificate** | | | | |
| **E. Doctoral Degree** | | | | |
| **Official transcripts must be provided from all graduate institutions.** | | | | |

CERTIFICATION/MEMBERSHIP STATUS

**Do you have a current certification as a Certified Clinical Mental Health Counselor (CCMHC) through the National Board of Certified Counselors (NBCC)? ☐ No ☐ Yes**

**(If yes, attach an official notification from the NBCC of professional CCMHC standing and submit along with notarized application and official, sealed transcript)**

**(If no, please continue with the rest of the application)**

**Please list the date you passed the National Clinical Mental Health Counseling Examination (NCMHCE)**

_______/______/________

SUPERVISED CLINICAL EXPERIENCE:

**Practicum Pre-Master's Degree Clinical Experience**

Dates of Clinical Experience: From ______________________ to _________________________

Name and Address of Facility ______________________________________________________

________________________________________________________________________________

Your Title _______________________________________________________________________

Name of Supervisor___________________________ Supervisor's Title _____________________

**Internship Pre-Master's Degree Clinical Experience**

Dates of Clinical Experience: From ______________________ to _________________________

Name and Address of Facility ______________________________________________________

________________________________________________________________________________

Your Title_______________________________________________________________________

Name of Supervisor _____________________________ Supervisor's Title ___________________

**Post-Master's Degree Clinical Experience**

Dates of Clinical Experience: From ______________________ to _________________________

Name and Address of Facility ______________________________________________________

________________________________________________________________________________

Your Title _______________________________________________________________________

Name of Supervisor ___________________________ Supervisor's Title _____________________

**(Use additional paper to list additional sites and supervisors)**

## AFFIDAVIT:

Pursuant to G.L. c. 119 s. 51A and G.L. c. 112, s. 1A, my signature on this application is my certification that I understand my obligation to report the abuse or neglect of children.

The applicant named on this application agrees to abide by the rules and regulations for the licensing of Mental Health Counselors and attests that all statements are truthful and are made under the pains and penalties of perjury.

**SIGN IN THE PRESENCE OF A NOTARY PUBLIC**

| | |
|---|---|
| ________________________ | ____________ |
| *Signature of Applicant* | *Date* |
| ________________________ | ____________ |
| *Signature of Notary Public* | *Date* |
| ________________________ | ____________ |
| *Printed Notary Name* | *Date Commission Expires* |

## COURSEWORK REQUIREMENTS FORM
## (For applicants who completed their degrees PRIOR to July 1, 1998)

### REQUIRED COURSES

Must have all three courses. Each course taken can only be used to fill one requirement.

| **Course Content Area** | **Course Number on Transcript** |
|---|---|
| Counseling Theory, Practice and Techniques | |
| Human Psychology, Development, Behavior and learning, and Personality Theory | |
| Psychopathology, Abnormal Psychology, Abnormal Behavior, Etiology, Dynamics, and Treatment of Abnormal Behavior | |

### ELECTIVE COURSES

Must have six (6) of the following courses. Each course taken can only be used to fill one requirement.

| **Course Content Area** | **Course Number on Transcript** |
|---|---|
| Social and Cultural Foundations, Populations and Cultures | |
| Group Dynamics and Development | |
| Appraisal/Assessment/Crisis Intervention/DSMIIIR | |
| Research and Evaluation | |
| Professional Orientation Ethics/Legal Issues | |
| Psychopharmacology for Non-Medical Professions | |
| Addiction Disorders | |
| Marriage and Family/Human Sexuality and Lifestyle Choices | |
| Psychotherapeutic Techniques, Treatments and Modalities | |
| School Counseling/Career and Lifestyle Choices | |

**COURSEWORK REQUIREMENTS FORM**
**(For applicants who completed their degrees AFTER July 1, 1998)**

**Please review your transcript and specify the course number, which corresponds to the course content area listed below.**

**A minimum three-semester hour or four-quarter hour course must be taken in each of the ten areas. Each course can be used to fill only one requirement.**

| **Course Content Area** | **Course Number on Transcript** |
|---|---|
| Counseling Theory: theories of psychotherapy and counseling, theories of personality, treatment and prevention modalities | |
| Human Growth and Development: understanding the nature of human development | |
| Psychopathology: identification, diagnosis of and treatment planning for abnormal, deviant or psychopathological behavior | |
| Social and Cultural Foundations: issues and trends of a multicultural and diverse society | |
| Helping Relationships: counseling techniques, skills and procedures | |
| Group work: dynamics and processes | |
| Special Treatment Issues * | |
| Professional Orientation: ethical and legal issues in counseling | |
| Appraisal: psychological assessment and techniques | |
| Research and Evaluation | |

* Special Treatment Issues: e.g. psychopharmacology, substance abuse, school and career issues, marriage and family treatment, sexuality and lifestyle choices, treating special populations.

## ELECTIVE AREAS

Elective courses must include knowledge and skills in the practice of mental health counseling. Students should understand the scope of practice and learn the responsibilities in the clinical practice of mental health counseling.

Appropriate courses could include any of the special treatment issues listed above, as well as modalities for maintaining and terminating counseling and psychotherapy, psychopharmacology, consultation skills, outreach and prevention strategies, diagnosis and treatment issues, historical perspectives and multiple dimensions of mental health counseling, professional identity and practice issues, mental health regulations and policy, management of community programs. Similar related courses are also appropriate

PRE-MASTERS PRACTICUM FORM

**Name of Applicant:________________________________________________________**

INSTRUCTIONS: **Please duplicate this form as necessary. See following page for the definition of Approved Supervisor. *PLEASE PRINT CLEARLY OR TYPE AND SUBMIT ORIGINAL SIGNED DOCUMENT.***

MINIMUM REQUIREMENTS**: 100 hours which includes: 40 hours of direct client contact and 25 hours of supervision with a minimum of 10 hours of individual supervision and 5 hours of group supervision. (50 hours of supervision by a LMHC must be documented during either pre-masters or post-masters experience.)**

Remainder of Form to be completed by Approved Supervisor

**Name of Supervisor: ____________________________________________________**
**Supervisor's Title:________________________________________________________**
**Supervisor's License Type and Number: ______________________________________-**
**Supervisor's phone number:________________________**

**Name/Address of Clinical Facility:______________________________________________________--**
**__________________________________________________________________________________**

**Dates of Supervision of the Applicant: From:____/____/______ To: ___/_____/________(month/date/year)**

**The applicant worked _____ hours per week for _____weeks for a total of __________MH experience hours**

**Number of direct, face-to-face, clinical hours completed during this period: ____________________**

**Number of Supervision Hours provided during this period by this supervisor:**
**Individual: _________ Group: _________**

**Has any disciplinary action been taken against you by any of the following: (if yes, please submit detailed explanation)**
**Professional Association or Organization: Yes: ____ No: ____**
**Governmental Authority (e.g. Professional Licensing Board): Yes: ____ No: ____**
**Third Party Insurance Carrier: Yes: ____ No: ____**
**Credentialing Board: Yes: ____ No: ____**

**I have read the definitions of Approved Supervisor listed in 262 CMR and/or provided on the following page and believe that I qualify as an approved supervisor, including having at least 5 years of post-graduate clinical mental health counseling experience at the time that supervision was provided and/ or qualifying under category (f).** The undersigned states that under the pains and penalties of perjury, the above statements are true and correct.

______________________________________________________________________
**Signature of Approved Supervisor** **Date**

## Definition of an Approved Supervisor:

An approved supervisor is a mental health practitioner who meets the qualifications listed under subcategory (a), (b), (c), (d), or (e); all of these approved supervisors must have five (5) years of full time or the equivalent part time postgraduate clinical mental health counseling experience.

(a) LMHC; a currently licensed mental health counselor.

(b) A CCMHC; a Certified Clinical Mental Health Counselor who holds a currently valid certificate.

(c) A **licensed** mental health practitioner who:

1. has a master's degree in social work (LICSW) and is licensed for independent clinical practice;
2. has a master's degree in marriage and family therapy; (LMFT)
3. has a doctoral degree in clinical, counseling or developmental psychology or a medical degree with a sub-specialization in psychiatry (Psychologist or Psychiatrist).

(d) A **licensed** mental health practitioner who has:

1. a master's or doctoral degree in rehabilitation counseling, pastoral counseling, psychiatric nursing, developmental or educational psychology, or related fields **and;**
2. successfully completed a Supervised Clinical Experience; **and**
3. achieved a passing score on the NCMHCE licensure examination.

(e) An out of state supervisor who is a licensed mental health practitioner (in states that have licensure in their discipline) and who meets the qualifications for licensure for independent clinical practice in Massachusetts in his/her respective discipline.

(f) For the specific purpose of the college supervision (e.g. support seminars) of students in a practicum or internship, an approved supervisor may be a mental health practitioner who:

1. holds a teaching or supervisory position in an educational institution which trains mental health counselors; and
2. holds a graduate degree in mental health counseling or a related field.

Site supervisors for practica and internships must meet the qualifications for Approved Supervisor (a), (b), (c), (d), or (e).

***MASSACHUSETTS SUPERVISOR***: Please list which of the above describes your license:

________________________________________ *LICENSE/CERTIFICATE #* ______________________

***OUT OF STATE SUPERVISOR:*** Please attest that you meet the qualifications for individual clinical practice in Massachusetts by your signature below.

License # __________ State________ Licensure type________________________________________

APPLICANT'S NAME: __________________________________________________________________

PRE-MASTERS INTERNSHIP FORM

**Name of Applicant:**_______________________________________________________

INSTRUCTIONS: **Please duplicate this form as necessary. See following page for the definition of Approved Supervisor.** ***PLEASE PRINT CLEARLY OR TYPE AND SUBMIT ORIGINAL SIGNED DOCUMENT.***

MINIMUM REQUIREMENTS: **600 hours which includes: 240 hours of direct client contact and 45 hours of supervision with a minimum of 15 hours of individual supervision and 15 hours of group supervision.**
**(50 hours of supervision by a LMHC must be documented during either pre-masters or post-masters experience.)**

Remainder of Form to be completed by Approved Supervisor

**Name of Supervisor:** _____________________________________________________
**Supervisor's Title:**_______________________________________________________
**Supervisor's License Type and Number:** ______________________________________
**Supervisor's phone number:**________________________

**Name/Address of Clinical Facility:**_______________________________________________________
_____________________________________________________________________________________

**Dates of Supervision of the Applicant: From:____/____/______To:__/_____/_______(month/date/year)**

**The applicant worked _____ hours per week for _____weeks for a total of __________MH experience hours**

**Number of direct, face-to-face, clinical hours completed during this period:** ____________________

**Number of Supervision Hours provided during this period by this supervisor:**
**Individual:** _________ **Group:** _________

**Has any disciplinary action been taken against you by any of the following: (if yes, please submit detailed explanation)**
**Professional Association or Organization:** Yes: ____ No: ____
**Governmental Authority (e.g. Professional Licensing Board):** Yes: ____ No: ____
**Third Party Insurance Carrier:** Yes: ____ No: ____
**Credentialing Board:** Yes: ____ No: ____

**I have read the definitions of Approved Supervisor listed in 262 CMR and/or provided on the following page and believe that I qualify as an approved supervisor, including having at least 5 years of post-graduate clinical mental health counseling experience at the time that supervision was provided and/ or qualifying under category (f).** The undersigned states that under the pains and penalties of perjury, the above statements are true and correct.

_____________________________________________________________ ______________________________

**Signature of Approved Supervisor** **Date**

## Definition of an Approved Supervisor:

Approved Supervisor. An approved supervisor is a mental health practitioner who meets the qualifications listed under subcategory (a), (b), (c), (d), or (e); all of these approved supervisors must have five (5) years of full time or the equivalent part time postgraduate clinical mental health counseling experience.

(a) LMHC; a currently licensed mental health counselor.

(b) A CCMHC; a Certified Clinical Mental Health Counselor who holds a currently valid certificate.

(c) A **licensed** mental health practitioner who:

1. has a master's degree in social work (LICSW) and is licensed for independent clinical practice;
2. has a master's degree in marriage and family therapy; (LMFT)
3. has a doctoral degree in clinical, counseling or developmental psychology or a medical degree with a sub-specialization in psychiatry (Psychologist or Psychiatrist).

(d) A **licensed** mental health practitioner who has:

1. a master's or doctoral degree in rehabilitation counseling, pastoral counseling, psychiatric nursing, developmental or educational psychology, or related fields **and;**
2. successfully completed a Supervised Clinical Experience; **and**
3. achieved a passing score on the NCMHCE licensure examination.

(e) An out of state supervisor who is a licensed mental health practitioner (in states that have licensure in their discipline) and who meets the qualifications for licensure for independent clinical practice in Massachusetts in his/her respective discipline.

(f) For the specific purpose of the college supervision (e.g. support seminars) of students in a practicum or internship, an approved supervisor may be a mental health practitioner who:

3. holds a teaching or supervisory position in an educational institution which trains mental health counselors; and
4. holds a graduate degree in mental health counseling or a related field.

Site supervisors for practica and internships must meet the qualifications for Approved Supervisor (a), (b), (c), (d), or (e).

***MASSACHUSETTS SUPERVISOR***: Please list which of the above describes your license:

___________________________________________ ***LICENSE/CERTIFICATE #*** _______________________

***OUT OF STATE SUPERVISOR:*** Please attest that you meet the qualifications for individual clinical practice in Massachusetts by your signature below.

License # __________ State________ Licensure type__________________________________________

APPLICANT'S NAME: __________________________________________________________________________

POST-MASTERS CLINICAL EXPERIENCE FORM

**Name of Applicant:_______________________________________________________**

INSTRUCTIONS: **Please duplicate this form as necessary. See following page for the definition of Approved Supervisor.** ***PLEASE PRINT CLEARLY OR TYPE AND SUBMIT ORIGINAL SIGNED DOCUMENT.***

MINIMUM REQUIREMENTS: **2 years full-time or equivalent part-time experience. 3360 total hours which includes the following minimums: 960 direct client contact hours ( maximum 250 hours may be group), 130 hours of supervision ( 75 hours must be individual). Must have 1 hour of supervision for every 16 hours direct client contact.**
**(50 hours of supervision by a LMHC must be documented during either pre-masters or post-masters experience.)**

Remainder of Form to be completed by Approved Supervisor

**Name of Supervisor: ______________________________________________________**
**Supervisor's Title:________________________________________________________**
**Supervisor's License Type and Number: _____________________________________-**
**Supervisor's phone number:_______________________**
**Name/Address of Clinical Facility:_____________________________________________--**
**____________________________________________________________________________**

**Dates of Supervision of the Applicant: From:____/____/______To:__/_____/______(month/date/year)**

**The applicant worked _____ hours per week for _____weeks for a total of __________MH experience hours**

**Number of direct, face-to-face, clinical hours completed during this period:**
**Individual/Couples/Family: _________ Group: _______ Total:____________**

**Number of Supervision Hours provided during this period by this supervisor:**
**Individual: _________ Group: _________**

**Has any disciplinary action been taken against you by any of the following: (if yes, please submit detailed explanation)**
**Professional Association or Organization: Yes: ____ No: ____**
**Governmental Authority (e.g. Professional Licensing Board): Yes: ____ No: ____**
**Third Party Insurance Carrier: Yes: ____ No: ____**
**Credentialing Board: Yes: ____ No: ____**

**I have read the definitions of Approved Supervisor listed in 262 CMR and/or provided on the following page and believe that I qualify as an approved supervisor, including having at least 5 years of post-graduate clinical mental health counseling experience at the time that supervision was provided.** The undersigned states that under the pains and penalties of perjury, the above statements are true and correct.

_____________________________________________________________________________
**Signature of Approved Supervisor** **Date**

**Definition of an Approved Supervisor:**

An approved supervisor is a mental health practitioner who meets the qualifications listed under subcategory (a), (b), (c), (d), or (e); all of these approved supervisors must have five (5) years of full time or the equivalent part time postgraduate clinical mental health counseling experience.

(a) LMHC; a currently licensed mental health counselor.

(b) A CCMHC; a Certified Clinical Mental Health Counselor who holds a currently valid certificate.

(c) A **licensed** mental health practitioner who:

1. has a master's degree in social work (LICSW) and is licensed for independent clinical practice;
2. has a master's degree in marriage and family therapy; (LMFT)
3. has a doctoral degree in clinical, counseling or developmental psychology or a medical degree with a sub-specialization in psychiatry (Psychologist or Psychiatrist).

(d) A **licensed** mental health practitioner who has:

1. a master's or doctoral degree in rehabilitation counseling, pastoral counseling, psychiatric nursing, developmental or educational psychology, or related fields **and;**
2. successfully completed a Supervised Clinical Experience; **and**
3. achieved a passing score on the NCMHCE licensure examination.

(e) An out of state supervisor who is a licensed mental health practitioner (in states that have licensure in their discipline) and who meets the qualifications for licensure for independent clinical practice in Massachusetts in his/her respective discipline.

(f) For the specific purpose of the college supervision (e.g. support seminars) of students in a practicum or internship, an approved supervisor may be a mental health practitioner who:

5. holds a teaching or supervisory position in an educational institution which trains mental health counselors; and
6. holds a graduate degree in mental health counseling or a related field.

Site supervisors for practica and internships must meet the qualifications for Approved Supervisor (a), (b), (c), (d), or (e).

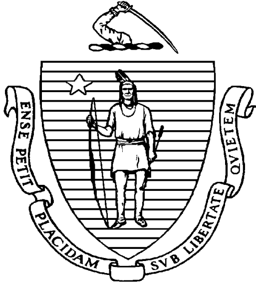
***MASSACHUSETTS SUPERVISOR***: Please list which of the above describes your license:

__________________________________________ *LICENSE/CERTIFICATE #* _______________________

***OUT OF STATE SUPERVISOR:*** Please attest that you meet the qualifications for individual clinical practice in Massachusetts by your signature below.

License # __________ State________ Licensure type_________________________________________

APPLICANT'S NAME: ______________________________________________________________________




The Commonwealth of Massachusetts
**Division of Professional Licensure**
Board of Registration of Allied Mental Health and
Human Services Professionals
1000 Washington Street, Suite 710
Boston, MA 02118-6100

## PROFESSIONAL REFERENCE FORM

**INSTRUCTIONS: All applicants must submit a minimum of TWO professional references. Please duplicate this form as necessary and provide it to your two most recent supervisors for completion. . *PLEASE PRINT CLEARLY OR TYPE AND SUBMIT ORIGINAL SIGNED DOCUMENT.***

Waiver of Liability: (Must be completed by licensure applicant)

**I, ____________________________________, hereby authorize ______________________________**
**(applicant's name) (reference's name)**
**(hereinafter "the reference") to provide the Board of Registration of Allied Mental Health and Human Service Professionals with all information of any kind that the reference may, in his or her absolute discretion, deem relevant to my qualifications as an applicant. I hereby release and discharge the professional reference from all claims arising out of the provision of such information.**

**Applicant's signature: ________________________________Date: ________________________**

Remainder of Form to be completed by Approved Supervisor

General information for references completing this form:

- The Board assumes that you, in recommending this applicant, will be willing to interpret or to substantiate to the Board your recommendation, should the Board desire to contact you. The Board will keep all information confidential to the maximum extent permitted by law.
- Complete this reference form only if the applicant has signed the above waiver of liability.

**Reference's name: __________________________________________ Title: ________________________**

**Reference's license type: _____________________ License number/Jurisdiction: ___________________**

**Length of time the reference has known the applicant: from __________ to __________**

**1.) Extent of knowledge of applicant's professional and ethical behavior:**
**☐Thorough ☐Moderate ☐Limited**

**2.) Based on my experience, to the best of my knowledge, the applicant is an individual of good moral character:**
**☐Yes ☐No** *(if no, please explain on a separate sheet)*

**3.) Quality and extent of endorsement:**
**☐Without reservation ☐With reservation ☐No recommendation**
***(if "with reservation" or "no recommendation", please explain on a separate sheet)***

______________________________________________________________________________
**Signature of Reference** **Date**

## Licensed Mental Health Counselor Application Checklist:
## (Be sure to include this with your completed application)

Prior to submitting an application, please make sure the following information is included and / or documented:

**__ Completed notarized application w/ photo**

**__ Check/Money Order for non-refundable application fee $117.00.**
Additional licensure fee will be assessed when all requirements have been met.

**__ Official, sealed Transcript(s) (Non-Baccalaureate degrees only)**

**__Completed Pre and Post Master's Experience forms (Originals only-- photocopies are not accepted)**

**__ Score report for the NCMHCE**

**__ If you have a current certification as a Certified Clinical Mental Health Counselor (CCMHC), official verification of status from NBCC.**

**__ If currently or previously licensed in another State, official letter of verification from that State in sealed envelope**

**__Two Professional Reference forms completed by two most recent supervisors (Originals only-- photocopies are not accepted)**

***Please be reminded: A required component of the application for licensure is that all applicants provide documentation of receiving 50 hours of approved LMHC supervision which may be from the Pre or Post Master's work and can be individual or group supervision.**

## MANDATORY

**My social security number is:**

☐☐☐-☐☐-☐☐☐☐ Pursuant to G.L. c. 62C, § 47A, the Division of Professional Licensure is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you comply with the tax laws of the Commonwealth.