



STATE OF ARIZONA
 BOARD OF BEHAVIORAL HEALTH EXAMINERS
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 Board Website: www.azbbhe.us
 Email Address: information@azbbhe.us

DOUGLAS A. DUCEY
 Governor

TOBI ZAVALA
 Executive Director

APPLICATION FOR BACCALAUREATE OR MASTER SOCIAL WORKER LICENSURE

CHOOSE ONE: BACCALAUREATE MASTER

PART I. PERSONAL INFORMATION

SOCIAL SECURITY NUMBER (MANDATORY)	DATE OF BIRTH (MM/DD/YYYY)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Mr. <input type="checkbox"/> Dr.		
LEGAL NAME	LAST NAME	FIRST NAME
		MIDDLE NAME
		MAIDEN
ALL OTHER NAME(S) OR ALIASES YOU HAVE BEEN KNOWN BY	CURRENT AZ BOARD LICENSE # (IF APPLICABLE)	
HOME ADDRESS	HOME PHONE	
CITY	STATE	ZIP
		CELL PHONE

NOTE: You must provide the Board with addresses and telephone numbers for all employers. Address and telephone information for the primary employer (below) becomes public information. **If you do not provide employer information, your home address and telephone number will become public information.** Please list additional employers on a separate sheet as needed.

AGENCY EMPLOYED BY	<input type="checkbox"/> EMPLOYEE	<input type="checkbox"/> INDEPENDENT	<input type="checkbox"/> OTHER _____
POSITION HELD			
BUSINESS ADDRESS			
CITY	STATE	ZIP	BUSINESS PHONE
PREFERRED E-MAIL ADDRESS			FAX NUMBER

Are you requesting special accommodations under the Americans With Disabilities Act (ADA) for taking the required examination? YES NO

PART III. EDUCATION INFORMATION

Starting with your undergraduate education, list **all** colleges and universities attended, whether completed or not, in chronological order.

COLLEGE OR UNIVERSITY (undergraduate and graduate)	LOCATION (City, State or Country)	DATES ATTENDED (Month/Yr to Month/Yr)	DEGREE EARNED (and date earned)	MAJOR

PART III, Section 1. OFFICIAL TRANSCRIPTS

You must include an official transcript for all education being submitted to meet requirements in a **SEALED** envelope from the educational institution. Transcripts submitted in open envelopes will not be accepted.

A. REQUIRED DEGREE CREDIT HOURS

Complete for the highest social work degree you hold.

College or University: _____

Degree Title (as indicated on transcript): _____

Date degree awarded: _____

B. ACCREDITATION OF SOCIAL WORK PROGRAM

NOTE: Complete for the social work degree listed above.

Please select one of the following:

- 1. The social work program I completed was accredited by the Council on Social Work Education (CSWE) on the date my degree was awarded.
- 2. The social work program I completed was NOT accredited by CSWE on the date my degree was awarded.

What is the accreditation date for the designation indicated in (B)(1) above? _____



APPLICANTS SELECTING (B)(1) ABOVE PROCEED TO PART IV - BACKGROUND INFO.

FOR APPLICANTS SELECTING (B)(2), YOUR EDUCATION DOES NOT MEET THE CURRICULUM REQUIREMENTS PURSUANT TO A.A.C. R4-6-401 AND YOU ARE NOT ELIGIBLE FOR SOCIAL WORK LICENSURE.

PART IV. BACKGROUND QUESTIONNAIRE

If the answer to any of the questions below is "YES", provide a complete explanation below.

QUESTIONS		
1.	Have you ever been denied a license, certificate, registration or membership by any state regulatory board, any professional or occupational credentialing authority or any professional association in Arizona or any other state?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.	Other than complaints filed by this Board, have you ever been or are you currently the subject of any complaint, investigation or disciplinary action against your license, certificate, registration or membership by any state regulatory board, any professional or occupational credentialing authority or any professional association in Arizona or any other state? If yes, please provide copies of the complaint and all final actions.	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.	Have you ever voluntarily surrendered, allowed to lapse, canceled or resigned your license, certificate, registration or membership in lieu of disciplinary proceedings or sanctions of any kind by any state regulatory board, any professional or occupational credentialing authority or any professional association in Arizona or any other state?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4.	Have you ever been arrested, charged with, convicted of or pled nolo contendere to a criminal offense, other than a minor traffic violation (DUI history must be reported), in any city, county, state, federal or tribal court, or in any other country? If yes, please provide copies of the police and court documents such as the police narrative, complaint, the pleadings and final order(s). <u>You must answer "yes" even if you received a pardon, the charges were dropped, the conviction was set aside, the records were expunged, or your civil rights were restored.</u>	<input type="checkbox"/> YES <input type="checkbox"/> NO
5.	Have you ever entered into any type of pretrial diversion or deferred prosecution agreement with a state or federal government? If yes, please provide a copy of your pretrial diversion agreement.	<input type="checkbox"/> YES <input type="checkbox"/> NO
6.	Have you ever been or are you currently a defendant in any type of civil or criminal action related to any professional services (i.e., malpractice)? If so, indicate whether you entered into a settlement agreement or were ordered to pay damages and whether such a suit is currently pending. Provide copies of the original complaint and response, any judgment entered and any settlement agreements.	<input type="checkbox"/> YES <input type="checkbox"/> NO
7.	Have you ever had any disciplinary action or sanctions of any kind taken against you by any behavioral health related employer in Arizona or any other state? If yes, please provide the name, address and telephone number of the employer, the name of your immediate supervisor and a description of the cause for disciplinary action or sanction.	<input type="checkbox"/> YES <input type="checkbox"/> NO
8.	Have you ever been involuntarily terminated or resigned in lieu of termination from any behavioral health position or related employment? If yes, please provide the name, address and telephone number of the employer, the name of your immediate supervisor and a description of the cause for the termination. If the cause of termination was due to a reduction in force, please include a copy of the letter advising you of the layoff.	<input type="checkbox"/> YES <input type="checkbox"/> NO
CONFIDENTIAL QUESTION		
9.	Have you received treatment within the last five years for use of alcohol or a controlled substance, prescription-only drug, or dangerous drug or narcotic, or a physical, mental, emotional, or nervous disorder or condition that currently affects your ability to competently and safely perform the essential functions of your profession? If so, provide the following: a. A detailed description of the use, disorder, or condition; and b. An explanation of whether the use, disorder, or condition is reduced or ameliorated because you're receiving ongoing treatment and if so, the name and contact information for all current treatment providers and for all monitoring or support programs in which you are currently participating. c. A copy of any public or confidential agreement or order relating to the use, disorder, or condition, issued by a licensing agency or health care institution within the last five years, if applicable.	<input type="checkbox"/> YES <input type="checkbox"/> NO

PART V. EMPLOYMENT HISTORY

Provide all employment for the previous ten years including an explanation of any breaks in employment of greater than one month. Copy sheet as needed.

PRESENT EMPLOYMENT	JOB TITLE	MM/DD/YY TO MM/DD/YY
NAME OF BUSINESS OR INSTITUTION (AGENCY OR ORGANIZATION) <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> INDEPENDENT CONTRACTOR <input type="checkbox"/> OTHER _____		
ADDRESS		
CITY, STATE, ZIP		TELEPHONE
NAME AND TITLE OF SUPERVISOR		
DESCRIPTION OF DUTIES PERFORMED		
REASON FOR LEAVING:	<input type="checkbox"/> RESIGNED – NEW POSITION	<input type="checkbox"/> RESIGNATION – OTHER (EXPLAIN)
<input type="checkbox"/> TERMINATION (EXPLAIN)	<input type="checkbox"/> RESIGNED IN LIEU OF TERMINATION (EXPLAIN)	
PRIOR EMPLOYMENT	JOB TITLE	MM/DD/YY TO MM/DD/YY
NAME OF BUSINESS OR INSTITUTION (AGENCY OR ORGANIZATION) <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> INDEPENDENT CONTRACTOR <input type="checkbox"/> OTHER _____		
ADDRESS		
CITY, STATE, ZIP		TELEPHONE
NAME AND TITLE OF SUPERVISOR		
DESCRIPTION OF DUTIES PERFORMED		
REASON FOR LEAVING:	<input type="checkbox"/> RESIGNED – NEW POSITION	<input type="checkbox"/> RESIGNATION – OTHER (EXPLAIN)
<input type="checkbox"/> TERMINATION (EXPLAIN)	<input type="checkbox"/> RESIGNED IN LIEU OF TERMINATION (EXPLAIN)	
PRIOR EMPLOYMENT	JOB TITLE	MM/DD/YY TO MM/DD/YY
NAME OF BUSINESS OR INSTITUTION (AGENCY OR ORGANIZATION) <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> INDEPENDENT CONTRACTOR <input type="checkbox"/> OTHER _____		
ADDRESS		
CITY, STATE, ZIP		TELEPHONE
NAME AND TITLE OF SUPERVISOR		
DESCRIPTION OF DUTIES PERFORMED		
REASON FOR LEAVING:	<input type="checkbox"/> RESIGNED – NEW POSITION	<input type="checkbox"/> RESIGNATION – OTHER (EXPLAIN)
<input type="checkbox"/> TERMINATION (EXPLAIN)	<input type="checkbox"/> RESIGNED IN LIEU OF TERMINATION (EXPLAIN)	

PART VI. EXAM INFORMATION

Have you previously passed the examination required for the license you are applying for in Arizona? Yes No

If yes, you must request that an official copy of your score report be sent to the Board directly from ASWB.

If not, you will be provided testing information once authorized to test.

PART VII. FEDERAL DATA BANK SELF-QUERY

The National Practitioner Data Bank (NPDB) retains information on behavioral health professionals. A self-query from NPDB is required to process your application. The self-query cannot be dated more than 90 days prior to applying for licensure, and must be submitted in an unopened envelope from the databank.

For information on obtaining your self-query, please visit www.npdb.hrsa.gov or contact the NPDB Customer Service Center at 1-800-767-6732.

I have attached a self-query in an unopened envelope that is dated not more than 90 days prior to my application.

PART VIII. PROFESSIONAL CREDENTIALS

Please list current or previous licenses or certifications issued by a state regulatory entity held as follows: any license or certification ever held in the practice of behavioral health; and any professional license or certification NOT in the practice of behavioral health held in the last ten years. Failure to disclose all licenses, certifications or registrations as required above may result in denial of your application or other appropriate action. It is not necessary to list licenses issued by the Board.

Title of Credential Held	State	Date Issued	Expiration Date	Credential #	Current Status

For all credentials listed above, attach a verification from the regulatory entity issuing the credential. The verification must include the following information:

- Professional’s name
- Credential title and number (if applicable)
- Credential issue and expiration date
- Credential status
- Whether there are pending complaints
- Past disciplinary actions

Applicants may use an online verification if it contains all required items above. If not, applicant must obtain verification from the regulatory entity using the form in **PART VIII, Section 1**.

PART VIII, Section 1. VERIFICATION OF CREDENTIALS

NOTE: Applicant will submit one completed form for EACH credential listed in **PART VIII**. An applicant may submit an online verification as long as ALL required information is included on the official state website verification.

Part A: TO BE COMPLETED BY THE APPLICANT

To: _____
State Regulatory Agency (please print)

DOB: _____ SSN: _____

From: _____
Applicant's Name (please print) Telephone

Applicant's Address

I have applied to the Arizona Board of Behavioral Health Examiners for licensure as a behavioral health professional. I hereby authorize you to release the information requested below.

Applicant's Signature

Date

THE APPLICANT MUST MAIL THIS FORM TO THE APPROPRIATE STATE CREDENTIALING AGENCY FOR VERIFICATION BEFORE SUBMISSION TO THE ARIZONA BOARD OF BEHAVIORAL HEALTH EXAMINERS

Part B: TO BE COMPLETED BY THE STATE CREDENTIALING AGENCY

Professional's Name _____

Credential Held _____

Credential Number _____

Issuance Date _____

Expiration Date _____

Current Status _____

Pending Complaints YES NO

Number of Past Disciplinary Actions _____

Pending complaints are not public information in our jurisdiction

Attach explanation of all disciplinary actions.

Form Completed By Date

Please Include State Seal

Credentialing Agency Name and Phone Number

PART IX. CERTIFYING STATEMENT

I give my permission for the Arizona Board of Behavioral Health Examiners ("Board") to secure additional information concerning me or my statements in this application from any person or source the Board deems necessary. My signature below authorizes entities in possession of applicable information to release such information to the Board.

I will notify the Board in writing within 10 working days if charged with a misdemeanor that may affect patient safety or a felony pursuant to A.R.S. § 32-3208. Additionally, I will report to the Board any updates to the information provided in this application after submission including, but not limited to: contact information, employment changes, and answers to background information questions.

I certify that by submitting this application for licensure, I have read and understand the Board's rules and statutes and agree to abide by them as an applicant and as a licensee in the event I am approved for licensure.

I, _____ certify under penalty of perjury that all information contained in my application, including all supporting documents, is true and correct to the best of my knowledge and belief, and with full knowledge that any false statements or misrepresentations made in this application may be grounds for refusal, subsequent revocation or suspension of my license(s), or other disciplinary action.

Signature of Applicant
(must be signed in front of a notary)

Date

TO BE COMPLETED BY NOTARY	
Subscribed and sworn before me this _____ day of _____, 20____, in the State	
of _____ and County of _____.	
Notary Public _____	My Commission Expires _____
Notary Seal	

IS MY APPLICATION READY TO SUBMIT?

I HAVE INCLUDED ALL OF THE FOLLOWING DOCUMENTS:

- Completed Application Form
- Non-refundable application fee of **\$250.00** (money order, certified or cashier’s check, or proof of online credit card payment accepted). If you are also sending payment for a criminal history background check, they may NOT be combined into one payment.
- A copy of legal document establishing legal residency (if not already on file and still current)
- A copy of my driver’s license, state-issued ID or social security card
- A copy of my current DPS fingerprint clearance card (front and back), or a complete set of fingerprints on a card obtained from the Board (if not already on file). If submitting a complete set of fingerprints, you must include a payment of **\$40.00** for the criminal history background check (personal check, money order, certified or cashier’s check, or proof of online credit card payment accepted). **NO PAYMENT** is needed with a current DPS fingerprint clearance card.
- An official transcript **in a sealed envelope**
- Data bank report (self-query) **in a sealed envelope from the data bank**
- Verification of professional credentials

SUBMIT TO:

Arizona Board of Behavioral Health Examiners

1740 West Adams St., Suite 3600

Phoenix, Arizona 85007

Office Hours: Monday – Friday 8:00 am to 5:00 pm, excluding state holidays

FOLLOWING SUBMISSION:

- Confirm receipt of the application on the Board’s website by:
 - Clicking on “Verifications,” then “Check for pending applications”
 - Search by your last name. Your application will display as “Pending” if received
- Staff will provide updates on the progress of your application including when your application is administratively and substantively complete, if additional information is needed, and next steps in the process
- Staff will notify you of any Committee or Board meetings at which your application will be reviewed
- If applicable, staff will provide information on taking an exam required for licensure
- Staff will direct you how/when to send your issuance fee once you have been recommended for licensure
- You must notify the Board if any information provided in the application changes including, but not limited to:
 - Contact information
 - Employment changes
 - Answers to background information questions.
- You must notify the Board in writing within 10 working days if charged with a misdemeanor that may affect patient safety or a felony pursuant to A.R.S. § 32-3208

Pursuant to A.R.S. § 41-1030, the following information must accompany all license applications.

41-1030. Invalidity of rules not made according to this chapter; prohibited agency action; prohibited acts by state employees; enforcement; notice

- A. A rule is invalid unless it is made and approved in substantial compliance with sections 41-1021 through 41-1029 and articles 4, 4.1 and 5 of this chapter, unless otherwise provided by law.
- B. An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition.
- C. An agency shall not:
 - 1. Make a rule under a specific grant of rulemaking authority that exceeds the subject matter areas listed in the specific statute authorizing the rule.
 - 2. Make a rule under a general grant of rulemaking authority to supplement a more specific grant of rulemaking authority.
- D. This section may be enforced in a private civil action and relief may be awarded against the state. The court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the state for a violation of this section.
- E. A state employee may not intentionally or knowingly violate this section. A violation of this section is cause for disciplinary action or dismissal pursuant to the Agency's adopted personnel policy.
- F. This section does not abrogate the immunity provided by section 12-820.01 or 12-820.02.
- G. An agency shall prominently print the provisions of subsections B, D, E and F of this section on all license applications, except license applications processed by the corporation commission.
- H. The licensing application may be in either print or electronic format.