STATE OF ARIZONA
BOARD OF BEHAVIORAL HEALTH EXAMINERS
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DOUGLAS A. DUCEY
Governor

TOBI ZAVALA
Executive Director

APPLICATION FOR CLINICAL SOCIAL WORKER LICENSURE

PART I. PERSONAL INFORMATION

SOCIAL SECURITY NUMBER (MANDATORY)	DATE OF BIRTH (MM/DD/YYYY)	GENDER ☐ MALE ☐ FEMALE
☐ MRS. ☐ MS. ☐ MR. ☐ 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 #	
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 ☐ EMPLOYEE ☐ INDEPENDENT ☐ 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 II. LEGAL RESIDENCY

Arizona Revised Statutes § 41-1080 requires, in general, that a person applying for a license must submit documentation to the licensing agency that satisfactorily demonstrates that the applicant is lawfully present in the United States.

Section 1. Citizenship or national status declaration

1. Are you a citizen or national of the United States? ☐ Yes ☐ No (if no, complete Section 2)
   - If yes, attach a legible copy of the front and back (if applicable) of your proof of citizenship document. To view a list of acceptable documents, see List A in the Application Resource Guide.
   - Name of document provided: _____ Expiration Date: _____

Section 2. Alien status declaration

For applicants who are NOT citizens or nationals of the United States, please indicate alien status by checking the appropriate box below. Attach a legible copy of the front and back (if applicable) of a document that evidences your status. To view a list of acceptable documents, see List B in the Application Resource Guide.

- Name of document provided: _____ Expiration Date: _____

"Qualified Alien" Status (8 U.S.C. §§ 1621(a)(1), -1641(b) and (c))

☐ 1. An alien lawfully admitted for permanent residence under the Immigration and Nationality Act (INA).
☐ 2. An alien who is granted asylum under Section 208 of the INA.
☐ 3. A refugee admitted to the United States under Section 207 of the INA
☐ 4. An alien paroled into the United States for at least one year under Section 212(d)(5) of the INA.
☐ 5. An alien whose deportation is being withheld under Section 243(h) of the INA.
☐ 6. An alien granted conditional entry under Section 203(a)(7) of the INA as in effect prior to April 1, 1980.
☐ 7. An alien who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980).
☐ 8. An alien who is, or whose child or child's parent is a "battered alien" or an alien subjected to extreme cruelty in the United States.

Nonimmigrant Status (8 U.S.C. § 1621(a)(2))

☐ 9. A nonimmigrant under the Immigration and Nationality Act [8 U.S.C. § 1101 et seq.] Nonimmigrants are persons who have temporary status for a specific purpose. See 8 U.S.C. § 1101(a)(15).

Alien Paroled into the United States For Less Than One Year (8 U.S.C. § 1621(a)(3))

☐ 10. An alien paroled into the United States for less than one year under Section 212(d)(5) of the INA

Other Persons (8 U.S.C. § 1621(c)(2)(A) and (C))

☐ 11. A nonimmigrant whose visa for entry is related to employment in the United States, or
☐ 12. A citizen of a freely associated state, if section 141 of the applicable compact of free association approved in Public Law 99-239 or 99-658 (or a successor provision) is in effect [Freely Associated States include the Republic of the Marshall Islands, Republic of Palau and the Federate States of Micronesia, 48 U.S.C. § 1901 *et seq*.];
☐ 13. A foreign national not physically present in the United States.

Otherwise Lawfully Present (A.R.S. § 41-1080)

☐ 14. A person not described in categories 1–13 who is otherwise lawfully present in the United States. **PLEASE NOTE: The federal Personal Responsibility and Work Opportunity Reconciliation Act may make persons who fall into this category ineligible for licensure.** See 8 U.S.C. § 1621(a).

Section 3. Declaration

I declare under penalty of perjury under the laws of the State of Arizona that the answers and evidence I have given are true and correct to the best of my knowledge.

_____ _____
Applicant Signature Date

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 level of social work degree you hold (a minimum of a master degree is required).

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?	☐ YES ☐ 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.	☐ YES ☐ 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?	☐ YES ☐ 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). **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.**	☐ YES ☐ 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.	☐ YES ☐ 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.	☐ YES ☐ 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.	☐ YES ☐ 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.	☐ YES ☐ 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.	☐ YES ☐ NO

PART IV. BACKGROUND QUESTIONNAIRE – (cont'd)

Use the space below to provide a complete explanation for any "YES" answers above. Use additional paper if necessary, and include copies of relevant documents, including court and/or regulatory agency documents showing the disposition of disciplinary and court-related matters.

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. If you hold an LMSW from the Board, provide the work history since submission of your LMSW application. Copy sheet as needed.

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

PART VI. VERIFICATION OF SUPERVISED WORK EXPERIENCE

IMPORTANT COMPLETION INSTRUCTIONS FOR APPLICANT AND SUPERVISOR(S):

1. Applicant signs where indicated in section A and forwards to agencies/entities where supervised work experience was acquired *(form may be copied if more than one agency/entity will be reporting work experience).*
2. Employer or supervisor completes section B and has their signature notarized.
3. Form is returned to applicant in a sealed envelope with employer's/supervisor's signature written on seal.
4. Applicant submits sealed envelope with application.
5. Pursuant to A.A.C. R4-6-211, to meet supervised work experience requirements for licensure, supervision shall:
    a. Be acquired after completion of degree required for licensure.
    b. Be acquired after licensure or certification by a state regulatory entity for hours earned outside Arizona.
    c. Be acquired before January 1, 2006 if acquired in Arizona as an unlicensed professional practicing under an exemption provided in A.R.S. § 32-3271.

SECTION A: TO BE COMPLETED BY APPLICANT

ATTN: _____
Supervisor's name

_____
Name of the agency/entity where you obtained your supervised work experience

I hereby authorize the above-named agency/entity to release the requested information to the Arizona Board of Behavioral Health Examiners.

_____ _____
Applicant's signature Date

SECTION B: TO BE COMPLETED BY APPLICANT'S EMPLOYER OR SUPERVISOR

I certify that _____ (applicant name) was engaged in supervised work experience in the practice of clinical social work that met the Board's requirements as follows:

NOTE: If applicant is still employed, enter the "through" date for the period you are reporting.

Dates of supervised work experience: From _____ through _____
mm/dd/yy mm/dd/yy

NOTE: Indicate the exact number of hours in the reported period for each item below, NOT the minimum/maximum for licensure purposes. Applicants are required to demonstrate they have met the supervised work experience requirements pursuant to A.A.C. R4-6-403.

Total hours of **supervised work experience** in the practice of clinical social work:_____*
(**This number must equal the total of 1. and 4. below*)

1. Total hours of **direct client contact** involving the use of psychotherapy and psychoeducation:_____
2. Total hours of **direct client contact** (from line 1.) involving psychotherapy: _____
3. Total hours of **direct client contact** (from line 1.) involving psychoeducation: _____
4. Total hours of **indirect client contact** related to psychotherapy: _____
   (Examples of indirect client contact may be found in A.A.C. R4-6-101(34)).

The applicant was receiving clinical supervision during the period of supervised work experience reported above that met the Board's requirements: ☐ Yes ☐ No
(Clinical supervisors must complete Part VIII of this application documenting clinical supervision hours that occurred during the reported period of applicant's acquisition of supervised work experience)

SECTION B: TO BE COMPLETED BY APPLICANT'S EMPLOYER OR SUPERVISOR (cont'd)

Please provide the following for the agency/entity where work experience was acquired:

Agency/entity name: _____

Address: _____

Description of agency/entity practice setting: _____

_____

During the period of supervised work experience, the applicant was an: ☐ Employee ☐ Independent contractor

Did applicant have ownership interest in, operate, or manage the agency/entity above? ☐ Yes ☐ No

Applicant's position or title: _____

Describe below the applicant's specific work activities related to the direct and indirect client contact verified above:

_____

_____

_____

IMPORTANT: Attach a copy of the published job description for the position(s) the applicant held during the work experience reported above.

Please provide the following for the person verifying supervised work experience reported above:

Name: _____ License # *(if applicable):* _____

Title: _____ Telephone: _____

Relationship to applicant: ☐ Supervisor ☐ Owner of entity ☐ Other *(please explain below)*

_____

I, _____certify under penalty of perjury that all information contained in this verification, including all supporting documents, is true and correct to the best of my knowledge. I understand that any false statements or misrepresentations made in this verification may be grounds for disciplinary action against any license I hold, and may result in the Board not accepting the applicant's supervised work experience hours and/or denying their licensure application.

_____ _____

Employer/Supervisor signature Date

(must be signed in front of a notary)

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

PART VII. CLINICAL SUPERVISION

Pursuant to A.A.C. R4-6-404(B), an applicant for clinical social worker counselor licensure shall demonstrate:

1. A minimum of 50 hours of clinical supervision were provided by a Licensed Clinical Social Worker (LCSW) licensed by the Board, and
2. The remaining hours were provided by an individual qualified under A.A.C. R4-6-212(A), or
3. The hours were provided by an individual for whom an exemption was obtained under A.A.C. R4-6-212.01

A. Have you previously applied for and been granted an exemption by the Board? ☐ Yes ☐ No

- If yes, please attach a copy of the letter granting the exemption from the Board and skip to **PART VII, Section 2**.
- If no, please read the following information on requesting exemptions and submit the Clinical Supervisor Exemption Request with your application if necessary.

B. Does your clinical supervision meet one of the following requirements? ☐ Yes ☐ No

1. You are submitting at least 100 hours of clinical supervision provided by a Board Licensed Clinical Social Worker(s) who was/were employed at the same agency/entity as you were while acquiring supervised work experience; or
2. You are submitting at least 50 hours of clinical supervision provided by a Board Licensed Clinical Social Worker(s) who was/were employed at the same agency/entity as you were while acquiring supervised work experience, and the balance of the 100 hours of clinical supervision was provided by an individual(s) qualified under A.A.C. R4-6-212(A) who was/were employed at the same agency/entity as you while acquiring supervised work experience.
   - If yes, skip to **PART VIII**.
   - If no, you will need an exemption for your clinical supervision to be considered.

REQUESTING EXEMPTIONS

An applicant must submit the Clinical Supervisor Exemption Request to request an exemption to the clinical supervision requirements if any of the following occurred:

- Supervised work experience being used for licensure purposes was acquired outside of Arizona.
- Clinical supervision hours being used for licensure purposes were provided by an individual who was not employed by the agency/entity where the applicant acquired their supervised work experience (clinical supervisor was contracted by the agency/entity or applicant).
- Applicant does not have a minimum of 50 hours of clinical supervision provided by a Board Licensed Clinical Social Worker.

The Clinical Supervisor Exemption Request follows on page 10 and should only be included by applicants answering "No" to questions A and B above. Additional information on what the Board considers when granting an exemption to the Clinical Supervisor requirements can be found in A.A.C. R4-6-212.01 or in the Application Resource Guide.

PLEASE NOTE: If the Clinical Supervisor who provided supervision was not licensed by the Arizona Board of Behavioral Health Examiners, you must also attach a verification of the supervisor's credential(s) on **PART VII, Section 2**.

PART VII, Section 1. CLINICAL SUPERVISOR EXEMPTION REQUEST

(Not required unless an exemption is needed)

Your Name:_____ Phone: _____

Address: _____

Current AzBBHE license number: _____ Expiration date: _____

CHOOSE ONE:

- ☐ I have submitted an application for licensure and am requesting an exemption for clinical supervision that has already occurred. Indicate application submission date: _____
- ☐ I anticipate applying for independent level licensure in the future and am requesting an exemption for clinical supervision that I am currently receiving or plan to receive. Indicate projected application date and type of license you will be applying for: _____

Proposed Clinical Supervisor name: _____

Licenses held: _____ Expiration date: _____
_____ Expiration date: _____

Agency/Entity where supervised work experience was/will be acquired: _____

Address of Agency/Entity: _____

Dates that supervision by proposed clinical supervisor occurred or will occur: _____ to _____
Start date *End date*

I am requesting an exemption pursuant to A.A.C. R4-6-212.01 based on the following:

****ADDITIONAL REQUIREMENTS BASED ON EXEMPTION CAN BE FOUND ON PAGE 2****

- ☐ **(1)(a)(i) Qualifications of a clinical supervisor**: A qualified supervisor is/was not available because of the size and geographic location of the professional setting in which clinical supervision will or did occur.
- ☐ **(1)(a)(ii) Qualified Physician/Nurse Practitioner**: The behavioral health professional who provided or will provide the clinical supervision is licensed as a physician with a certification in psychiatry or addiction medicine, or as a nurse practitioner with a certification in mental health, and has the necessary education, training, and experience.
- ☐ **(1)(b) Clinical Supervisor not employed at supervisee's employer**: A Clinical Supervisor meeting Board's requirements was not/is not available, so the Agency/Entity is contracting a Clinical Supervisor.
- ☐ **(1)(c) Revised requirements:** Clinical supervision acquired before new rule requirements as of November 1, 2015 or completed no later than October 31, 2017, met or would meet the requirements in existence before November 1, 2015, so I wish for my clinical supervision to be considered under the previous requirements.
- ☐ **(2) Supervision acquired outside of Arizona:** Clinical supervision and supervised work experience will be or was acquired outside of Arizona.

I understand that if my request is approved, the proposed Clinical Supervisor meets the requirements for the exemption. It does not ensure that supervised hours will be accepted from the Clinical Supervisor if the supervisor fails to maintain their licensure and comply with ongoing training requirements as prescribed in A.A.C. R4-6-214. In addition, the supervised work experience and clinical supervision hours must meet the requirements in A.A.C. R4-6-211 and 212, and Articles 4, 5, 6, and 7 for supervision to be accepted.

I certify under penalty of perjury that the above information and all supporting documents are true and accurate to the best of my knowledge.

_____ _____
Signature Date signed

IF REQUESTING AN EXEMPTION BASED ON:

(1)(a)(i) Qualifications of a clinical supervisor

Please include the following:

1. A letter from the Agency/entity where clinical supervision will or did occur that includes the following information:
    a. Total number of independently licensed professionals in your discipline at your physical location
    b. Total number of independently licensed professionals in your discipline in the Agency (all locations)
    c. Does the Agency/entity have the capability to videoconference?
    d. Has the Agency/entity attempted to contract a clinical supervisor outside the Agency?
2. For the proposed clinical supervisor:
    a. Resume
    b. Verification of education (if not licensed by the Board)
    c. Documentation of compliance with the clinical supervisor educational requirements pursuant to A.A.C. R4-6-214 (not needed if they are included on the Board's supervisor registry)

(1)(a)(ii) Qualified Physician/Nurse Practitioner

Please include the following information for the proposed clinical supervisor:

1. Resume
2. Verification of education (including mental health certification)
3. Documentation of compliance with the clinical supervisor educational requirements pursuant to A.A.C. R4-6-214 (not needed if they are included on the Board's supervisor registry)

(1)(b) Clinical Supervisor not employed at supervisee's employer

Please include verification that:

1. The clinical supervisor and behavioral health entity where the supervision occurred or will occur have/had a written contract providing the supervisor the same access to the supervisee's clinical records provided to employees of the behavioral health entity; and
2. The supervisee's clients authorize(d) the release of their clinical records to the supervisor.

(1)(c) Revised requirements

Please provide the reason for this request:_____

_____

If you are requesting to have your clinical supervision reviewed under rules in existence prior to November 1, 2015:

1. You may need to submit an additional exemption form if it was required by previous rules (ask your credentialing specialist if this applies to you)
2. If approved to be reviewed under old rule, your clinical supervisor MUST submit the verification form that was used under old rule.
3. If required under old rule, you may need to submit your proposed clinical supervisor's:
    a. Resume
    b. Transcript
    c. Curriculum vitae

(2) Supervision acquired outside of Arizona

Please include the following information for the proposed supervisor:

1. Resume
2. Verification of education
3. Evidence that the supervisor met one of the following:
    a. The educational requirements in A.A.C. R4-6-214
    b. The clinical supervisor educational requirements of the state in which supervision occurred
    c. Was approved to provide supervision to the applicant by the state in which supervision occurred

PART VII, Section 2.VERIFICATION OF SUPERVISOR'S CREDENTIALS

(Not required if the Clinical Supervisor held/holds an active license from the Board)

If your Clinical Supervisor did not hold an active license by the Arizona Board of Behavioral Health Examiners, you must submit verification of their credential(s) from the regulatory entity in which they are licensed or certified.

Title of Clinical Supervisor's 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
- Past disciplinary actions

Applicants may use an online verification if it contains all required items above and is printed from the regulatory entity's official website. If not, applicant must request an official verification from the regulatory entity and attach it to this application.

PART VIII. VERIFICATION OF CLINICAL SUPERVISION AND ASSESSMENT

IMPORTANT COMPLETION INSTRUCTIONS FOR APPLICANT AND CLINICAL SUPERVISOR(S):

1. Applicant signs where indicated in section A and forwards to Clinical Supervisor(s) *(form may be copied as needed)*.
2. Clinical Supervisor completes section B and has their signature notarized.
3. Form is returned to applicant in a sealed envelope with Clinical Supervisor's signature written on seal.
4. Applicant submits sealed envelope with application.
5. Hours of clinical supervision must be acquired in the supervised work experience period submitted by the applicant. Pursuant to A.A.C. R4-6-211, to meet supervised work experience requirements for licensure, supervision shall:
   a. Be acquired after completion of degree required for licensure.
   b. Be acquired after licensure or certification by a state regulatory entity for hours earned outside Arizona.
   c. Be acquired before January 1, 2006 if acquired in Arizona as an unlicensed professional practicing under an exemption provided in A.R.S. § 32-3271.

SECTION A: TO BE COMPLETED BY THE APPLICANT

ATTN: _____
Clinical Supervisor's name

I have applied to the Arizona Board of Behavioral Health Examiners for licensure as a Clinical Social Worker. I hereby authorize the above-named individual to release the requested information to the Board.

_____ _____
Applicant's Signature Date

SECTION B: TO BE COMPLETED BY THE APPLICANT'S CLINICAL SUPERVISOR

I certify that _____ (applicant name) received clinical supervision that met the Board's requirements from me as follows:

NOTE: If applicant is still employed, enter the "through" date for the period you are reporting.

Dates of clinical supervision: From _____ through _____
mm/dd/yy mm/dd/yy

NOTE: Indicate the exact number of hours in the reported period for each item below, NOT the minimum/maximum for licensure purposes. Applicants are required to demonstrate they have met the clinical supervision requirements pursuant to A.A.C. R4-6-404.

Total hours of clinical supervision (including direct observation) during the dates reported above: _____

From the total above, please indicate the clinical supervision hours provided to this applicant in each of the following settings:

Individual _____ Group (of 2 supervisees) _____ Group (of 3-6 supervisees) _____

Total hours of direct observation *(as prescribed in A.A.C. R4-6-212(E))* of applicant providing treatment: _____

Please provide the following for the practice setting where clinical supervision was acquired:

Applicant's employer during clinical supervision: _____

Applicant's position or title: _____

SECTION B: TO BE COMPLETED BY THE APPLICANT'S CLINICAL SUPERVISOR (cont'd)

Please provide the following for Clinical Supervisor verifying clinical supervision hours reported above:

Name: _____ License #: _____

Title: _____ Telephone: _____

During the period of clinical supervision, I was:

- ☐ Employed by the same agency/entity as the applicant
- ☐ Hired by the agency/entity to provide clinical supervision to applicant
- ☐ Hired by the applicant to provide clinical supervision

OVERALL RATING: Please provide an overall rating for the applicant for the period of clinical supervision reported above. In determining your selection, please consider the applicant's skills in individual/group psychotherapy, psychoeducation, assessment, diagnosis, and ethical conduct.

☐ Below Satisfactory ☐ Satisfactory ☐ Above Satisfactory

Explanation of rating (optional):_____

_____

_____

I certify that I have complied with the Board's Clinical Supervisor educational requirements and that I have included documentation demonstrating compliance. *(Compliance documentation is not required from Clinical Supervisors included on the Board's supervisor registry).*

I certify that I have read and understand the clinical supervision requirements in A.A.C. R4-6-212 and that the clinical supervision identified above complied with those requirements.

I certify that I have maintained clinical supervision documentation in compliance with the Board's rules and that I agree to provide such documentation upon request.

I, _____certify under penalty of perjury that all information contained in this verification, including all supporting documents, is true and correct to the best of my knowledge. I understand that any false statements or misrepresentations made in this verification may be grounds for disciplinary action against any license I hold, and may result in the Board not accepting the clinical supervision hours I provided the applicant and/or denying the applicant's licensure application.

_____ _____

Supervisor Signature Date

(must be signed in front of a notary)

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

PART IX. 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 X. 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 XI. 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 XI, Section 1**.

PART XI, Section 1. VERIFICATION OF CREDENTIALS

NOTE: Applicant will submit one completed form for EACH credential listed in **PART XI**. 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 XII. 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 Date

(must be signed in front of a notary)

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** (not needed if you hold a LMSW license from the Board)
- ☐ Data bank report (self-query) **in a sealed envelope from the data bank**
- ☐ Verification of professional credentials
- ☐ Verification of supervised work experience **in a sealed envelope** with job description included
- ☐ Verification of clinical supervision hours **in a sealed envelope**
- ☐ Clinical Supervisor Exemption Request and verification of supervisor's credentials (if applicable)
- ☐ Verification of Clinical Supervisor's compliance with Board educational requirements if supervisor is not included on the Board's supervisor registry

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.