



STATE OF ARIZONA
 BOARD OF BEHAVIORAL HEALTH EXAMINERS
 1740 WEST ADAMS STREET, SUITE 3600
 PHOENIX, AZ 85007
 PHONE: 602.542.1882 FAX: 602.364.0890
 Board Website: www.azbbhe.us
 Email Address: information@azbbhe.us

DOUGLAS A. DUCEY
 Governor

TOBI ZAVALA
 Executive Director

APPLICATION FOR ASSOCIATE COUNSELOR LICENSURE (LAC)

PART I. PERSONAL INFORMATION

<input type="checkbox"/> MRS. <input type="checkbox"/> MS. LEGAL NAME (FIRST NAME, MI, LAST NAME)		PREVIOUS LAST NAMES (IF APPLICABLE)	
<input type="checkbox"/> MR. <input type="checkbox"/> DR.			
DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER		CURRENT AZ BOARD LICENSE (IF APPLICABLE)
HOME ADDRESS			PREFERRED PHONE
CITY	STATE	ZIP CODE	ALTERNATIVE PHONE
PREFERRED EMAIL (FOR APPLICATION/LICENSE UPDATES)		ALTERNATIVE EMAIL	

APPLICATION UPDATES AND RENEWAL NOTIFICATIONS WILL BE SENT VIA EMAIL, SO AT LEAST ONE EMAIL MUST BE PROVIDED.

EMPLOYER INFORMATION

PRIMARY EMPLOYER NAME		CURRENT TITLE	
EMPLOYER ADDRESS			
CITY	STATE	ZIP CODE	EMPLOYER PHONE

NOTE: THE BOARD MUST PROVIDE THE PUBLIC AN ADDRESS AND PHONE NUMBER FOR REGULATED APPLICANTS AND PROFESSIONALS. THE ADDRESS AND TELEPHONE INFORMATION FOR THE PRIMARY EMPLOYER (ABOVE) BECOMES PUBLIC INFORMATION. IF YOU DO NOT PROVIDE EMPLOYER INFORMATION, YOUR HOME ADDRESS AND TELEPHONE NUMBER WILL BECOME PUBLIC INFORMATION. PLEASE LIST ADDITIONAL EMPLOYERS IN THE EMPLOYMENT HISTORY SECTION OF THE APPLICATION.

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).

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

Applicants for counselor licensure shall have a master’s or higher degree with a major emphasis in counseling with a minimum of 60 semester or 90 quarter credit hours. Choose one of the following:

- Master’s program with 60 semester credit hours
- Master’s program with 90 quarter credit hours
- Master’s program with less than 60/90 semester/quarter credits with additional graduate counseling related coursework
(provide a transcript for all coursework and complete Part III, Section 3.)

College or University: _____

Degree Title (as indicated on transcript): _____

Date degree awarded: _____

B. ACCREDITATION OF GRADUATE COUNSELING PROGRAM

NOTE: Complete for the counseling degree listed above.

Please select which of the following designations your graduate program held on the date your degree was awarded:

- 1. Accreditation from the Council for Accreditation of Counseling & Related Educational Programs (CACREP)
- 2. Accreditation from the Council on Rehabilitation Education (CORE)
- 3. A Board approved curriculum pursuant to A.R.S. § 32-3253(14) as indicated on the Board’s website
- 4. None of the above

What is the approval/accreditation date for the designation indicated in (B)(1-3) above? _____



APPLICANTS SELECTING (B)(1-2) ABOVE PROCEED TO PART IV – BACKGROUND INFO.

APPLICANTS SELECTING (B)(3-4) ABOVE PROCEED TO PART III, Section 2. – CURRICULUM.

PART III, Section 2. CURRICULUM

PLEASE NOTE: Not required for applicants whose graduate degree held a designation indicated in (B)(1-2) in Section 1 above at the time of graduation. For applicants who completed a Board approved curriculum indicated in (B)(3) in Section 1, please list any core content area coursework taken PRIOR to the effective date of the approval. It is not necessary to list coursework taken during or after the semester/year the approval was effective (see Board website for this date). Applicants selecting (B)(3-4) in Section 1 **MUST** complete the Verification of Practicum form in Part B below. For curriculum requirements, please see the Application Resource Guide.

Part A: TO BE COMPLETED BY APPLICANT

Indicate all courses taken that fulfill the requirements for the eight core content areas as defined in R4-6-501(C). For each core content area, list ALL courses that meet the requirement. However, each course may only be used to meet a single area. Do not list the same course in more than one area unless indicating embedded coursework.

Please submit published college or university course descriptions for the year and semester you were enrolled for every course you submit to meet the curriculum requirements. Please highlight the courses you are using to meet curriculum requirements. To assist in the review process, applicants are strongly encouraged to include complete syllabi for the core content area coursework from the year/semester attended.

One 3-semester or 4-quarter credit hour course is **required in each core content area.**

					FOR COMMITTEE USE ONLY			
CORE CONTENT AREA	COURSE NO.	COURSE NAME	TERM/YEAR COMPLETED	CREDITS (Semester or Quarter)	ELEMENTS COVERED	Review #1	Review #2	NOTES
Professional orientation and ethical practice					a b c d			
					a b c d			
					a b c d			
Social and cultural diversity					a b			
					a b			
					a b			
Human growth and development					a b			
					a b			
					a b			
Career development					a b			
					a b			
					a b			

					FOR COMMITTEE USE ONLY			
CORE CONTENT AREA	COURSE NO.	COURSE NAME	TERM/YEAR COMPLETED	CREDITS (Semester or Quarter)	ELEMENTS COVERED	Review #1	Review #2	NOTES
Helping relationship					a b c			
					a b c			
					a b c			
Group work					a b c			
					a b c			
					a b c			
Assessment					a b c			
					a b c			
					a b c			
Research and program evaluation					a b			
					a b			
					a b			
Supervised counseling practicum	There is not a course requirement for the supervised counseling practicum, but the graduate program must include 700 clock hours in a professional counseling setting, of which 240 involve direct client contact. The practicum must provide an opportunity for the supervisee to perform all activities associated with employment as a professional counselor, have oversight by a faculty member, and onsite supervision by an individual approved by the college or university. Please complete PART B below with this information.							

Part B: VERIFICATION OF PRACTICUM

NOTE: Applicant must mail this form to the college/university for verification before submission to the Board.

TO BE COMPLETED BY THE APPLICANT

To: _____ Applicant's SSN: _____
University (please print)

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

Applicant's Address

Briefly describe practicum setting and your activities: _____

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

TO BE COMPLETED BY THE COLLEGE/UNIVERSITY

NOTE: After completing this verification form, college/university personnel must send this verification form back to the applicant for submission with their application.

Applicant's Name: _____

College/University Verification

I attest that the applicant completed a supervised counseling practicum, field work experience, or internship in a professional counseling setting under the direction and supervision of a faculty member and an onsite supervisor approved by the college/university as follows:

Dates of participation: From _____ To _____

Total clock hours spent in the development of counseling skills under supervision: _____

Total hours of direct client contact during practicum: _____

Name

Title

Signature

Date

College/University name

Telephone number

College/University Seal

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 seven years. Copy sheet as needed. **IMPORTANT:** include an explanation of any breaks in employment of greater than one month. Failure to do so may delay processing of your application.

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, the Board needs an official score report from NBCC. You can request a copy be sent to you and submit the unopened envelope with your application, or request that NBCC places your test results in the Board’s portal.
- If not, you will be provided testing information once authorized to test.

Are you requesting special accommodations under the Americans with Disabilities Act (ADA) for taking the required examination? YES NO *(if yes, please attach documentation supporting request)*

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.

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 from the NPDB 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. Do not 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 issuing the credential.

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

Date

IS MY APPLICATION READY TO SUBMIT?

I HAVE INCLUDED ALL OF THE FOLLOWING DOCUMENTS:

- Completed Application Form
- Non-refundable application fee of **\$250.00** (NO PERSONAL CHECKS accepted. 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 the FRONT and BACK 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 standard card (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** (if not already on file)
- A copy of my test score (if previously taken and passed)
Applicant may request that their score be sent electronically from NBCC to the Board. If the test score is submitted with the application, it must be in a sealed envelope from NBCC.
- Data bank report (self-query)
- Verification of professional credentials
- Employment history for previous SEVEN years including an explanation of any gaps in employment of greater than one month
- Make all checks payable to "Arizona Board of Behavioral Health Examiners" or "AZBBHE"***

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.