For Office Use	License #:	Date Issued:	☐ $120.00 Fee

Application for Mental Health Counselor Licensure
Iowa Department of Public Health/Bureau of Professional Licensure

☐ **Temporary License** ☐ **Permanent License**

PLEASE PRINT

1. ______________________ *Last Name*
2. ______________________ *First Name and Middle Name*
3. ______________________ *Mailing Address (Including PO Box if applicable)*
4. ______________________ *City, State, Zip Code*
5. ______________________ *E-Mail Address*
6. ______________________ *Daytime Phone (Including Area Code)*
7. ______________________ *Date of Birth*
8. ______ -- ______ -- ______ *Social Security Number**
9. ☐ Male ☐ Female *Gender (optional question)*
10. ______________________ *If any of your documentation is in a name other than your current name, list the previous names of record.*

The following questions must be answered. If you answer "Yes" to the next six questions, (1) attach a signed letter of explanation providing the details of the incident, (2) attach a copy of any court ordered evaluations, showing completion and recommendations, and (3) attach a copy of all official court documents regarding your conviction/malpractice suit, including final disposition and/or settlement. You must answer "Yes" even when a conviction or judgment has been deferred or expunged from your record.

Question	Yes	No
11. Been convicted, found guilty of or entered a plea of guilty or no contest to a felony or misdemeanor crime (Other than minor traffic violations with fines under $500)?	Yes	No
12. Had any judgments or settlements paid on your behalf as a result of a malpractice suit or claim against you?	Yes	No
13. Been investigated by a licensing, registration, or certification authority or organization; or had a licensing, registration, or certification authority or organization institute disciplinary action against you related to your professional practice? (If the investigation or action was instituted by this licensing board you may answer "NO" to this question).	Yes	No
14. Been disciplined or sanctioned by any licensing, registration, or certification authority or organization related to your professional practice? (If this licensing board took the disciplinary action, you may answer "NO" to this question).	Yes	No
15. Developed a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? (If you are currently a participant in the Impaired Practitioner Review Committee, you may answer "NO" to this question.)	Yes	No
16. Been engaged in illegal or improper use of drugs or other chemical mood altering substances? (If you are currently a participant in the Impaired Practitioner Review Committee, you may answer "NO" to this question.)	Yes	No

Type of Application:

17. Check applicable examination if previously taken:
    National Clinical Mental Health Counselor Examination Yes ☐ No ☐ Date taken: ________/________/________
    National Certified Counselor Examination Yes ☐ No ☐ Date taken: ________/________/________

18. Do you wish to inform the board of any physical or mental condition which would require special accommodations for the administration of the examination? Yes ☐ No ☐

19. Are you or have you ever been licensed, certified, or registered in another state territory or country? Yes ☐ No ☐

If yes, list the two letter postal codes of the state(s). __________ __________ __________ __________
(Please note: Official verifications must be received directly from each state's licensing board office.)

20. Have you achieved the Certified Clinical Mental Health Counselor (CCMHC) credential with the National Board of Certified Counselors? (If yes, please submit proof of credential.) Yes ☐ No ☐

Education *(Please check the applicable box)*

21. ☐ Masters: ______________________________
Name of Educational Institution

____
Name of Educational Institution

22. ☐ Doctorate: ______________________________
Name of Educational Institution

23. Highest Degree date: ______________________
Month/Year

24. **Applicant must complete either (A or B) depending on education and accreditation:** (Please read very carefully.)

A. **Graduate of a CACREP Accredited Mental Health Counseling Program**
I hold a master's or doctoral degree in counseling with emphasis in mental health counseling of at least 60 semester credit hours or equivalent quarter credit hours. My masters or doctoral **program** was accredited specifically in Mental Health Counseling by the Council for Accreditation of Counseling and Related Educational Programs (CACREP).

NOTE: Some institutions hold CACREP accreditation in related counseling programs. Answer YES to this question **onl**y if:

- You graduated from a masters or doctoral Mental Health Counseling **program** in a nationally accredited institution.
- Your Mental Health Counseling **program** was accredited by CACREP at the time of graduation.

Yes ☐ **No** ☐

If you answered YES to this question, request that your school submit an official transcript with the school seal that identifies the date of graduation and degree earned directly to the Iowa Board of Behavioral Science.

B. **Graduate of a non-CACREP Accredited Mental Health Counseling Program**

I hold a degree that may be content equivalent to a master's or doctoral degree in counseling with emphasis in mental health counseling from a college or university accredited by an agency recognized by the U.S. Department of Education

NOTE: Answer YES to this question if **all** the following apply:

- You graduated from a master's or doctoral program in mental health counseling or in counseling with emphasis in mental health counseling.
- The masters or doctoral **program** from which you graduated was not CACREP Accredited in Mental Health Counseling at the time of graduation.
- The institution from which you earned the masters or doctoral degree was accredited by an agency recognized by the U.S. Department of Education
- You completed at least 60 semester or equivalent quarter credit hours in mental health counseling content equivalent areas at the masters or doctoral level.
- You are prepared to submit a transcript, course descriptions or syllabi, and credential evaluation fee to the national credentialing agency that conducts initial education review for the Iowa Board of Behavioral Science.

Yes ☐ **No** ☐

If you answered YES to this question, request an application for education review from the Center for Credentialing and Education at 888-817-8283 (toll free) or cce@cce-global.org. Submit the completed application for education review to the Center for Credentialing and Education.

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I certify that I have carefully read the questions on this application and have answered them completely and truthfully. I declare under penalty of perjury that my answers, and all other statements or information submitted by me in this application process, are true and correct. If it is determined at any time that I have provided misleading or false information on or in support of this application, I understand that my application may be denied or that I may be subject to disciplinary action and criminal prosecution if I am already licensed.

I understand that I am required to update answers or information submitted herewith if the response or the information changes during the time period the application is pending. I also understand that this application is a public record in accordance with Iowa Code, Chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law. Finally in submitting this application, I consent to any reasonable inquiry that may be necessary to verify the information I have provided on or in conjunction with this application.

This information is collected pursuant to Iowa Code Chapters 252J, 261 & 272C. Failure to provide mandatory information will result in license denial. **Privacy Act Notice:** Disclosure of your Social Security Number on this license application is required by 42 U.S.C. § 666(a)(13) and Iowa Code § 252J.8(1). The number will be used in connection with the collection of child support obligations and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code § 421.18.

26. ____ ____

Applicant sign here in ink **Date**

Applications must be complete and signed to be processed. No application will be considered complete until all required supporting documents and fees have been received in the board office. Questions regarding the application process may be directed to 515 281-0254. An applicant who has been denied licensure by the board may appeal the denial and request a hearing on the issues related to licensure denial by serving a notice of appeal and request for hearing upon the board not more than 30 days following the date of mailing of the notification of licensure denial to the applicant.

All applicants must mail this form bearing their signature in ink and the licensure fee to:

The Iowa Board of Behavioral Science
Lucas State Office Bldg., 5th Floor
321 E. 12th Street
Des Moines, Iowa 50319-0075

http://idph.iowa.gov/Licensure/Iowa-Board-of-Behavioral-Science