



STATE OF ARIZONA
BOARD OF BEHAVIORAL HEALTH EXAMINERS
3443 NORTH CENTRAL AVENUE, SUITE 1700
PHOENIX, AZ 85012
PHONE: 602.542.1882 FAX: 602.364-0890
Arizona State Website: www.az.gov
Board Website: www.azbbhe.us
Board E-mail Address: information@azbbhe.us

JANICE K. BREWER
Governor

DEBRA RINAUDO
Executive Director

RECIPROCAL LICENSE APPLICATION INSTRUCTIONS

1. Self-managed Application Packets

Applicants must submit all required materials WITH THEIR APPLICATIONS. Complete applications include a completed Reciprocal License Application and the application fee of \$250. A.R.S. §32-3272. **Incomplete applications will not be processed.**

2. Notices Provided to Applicants

After you submit an application, the Board will keep you informed regarding the progress of your application. You will receive written notice from the Board that your application has been received and after the administrative and substantive reviews have been completed.

3. Application Fee

The application fee of \$250 is **NON-REFUNDABLE** and must be in the form of a cashier's check, certified check or money order payable to the AZ Board of Behavioral Health Examiners. Personal checks cannot be accepted.

4. License Issuance Fee

A license issuance fee will be due prior to the Board approving your license A.R.S. §32-3272. The fee is \$100 for non independent level licenses (LBSW-R, LMSW-R, LAC-R, LAMFT-R, LSAT-R and LASAC-R) and \$250 for independent level licenses (LCSW-R, LPC-R, LMFT-R and LISAC-R).

5. Legal Residency Requirement

In accordance with federal and state law, each professional licensing agency in Arizona is required to request proof of residency status from new applicants. Applicants must submit the completed form for proof of legal residency in the United States, including a copy of the verifying document.

6. Legal Name and Name Changes

You must submit a copy of your driver's license or social security card. If the name shown on your supporting documents is different than that shown on your application and driver's license or social security card, you must submit proof of a legal name change, such as a copy of your marriage license, divorce decree, or court order. All applications, application files and licenses shall be in legal names only.

7. Reporting

Please be aware that the Board is required to report all licensure denials to the Healthcare Integrity Protection and the National Practitioners data banks.

8. Social Security Number

Pursuant to A.R.S. § 25-320(K), you must provide your Social Security number on your application.

9. Criminal Background History

All licensure applicants are required to submit information with regard to their criminal background history. Applicants may provide either of the following types of documentation:

*If you hold a current fingerprint clearance card issued by the Department of Public Safety, you may submit a copy of your clearance card with your application.

OR

*A complete set of fingerprints. Applicants must obtain a card on which to be fingerprinted directly from the Board. Call 602-542-1882 to request a card for fingerprinting. Submission of a completed fingerprint card authorizes the Board to obtain a criminal background check from the Department of Public Safety. The fee for the criminal background check is \$40. A.R.S. §32-3280. THIS FEE IS SEPARATE FROM YOUR LICENSURE APPLICATION FEE AND MUST BE PAID BY A SEPARATE CHECK OR MONEY ORDER. You may pay this fee by personal check or money order made payable to the Board of Behavioral Health Examiners.

Name _____ Social Security Number _____

ARIZONA BOARD OF BEHAVIORAL HEALTH EXAMINERS RECIPROCAL LICENSE APPLICATION

Marriage & Family Therapy

- Marriage & Family Therapist
 Associate Marriage & Family Therapist

Substance Abuse Counselor

- Independent Substance Abuse Counselor
 Associate Substance Abuse Counselor
 Substance Abuse Technician

Social Work

- Clinical Social Worker
 Master Social Worker
 Bachelor Social Worker

Counseling

- Professional Counselor
 Associate Counselor

For office use only

PART I. PERSONAL INFORMATION

SOCIAL SECURITY NUMBER (MANDATORY)	DATE OF BIRTH (MM/DD/YYYY)	GENDER <input type="checkbox"/> Male <input type="checkbox"/> 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		
Home address		Home Phone
City	State	Zip
		Cell Phone

NOTE: You must provide the Board with a business address and telephone number. This becomes public information. **If you do not provide a business address and telephone number, your home address and telephone number will become public information.**

Agency employed by			[] Employee	[] Independent Contractor	[] 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. 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. PROFESSIONAL CREDENTIALS

If you have ever held **state** licensure, certification or registration in any occupation or profession in Arizona or any other state or country, **OTHER THAN THE CREDENTIAL YOU ARE USING TO QUALIFY FOR A RECIPROCAL LICENSE**, complete the section below. Failure to disclose all licenses, certifications or registrations currently or ever held may result in denial of your application or other appropriate action.

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

Name _____ Social Security Number _____

PART IV. VERIFICATION OF CREDENTIALS

NOTE: Applicant will submit one completed form for EACH credential listed in Part III.
(Not required for Arizona Board of Behavioral Health licenses)

SECTION 1: 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 (AzBBHE) 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

SECTION 2: TO BE COMPLETED BY THE STATE CREDENTIALING AGENCY

Professional's Name _____

Credential Held _____ Credential Number _____

Issuance Date _____ Expiration Date _____

Current Status _____

Pending Disciplinary Actions YES NO

Number of Past Disciplinary Actions _____

Attach explanation of all disciplinary actions.

Form Completed By Date Please Include State Seal

Credentialing Agency Name and Phone Number

PART V. BACKGROUND INFORMATION

If the answer to any of the questions below is “yes”, provide a complete explanation below. 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. Place your name and Social Security number on each supplemental page or document enclosed.

	Question	
1.	Have you ever applied for and 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 or country?	<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 federal agency, state regulatory board, any professional or occupational credentialing authority or any professional association in Arizona or any other state or country. If yes, please provide copies of the complaint and all final actions. <u>You must identify all complaints ever filed against you, pending or completed, other than those filed by this Board, and attach an explanation. For example, even if a complaint against you was dismissed as unsubstantiated or unfounded, you must answer “yes” and include an explanation.</u>	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.	To your knowledge, have any unresolved or pending complaints been filed against you by any federal agency, state regulatory board, any professional or occupational credentialing authority or any professional association in Arizona or any other state or country?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4.	Have you ever had any disciplinary action or sanctions of any kind taken against you by any state or federally licensed facility or employer in Arizona or any other state or country?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5.	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 or country?	<input type="checkbox"/> YES <input type="checkbox"/> NO
6.	Have you <u>ever</u> 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 court documents such as the complaint, the pleadings and final order(s). <u>You must answer “yes” even if you received a pardon, the conviction was set aside, the records were expunged, your civil rights were restored and whether or not sentence was imposed or suspended.</u>	<input type="checkbox"/> YES <input type="checkbox"/> NO
7.	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
8.	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
9.	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 lay off.	<input type="checkbox"/> YES <input type="checkbox"/> NO
10.	Are you currently engaged in the illegal use of any controlled substance, habit-forming drug or prescription medication?	<input type="checkbox"/> YES <input type="checkbox"/> NO
11.	Has consumption of alcohol impaired or limited in any way your present ability to competently and safely perform the essential functions of your profession?	<input type="checkbox"/> YES <input type="checkbox"/> NO

PART VI. EMPLOYMENT HISTORY

YOU MUST LIST ALL EMPLOYMENT FOR THE PREVIOUS TEN YEARS. Also list all employment since the date of graduation from your highest level of education if you graduated more than ten years ago. Also list all experience in your profession whenever obtained. You are authorized to photocopy this form if additional space is required.

EXPLAIN ANY BREAKS IN EMPLOYMENT OF GREATER THAN ONE MONTH

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		
CHECK A BOX AND NOTE THE REASON: <input type="checkbox"/> VOLUNTARY RESIGNATION <input type="checkbox"/> TERMINATION <input type="checkbox"/> RESIGNATION IN LIEU OF TERMINATION		
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		
CHECK A BOX AND NOTE THE REASON: <input type="checkbox"/> VOLUNTARY RESIGNATION <input type="checkbox"/> TERMINATION <input type="checkbox"/> RESIGNATION IN LIEU OF TERMINATION		
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		
CHECK A BOX AND NOTE THE REASON: <input type="checkbox"/> VOLUNTARY RESIGNATION <input type="checkbox"/> TERMINATION <input type="checkbox"/> RESIGNATION IN LIEU OF TERMINATION		

PART VIII. FEDERAL DATA BANK SELF-QUERY

PLEASE BE ACCURATE WHEN COMPLETING THE SELF-QUERY FORM.

The two data banks that retain information on behavioral health professionals are the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB).

A report from these data banks is required as part of the application process to become a licensed behavioral health professional in the State of Arizona.

YOUR APPLICATION CANNOT BE PROCESSED WITHOUT A CURRENT REPORT (WITHIN 90 DAYS OF THE DATE YOU APPLY) FROM THE DATA BANKS

To obtain information (self-query) from the NPDB-HIPDB, please visit www.npdb-hipdb.hrsa.gov, scroll to the right side of the home page, and click **Perform a Self-Query**.

The self-query fee is \$16.00, payable by credit card (VISA, MasterCard, Discover or American Express). If you do not have Internet access, contact the Customer Service Center at 1-800-767-6732 from 8:30 a.m. to 6:00 p.m. Eastern Time (8:30 a.m. to 5:30 p.m. Fridays).

**National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank**
P.O. Box 10832
Chantilly, VA 20153-0832

Data Bank Help Line is 800-767-6732

You will receive your reports from the databanks within approximately two weeks.

Submit the unopened envelope with your application.

REPORTS MUST BE PROCESSED WITHIN 90 DAYS OF THE DATE THIS AGENCY RECEIVES YOUR APPLICATION FOR LICENSURE -- PLEASE BE AWARE THAT PROCESSING BEGINS AT THE TIME YOU CLICK 'SUBMIT' FOR YOUR REPORT ON-LINE

Name _____ Social Security Number _____

PART X: VERIFICATION OF WORK EXPERIENCE FOR RECIPROCAL LICENSE

To be completed by a person with sufficient knowledge to attest to the applicant's work experience during the five years prior to submission of the application, such as an employer or supervisor.

PART A: TO BE COMPLETED BY THE APPLICANT

TO: _____
(Name of person attesting to required work experience)

Agency Address: _____ Phone Number: _____

I have applied to the Arizona Board of Behavioral Health Examiners (AzBBHE) for licensure as a behavioral health professional. Please verify my work experience during the last five years, have the form notarized and return it to me at the address listed below:

Applicant's Name (please print) () - Telephone

Applicant's Address

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

NOTE: After notarization, the person completing this section must send the verification form back to the applicant in a sealed envelope with that person's signature across the seal. Applicants must submit these unopened work experience envelopes with their applications. **AzBBHE will not accept unsigned or unsealed envelopes.**

I certify that I have direct personal knowledge of _____ (applicant's name) work history during the last five years and can truthfully attest that _____ (applicant's name) was engaged in the practice of behavioral health for at least 6000 hours during the last five years (date of application back 5 years) as follows:

Dates of behavioral health work experience within 5 years of this application: From _____ through _____
(mm/dd/yy) (mm/dd/yy)

Applicant's position or title _____

Describe below the applicant's work activities:

Describe below your personal relationship with the applicant during the work experience identified above:

Name: _____ Degree: _____ Title: _____

Agency: _____ Telephone: _____

Address: _____

I hold the following professional credentials:

Type of Credential	Issuing State	Date Issued	Expiration Date	License # and Current Status

Signature of Person Attesting to the Applicant's Work Experience

Date

TO BE COMPETED BY NOTARY

Subscribed and sworn before me this _____ day of _____, 20____, in the State

of _____ and County of _____.

Notary Seal

Notary Public _____ My Commission Expires _____

I HAVE PROVIDED THE FOLLOWING WITH THIS APPLICATION:

_____ **A COMPLETED LEGAL RESIDENCY FORM AND COPY OF LEGAL RESIDENCY DOCUMENTATION**

_____ **A COPY OF MY DRIVER'S LICENSE OR SOCIAL SECURITY CARD**

_____ **A COMPLETED VERIFICATION OF LICENSE FOR RECIPROCAL LICENSE APPLICATION FORM**

_____ **A COPY OF THE RULES THAT WERE IN PLACE AT THE TIME YOU RECEIVED THE LICENSE YOU ARE USING TO OBTAIN YOUR RECIPROCAL ARIZONA LICENSE**

_____ **A COMPLETED WORK EXPERIENCE FOR RECIPROCAL LICENSE FORM**

_____ **DATA BANK REPORTS IN THE SEALED ENVELOPE (SELF-QUERY)**
(data bank reports are only acceptable for 90 days from the process date)

_____ **A FINGERPRINT CARD OR COPY OF MY FINGERPRINT CLEARANCE CARD**
_____ **ALREADY ON FILE**

_____ **EXAMINATION SCORE**
(required if you previously passed the exam required for licensure in Arizona)

A reciprocal license must be renewed every two years. To qualify for a regular license in Arizona, you must submit a completed Reciprocal License Upgrade Application.

Requirements for a regular license include:

- Completion of at least 1600 hours of work experience in the clinical practice of behavioral health in Arizona in no less than 12 months after issuance of a reciprocal license.
- During the period of qualifying work experience, completion of at least 50 hours of clinical supervision by a qualified clinical supervisor.

Name _____ Social Security Number _____

PART XI. CERTIFYING STATEMENT

A.R.S. §32-3208 requires that any applicant for licensure and all persons licensed by the Board report to the Board, in writing, within 10 days of being charged with any felony or misdemeanor that may affect client safety. Failure to submit this notification may be considered by the Board to be an act of unprofessional conduct.

I hereby authorize the Arizona Board of Behavioral Health Examiners (AzBBHE) to verify any and all information contained in this application, including information maintained in applicable data banks. I also authorize AzBBHE to obtain any records or documents maintained by my current and/or previous employers, state files pertaining to any other licensing, certification or registration records, all law enforcement records, administrative records, motor vehicle records and court documents pertaining to myself to confirm the accuracy and completeness of the information provided herein. My signature below authorizes entities in possession of applicable information to release such information to AzBBHE.

All applicants have an obligation to update and supplement the information and responses on the Reciprocal Application if it changes. You must immediately notify the Board if any of the addresses or phone numbers you have provided change. You must also immediately notify the Board if any of the information or responses you have provided becomes incorrect or misleading. Failure to supplement information and responses provided may result in denial or other appropriate action.

I understand that in addition to the information requested in the Reciprocal Application the Board may request any additional information necessary to determine my eligibility 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.

PLEASE NOTE:

YOU MUST SIGN AND DATE THIS AFFIDAVIT IN THE PRESENCE OF THE NOTARY AND THE DATE YOU WRITE MUST BE THE SAME AS THE DATE WRITTEN BY THE NOTARY. AFFIDAVITS WITH DIFFERENT DATES WILL NOT BE ACCEPTED.

Signature of Applicant

Date

Printed Name of Applicant

Date

TO BE COMPETED 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	