



STATE OF ARIZONA
BOARD OF BEHAVIORAL HEALTH EXAMINERS
3443 NORTH CENTRAL AVENUE, SUITE 1700
PHOENIX, AZ 85012
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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 UPGRADE APPLICATION INSTRUCTIONS

1. Self-managed Application Packets

Applicants must submit all required materials WITH THEIR APPLICATIONS. A complete application is a completed Reciprocal Upgrade Application, a supplement application, and the application fee of \$250. **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 Arizona 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. The fee is \$100 for non-independent level licenses (LBSW, LMSW, LAC, LAMFT, LSAT and LASAC) and \$250 for independent level licenses (LCSW, LPC, LMFT and LISAC).

5. 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.

6. 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.

7. Social Security Number

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

Name _____ Social Security Number _____

ARIZONA BOARD OF BEHAVIORAL HEALTH EXAMINERS RECIPROCAL LICENSE UPGRADE 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

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 SINCE ISSUANCE OF YOUR RECIPROCAL LICENSE.

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 4. VERIFICATION OF SUPERVISED WORK EXPERIENCE

NOTE: After notarization, the supervisor must send the verification form back to the applicant in a sealed envelope with the supervisor's name written across the seal. Applicants must submit these unopened supervision envelopes with their applications. **The Board will not accept unsigned, unnotarized or unsealed envelopes.** If your work experience was acquired as an independent contractor, please contact the Board for additional instructions.

SECTION A: TO BE COMPLETED BY APPLICANT

Supervisor's Name

Name of the agency where you obtained your supervised work experience

I have applied to the Arizona Board of Behavioral Health Examiners (AzBBHE) for licensure. Please complete the following information verifying my supervised work experience, have the form notarized, and return the form to me in a sealed envelope. Please sign your name across the seal. I hereby authorize the above-named individual and agency to release the requested information to AzBBHE. **DO NOT INCLUDE DATES OR HOURS OF EMPLOYMENT PRIOR TO THE DATE MY RECIPROCAL LICENSE WAS ISSUED ON _____.**

Applicant's Signature

Date

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

NOTE: After notarization, the supervisor must send the verification form back to the applicant in a sealed envelope with the supervisor's name written across the seal. Applicants must submit these unopened supervision envelopes with their applications. **The Board will not accept unsigned, unnotarized or unsealed envelopes.**

I certify that _____ (applicant name) was engaged in supervised work experience in the clinical practice of behavioral health as follows:

NOTE: You must list a specific end date. "Current" or "Present" will not be accepted.

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

(NOTE: In both places below, identify total hours worked, not hours per week.)

Total hours of **direct client contact** involving the use of psychotherapy for the purpose of assessment, diagnosis and treatment of individuals, couples, families and groups during the time period identified above: _____

Total hours of supervised work experience: Direct client contact hours plus the hours the supervisee spent in activities directly related to the provision of the psychotherapy, such as time spent doing documentation and receiving clinical supervision, during the time period identified above: _____

You must attach a copy of the published job description for the position(s) the applicant held during the work experience identified above.

YES NO I have attached a copy of the applicant's published job description.

Identify your position with the entity / agency where the applicant obtained the work experience which you are verifying:

Name _____ Social Security Number _____

During the period of supervised work experience, the applicant was an:

employee independent contractor other

I was the applicant's: Employer Supervisor

Name: _____ Degree: _____

Title: _____ Telephone: _____

Agency: _____

Address: _____

Agency OBHL License # if applicable: _____

I hold the following professional license(s) or certification(s):

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

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.

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 and belief with full knowledge that any false statements or misrepresentations made in this verification may be grounds for disciplinary action against any license I hold.

Employer/Supervisor Signature

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

INSTRUCTIONS FOR COMPLETING THE VERIFICATION OF SUPERVISED WORK EXPERIENCE FORM

1. Your employer or supervisor must list the dates of the supervised work experience in a mm/dd/yy format. Using the words "current" or "present" is not acceptable.
2. Your employer or supervisor must verify your hours of direct client contact providing **psychotherapy only**. **Hours counted must be limited to only those hours spent providing assessment, diagnosis and treatment services.**
3. **TOTAL hours of supervised work experience verified should include all direct client contact hours AND all indirect hours RELATED to direct services, such as training, supervision hours you received and documentation. DO NOT include non-clinical hours, such as case management, administrative time or supervision hours you provided to others.**
4. **Total hours of direct client contact must be limited to only those hours spent providing assessment, diagnosis and treatment services.**

NOTE: You must list a specific end date. "Current" or "Present" will not be accepted.

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

(NOTE: In both places below, identify total hours worked, not hours per week.)

Total hours of **direct client contact** involving the use of psychotherapy for the purpose of assessment, diagnosis and treatment of individuals, couples, families and groups during the time period identified above: _____

Total hours of supervised work experience: Direct client contact hours plus the hours the supervisee spent in activities directly related to the provision of the psychotherapy, such as time spent doing documentation and receiving clinical supervision, during the time period identified above: _____

Part 5. VERIFICATION OF CLINICAL SUPERVISION AND ASSESSMENT

NOTE: After notarization, the supervisor must send the verification form back to the applicant in a sealed envelope with the supervisor's name written across the seal. Applicants must submit these unopened supervision envelopes with their application. **The Board will not accept unsigned, unnotarized or unsealed envelopes.**

SECTION A: TO BE COMPLETED BY THE APPLICANT BEFORE SUBMITTING TO EACH SUPERVISOR

To: _____ (Supervisor's name)

I have applied to the Arizona Board of Behavioral Health Examiners (AzBBHE) for licensure. Please complete the following information verifying the clinical supervision that I received from you, have the form notarized, and return the form to me in a sealed envelope. Please sign your name across the seal. I hereby authorize the above-named individual to release the requested information to AzBBHE. **DO NOT INCLUDE SUPERVISION HOURS PRIOR TO THE DATE MY RECIPROCAL LICENSE WAS ISSUED ON _____.**

Applicant's Signature

Date

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

NOTE: After notarization, the supervisor must send the verification form back to the applicant in a sealed envelope with the supervisor's name written across the seal. Applicants must submit these unopened supervision envelopes with their applications. **The Board will not accept unsigned, unnotarized or unsealed envelopes**

I certify that _____ (applicant name) received face-to-face clinical supervision from me as follows:

NOTE: You must list a specific end date. "Current" or "Present" will not be accepted.

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

Applicant's position or title: _____

Describe below the applicant's specific work activities:

Skills / Attributes	Outstanding	Above Avg	Average	Below Avg	Poor	Can't evaluate
Assessment						
Diagnosis						
Individual psychotherapy skills						
Ability to make appropriate referrals						
Group psychotherapy skills						
Personal integrity						
Appropriate use of supervision						
Insight into client's problems						
Ability to maintain appropriate boundaries						
Ability to be objective on the job						
Ethical conduct						
Concern for welfare of clients						
Sense of responsibility						
Recognition of own limits						
Ability to maintain confidentiality						

Name _____ Social Security Number _____

(NOTE: Identify total supervision hours, not supervision hours per week.)

Total hours of clinical supervision during the above dates: _____

Total hours of direct observation or review of audio or video tapes of applicant providing treatment: _____

Of the total hours of clinical supervision identified above, indicate the following:

Group supervision hours _____ Individual supervision hours _____

Name: _____ Degree: _____

Title: _____ Telephone: _____

Agency: _____

Address: _____

I hold the following professional license(s) or certification(s):

NOTE to Supervisor: If you were not licensed or certified as a behavioral health professional in Arizona or any other state when you provided this supervision, you must enclose a copy of your graduate transcript and curriculum vitae with this form.

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

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.

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 and belief with full knowledge that any false statements or misrepresentations made in this verification may be grounds for disciplinary action against any license I hold.

I certify that I have complied with the requirement for continuing education that addresses clinical supervision or that I hold a clinical supervisor certification as provided in A.A.C. R4-6-212(J). YES NO

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. YES NO

I certify that I have maintained clinical supervision documentation in compliance with A.A.C R4-6-212(F)(4) and that I agree to provide such documentation upon request. YES NO

Supervisor Signature

Date

Printed Name of Supervisor

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

**INSTRUCTIONS FOR COMPLETING THE
VERIFICATION OF CLINICAL SUPERVISION AND ASSESSMENT FORM**

1. Your clinical supervisor must verify hours he/she spent **meeting directly with you** to review and discuss clinical practice issues only. Time spent discussing non-clinical matters, such as staff meetings covering administrative issues cannot be verified.
2. ALL clinical supervision hours verified on the Clinical Supervision and Assessment form **MUST** occur during the supervised work period identified on your completed Verification of Supervised Work Experience form.
3. Your clinical supervisor can only verify clinical supervision hours he/she provided directly to you. A supervisor cannot verify clinical supervision hours provided by another supervisor.
4. The clinical supervisor must verify that he/she has maintained written documentation to validate all clinical supervision hours he/she verifies. The supervisor's clinical supervision documentation must comply with Board standards set out in A.A.C. R4-6-212(F)(4). A copy of the Board standards for clinical supervision documentation is attached for your convenience. PLEASE NOTE that the Board may request copies of clinical supervision documentation during the application process.
5. Group supervision hours may be verified for clinical supervision provided to two but no more than six supervisees. Typically, staff meetings do not qualify as clinical supervision hours because the supervisor meets with more than six supervisees, discussions are not limited to clinical practice issues ONLY, or the supervisor does not maintain clinical supervision documentation for staff meetings in accordance with the standards set out in A.A.C. R4-6-212(F)(4).
6. Individual supervision hours may be verified for clinical supervision meetings between the clinical supervisor and the applicant.
7. Any clinical supervision submitted for work experience acquired after July 1, 2006, must include at least 10 hours of clinical supervision acquired through direct observation or review of video/audio tapes by the clinical supervisor (A.A.C. R4-6-212(G)) of the applicant providing treatment and evaluation services to a client.
8. The clinical supervisor must have completed the continuing education required in A.A.C. R4-6-212(J)

Name _____ Social Security Number _____

PART 6. SUPERVISOR VERIFICATION OF CREDENTIAL FORM

NOTE: Use this form only if your clinical supervisor(s) was licensed or certified in another state.

Complete Section I and mail to your supervisors to obtain a verification of their license, registration or certification. Your supervisor must complete Section 2 and mail to their licensing, registering or certifying agency.

SECTION 1: TO BE COMPLETED BY THE APPLICANT BEFORE SUBMITTING THE FORM TO EACH SUPERVISOR

To: _____ (Supervisor)

I have applied to the Arizona Board of Behavioral Health Examiners for licensure as a behavioral health professional. Please submit the following form to your licensing, registering or certifying agency to verify your credentials. Please return this form with the supervision forms that you completed in an envelope sealed and signed across the seal.

Applicant's Signature

Date

SECTION 2: TO BE COMPLETED BY THE APPLICANT'S SUPERVISOR

Mail this form and any necessary fee to your licensing, registering or certifying agency. Upon receipt of the completed verification form from your licensing, registering or certifying agency, please submit the verification form with the supervision and work experience forms that you completed.

Name: _____ License/Registration/Certification No: _____

Address: _____ Phone Number: _____

Section 3: TO BE COMPLETED BY THE STATE IN WHICH THE INDIVIDUAL IDENTIFIED IN SECTION 2 ABOVE IS LICENSED, REGISTERED, OR CERTIFIED:

I am the person named in Section 2 who provided supervision to an applicant of the Arizona Board of Behavioral Health Examiners. I hereby authorize you to release the information requested below. **Please return the completed form to me at the address listed in Section 2 above.**

Supervisor's Signature

Date

Professional's Name (supervisor) _____

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

Credentiaing Agency Name and Phone Number

I HAVE PROVIDED THE FOLLOWING WITH THIS APPLICATION:

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

_____ **A COMPLETED SUPERVISED WORK EXPERIENCE FORM**

_____ **A COMPLETED CLINICAL SUPERVISION FORM**

Requirements to upgrade a reciprocal license to 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.

PART IX. 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	