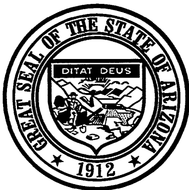

STATE OF ARIZONA
BOARD OF BEHAVIORAL HEALTH EXAMINERS
3443 N CENTRAL AVENUE, SUITE 1700
PHOENIX, AZ 85012
PHONE: 602.542.1882 FAX: 602.364.0890
BBHE Website: www.azbbhe.us
AZ Website: www.az.gov
E-Mail Address: information@azbbhe.us

JANICE K. BREWER
Governor

DEBRA RINAUDO
Executive Director

APPLICATION FOR LICENSE RENEWAL (Revised 8/18/10)

Type or print all information in black ink. A **non-refundable fee of $350.00** must accompany this renewal A.R.S. §32-3272. ($175.00 for each additional discipline only if renewed at the same time. You may renew your additional license[s] early to take advantage of this price reduction if you meet all other renewal requirements.) Each renewal requires its own renewal application and continuing education activities form. Payment must be made by certified check, cashier's check or money order payable to the Arizona Board of Behavioral Health Examiners. **PERSONAL OR BUSINESS CHECKS WILL NOT BE ACCEPTED**.

I. PERSONAL INFORMATION

[ ] Dr. [ ] Ms. [ ] Mr. [ ] Mrs.

Last Name__________________________________ First___________________ Middle___ Maiden ___________

Other Names Used, if any ____

Date of Birth______________________________________**Social Security Number #**_________-______-_______(mandatory)

Home Address:____ **License #**_______________

City:____________________________ State:______ Zip:__________ Hm Phone #: (___)_____-_______ Cell#: (___)_____-_______

Email Address: _______________________________________ May we use your email for general correspondence? [ ] YES [ ] NO

Agency Name: ____

Agency OBHL License #: ____________________ (If applicable)

Work Address: ____

City:____________________________ State:_____ Zip:___________Wk Phone #: (___)______-______ Fax#: (___)______-_______

You must provide your supervisor's name and phone number if you are licensed as a LAC, LBSW, LAMFT, LASAC, or LSAT. You must also provide your supervisor's name and phone number if you are licensed as a LMSW and are engaged in the practice of clinical social work.

Supervisor's Name: ____ Wk. Phone #: (___)_____-_______

Please note that if you provide only a home address and phone number, then the home address and phone number becomes the public record required by law. Otherwise, the business address and phone number are the public record.

You must notify the Board in writing within 30 days of any change of address or name change. Such changes must be reported on a form available from the Board's website or by calling 602/542-1882 and requesting a Name/Address Change Form

II. RECORD PROTOCOL COMPLIANCE

Please select one of the following. A copy of A.R.S. §32-3211 is enclosed.

[ ] I certify that I am aware of the requirements of A.R.S. §32-3211 regarding the secure storage, transfer and access of patient records and am in compliance with the requirements.

[ ] I certify that I am exempt from the requirements of A.R.S. §32-3211 regarding the secure storage, transfer and access of patient records because I am employed by a health care institution as defined in A.R.S. §36-401.

III.. BACKGROUND INFORMATION

Please read the following questions carefully. You must answer every question. If any questions are answered YES, attach a separate sheet with a thorough explanation and include appropriate documentation such as related court orders and treatment and/or rehabilitation plans. Include your name and social security number on each page.

[ ]YES [ ]NO (a) 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?

[ ]YES [ ]NO (b) 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. ***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, you must answer "yes" and include an explanation.***

[ ]YES [ ]NO (c) 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?

[ ]YES [ ]NO (d) 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?

[ ]YES [ ]NO (e) 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?

[ ]YES [ ]NO (f) 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 court documents such as the complaint, the pleadings and final order(s). **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.**

[ ]YES [ ]NO (g) 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 and proof of compliance.

[ ]YES [ ] NO (h) 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 (i) 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.

[ ]YES [ ]NO (j) Are you currently engaged in the illegal use of any controlled substance, habit-forming drug or prescription medication?

[ ]YES [ ]NO (k) Has consumption of alcohol impaired or limited in any way your present ability to competently and safely perform the essential functions of your profession?

[ ]YES [ ]NO (l) Are you now or have you in the last 5 years been addicted to any chemical substance including alcohol (excluding tobacco and caffeine)?

[ ]YES [ ]NO (m) Are you now being treated or have you in the last 5 years been treated for a drug or alcohol addiction or participated in a rehabilitation program?

[ ]YES [ ]NO (n) Do you have or have you had within the last 5 years any disease or medical condition that in any way impairs or limits your ability to competently and safely perform the essential functions of your profession? "Medical condition" includes physiological, mental or psychological conditions or disorders such as, but not limited to, physical impairments, emotional or mental diseases or conditions or alcohol or other substance abuse. If yes, include a letter from your physician indicating your diagnosis and if you are compliant with treatment and currently able to practice safely and competently.

[ ]YES [ ]NO (o) Within the last 5 years, have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of Bi-Polar Disorder, Schizophrenia, Paranoia or any psychotic disorder? If yes, include a letter from your physician indicating if you are compliant with treatment and currently able to practice safely and competently.

IV. AFFIDAVIT

I certify under penalty of perjury that all information contained in this renewal application, including all supporting documents, is true and correct to the best of my knowledge and belief with full knowledge that all statements made in this renewal application may be grounds for refusal or subsequent revocation or suspension of my license(s).

I authorize the Board of Behavioral Health Examiners to obtain any relevant information regarding my renewal application. I further authorize any entity holding relevant information to release said information to the Board.

I affirm that I have completed the required 30 hours of continuing education according to R4-6-802 within the preceding two years of the expiration date of my current license. (Please fill out the attached form listing the 30 hours of continuing education.)

I will obtain signed provider verification or other documentation of continuing education activities used for license renewal and retain these documents for a minimum of 48 months from the date of renewal of my license. These verification documents will be made available to the Board upon request.

Signature of Applicant____ Date___________________________

IV.

NAME: ______________________________________
SSN: ____

USE THIS SHEET ONLY TO LIST:

1. **3 clock hours in behavioral health ethics or mental health law**
2. **3 hours in cultural competency and diversity**

PURSUANT TO R4-6-804 (A), IF YOU ARE SUBMITTING YOUR RENEWAL APPLICATION AFTER JULY 1, 2006, YOU ARE REQUIRED TO INCLUDE THESE CONTINUING EDUCATION UNITS IN THE 30 HOURS. YOU NEED NOT LIST THEM AGAIN; THEY WILL BE COUNTED TOWARDS THE REQUIRED 30 HOURS.

ACTIVITY TYPE *	NAME OF ACTIVITY	SPONSORING ORGANIZATION	DESCRIPTION OF CONTENT	DATES ATTENDED	HOURS	Office use only **

*college course, workshop, conference, seminar, on-line course, in-service training or presentation you gave.
** OT=not w/in 24 mos prior to renewal; NR=needs committee review; E=exceeds maximum hour allowed; A=approved; D=denied, not w/in rule definition

NAME: ____
SSN: ____

<u>USE THIS SHEET ONLY IF YOU HOLD A LISAC, LASAC OR A LSAT LICENSE</u>. PLEASE INDICATE BELOW ONLY THE 20 HOURS OFCONTINUING EDUCATION ACTIVITIES YOU ARE SUBMITTING TO MEET THE REQUIREMENTS PURSUANT TO R4-6-804 (B).

ACTIVITY TYPE *	NAME OF ACTIVITY	SPONSORING ORGANIZATION	DESCRIPTION OF CONTENT	DATES ATTENDED	HOURS	Office use only **

*college course, workshop, conference, seminar, on-line course, in-service training or presentation you gave.
** OT=not w/in 24 mos prior to renewal; NR=needs committee review; E=exceeds maximum hour allowed; A=approved; D=denied, not w/in rule definition

NAME: ____
SSN: ____

<u>USE THIS SHEET ONLY IF YOU ARE PROVIDING CLINICAL SUPERVISION</u> TO QUALIFY A SUPERVISEE FOR LICENSURE, PLEASE INDICATE BELOW THE 12 HOURS INITIAL OR 6 HOURS SUBSEQUENT CONTINUING EDUCATION ACTIVITIES YOU ARE SUBMITTING TO MEET THE REQUIREMENTS PURSUANT TO R4-6-804 (C), OR INCLUDE A COPY OF YOUR CURRENT NBCC/CCE OR ICRC CLINICAL SUPERVISOR CERTIFICATION.

ACTIVITY TYPE *	NAME OF ACTIVITY	SPONSORING ORGANIZATION	DESCRIPTION OF CONTENT	DATES ATTENDED	HOURS	Office use only **

*college course, workshop, conference, seminar, on-line course, in-service training or presentation you gave.
** OT=not w/in 24 mos prior to renewal; NR=needs committee review; E=exceeds maximum hour allowed; A=approved; D=denied, not w/in rule definition

GENERAL CONTINUING EDUCATION ACTIVITIES LISTING

Name:____
SSN: ____

(Total of 30 hours required, <u>which includes CE's listed on previous pages</u>)

ACTIVITY TYPE *	NAME OF ACTIVITY	SPONSORING ORGANIZATION	DESCRIPTION OF CONTENT	DATES ATTENDED	HOURS	Office use only **

*college course, workshop, conference, seminar, on-line course, in-service training or presentation you gave.
** OT=not w/in 24 mos prior to renewal; NR=needs committee review; E=exceeds maximum hour allowed; A=approved; D=denied, not w/in rule definition

STATE OF ARIZONA
BOARD OF BEHAVIORAL HEALTH EXAMINERS
3443 N. Central Avenue, Suite 1700
PHOENIX, AZ 85012
PHONE: 602.542.1882 FAX: 602.364.0890
BBHE Website: www.azbbhe.us
AZ Website: www.az.gov
E-Mail Address: information@azbbhe.us

JANICE K. BREWER
Governor

DEBRA RINAUDO
Executive Director

<u>CHANGE OF NAME/ADDRESS REQUEST</u>: You must notify the Board within 30 days of any change in residence or employer mailing address or phone number. A.A.C. R4-6-205, 206.

NOTE: Please complete **ALL** parts even if "not new" information. If you provide only a home address and phone number, then the home address and phone number become the public record required by law. Otherwise, the business address and phone number is the public record.

(please print)

Name____

Social Security #_____________________License Number(s)_____________________

Do you have a pending application? _______

Check if New - Home Address Change

Street Address____

City/State/Zip____

Home Phone #_____________________ Mobile #_____________________

Email Address ____

Check if New - Work Address Change

Agency____

Street Address____

City/State/Zip____

Work Phone #_____________________ Fax # _____________________

Check if Name Change

Previous Name____

New Name____

Name change request must include supporting legal documents such as a copy of your marriage certificate or court order granting the name change.

_______________________________ _______________
Name Date