

## LICENSED CLINICAL PROFESSIONAL COUNSELOR

### **\* Out of State Applicants\***

*This form should be completed if you are **currently licensed** as a **clinical professional counselor** in a jurisdiction outside the State of Maryland.*

### APPLICATION INSTRUCTIONS

#### **\*\* IMPORTANT \*\***

BEFORE submitting your application, please:

- Retain a copy of all documents for your records. Documents **will not** be returned once received by the Board.
- Within 30 days after receipt of the application, the Board will determine if the application is complete.**

PLEASE DO NOT CONTACT THE BOARD REGARDING THE STATUS OF YOUR APPLICATION **LESS THAN 30 DAYS** FROM THE DATE IT WAS SUBMITTED. DUE TO THE VOLUME OF APPLICATIONS RECEIVED BY THE BOARD, SUCH REQUESTS CANNOT BE ANSWERED.

If the application is not complete, the Board will notify you, in writing, and you will have 90 days from the date of the notice to provide the requested documentation. If you do not provide the required information within 90 days, your application will be closed and all documents will be discarded. The Board does not retain incomplete applications. You will be required to submit a new application and pay the required application fee.

- All forms must be legible, complete, signed, and dated (where applicable) or processing may be delayed.
- Include a check or money order in the amount of \$250 payable to: *Maryland Board of Professional Counselors and Therapists*. A separate license fee of \$150 will be due upon notification of eligibility from the Board. Fees are **non-refundable and non-transferable.**
- Applications **may not** be submitted via fax, email or in-person. Please mail to:

*Board of Professional Counselors and Therapists*  
Attn: LCPC Licensing Coordinator  
4201 Patterson Avenue, Suite 316  
Baltimore, MD 21215

ELIGIBILITY/REQUIREMENTS: *The following is a summary only. For complete requirements and definitions, see Md. Code Ann. Health Occ., §17-101, et. seq. and COMAR 10.58.01.10, which may be found on the Board's website, [www.health.maryland.gov/bopc](http://www.health.maryland.gov/bopc).*

□ **Verification of Out of State License:** Applicant must include a copy of the license currently held in another jurisdiction. Applicant must also complete the Verification of Out of State License form (attached to this application) and send the form to the appropriate State licensing authority for completion. The licensing authority must forward the completed form *directly* to the Board.

□ If you are currently licensed as a clinical professional counselor in another jurisdiction that has requirements that are **equivalent to or exceed** the requirements in Health Occ. Article, Md. Ann. Code §17-304, you may complete this application and upon review by the Board, may be entitled to licensure as a clinical professional counselor. You must provide your jurisdiction's requirements for clinical licensure for comparison with Maryland's requirements.

□ If your jurisdiction's requirements for clinical licensure are **not equivalent** to Maryland's requirements, the Board may waive the educational and/or experiential requirements in certain circumstances, as set forth in COMAR 10.58.01.10 and summarized below:

□ **Equivalent Educational Requirements:** Applicant shall:

Provide **official** transcripts confirming completion of a master's or doctoral degree in a professional counseling from an accredited educational institution approved by the Board.

Documentation of graduate coursework as set forth in COMAR 10.58.01.10, which includes 3 semester credits in each of the following areas:

- Professional, legal, and ethical responsibilities;
- Diagnosis and psychopathology; and
- Psychotherapy and treatment of mental and emotional disorders.

□ **Equivalent Experience Requirements:**

If the applicant holds *a master's degree* and has a minimum of 60 graduate credit hours, the applicant must provide documentation satisfactory to the Board, of not less than 3 years with a minimum of 3,000 hours of supervised clinical experience in professional counseling, 2 years of which shall have been completed after the award of the master's degree;

If the applicant holds *a master's degree* consisting of less than 60 graduate credit hours, the applicant must provide documentation satisfactory to the Board, of not less than 3 years' experience practicing as a licensed clinical professional counselor, with a minimum of 3,000 hours of clinical professional counseling experience; **or**

If the applicant holds *a doctoral degree*, the applicant must provide documentation satisfactory to the Board, of not less 2 years practicing as a clinical professional counselor, or a minimum of 2000 hours of clinical professional counseling experience.

Please use the Professional Experience Verification form attached to this application. You may copy and submit additional forms, if necessary.

□ **National Credentials Registry (NCR) of the American Association of State Counseling Boards (AASCB):** if the applicant is registered with NCR or its successor as meeting the out of State applicant requirements for Maryland, the Board may issue a license upon the applicant's achieving a passing score on the Maryland law exam.

- **Examinations.** Applicant must pass the following:
  - 1) The National Counselors Exam (NCE); ***and***
  - 2) Maryland Law Assessment
- 1) **NCE (or NCMHCE):** Please include a copy of your score with the application.
- 2) **Maryland law exam:**

**Maryland Law Assessment (MLA):**

The purpose of the assessment is to determine if a candidate is familiar with the state laws and ethical code related to safe and effective practice across several content areas. The MLA is a no-fail, no score assessment. Content areas include supervision and ethics questions based on excerpts from the Code of Maryland Regulations (COMAR) and Md. Code Ann., Health Occupations Art., Title 17.

The MLA consists of 36 questions. You will be presented with readings and questions until all items are answered correctly. Upon successful completion, you will receive a Certificate of Completion that you will submit to the Board with your application for licensure or certification.

Prior Board approval is not required to take the MLA. However, if you take the MLA before you submit an application for licensure/certification with the Board, please note the following:

- Should you later decide not to apply for licensure/certification with the Board, the MLA fee will not be refunded.
- You are responsible for submitting the MLA Certificate of Completion to the Board with your application for licensure/certification. Do not email, fax or mail the certificate of completion separately to the Maryland Board. MLA Certificates of Completion received without a completed application will not be retained.
- MLA Certificates of Completion are valid for one year from the date of the MLA. If you do not apply for licensure/certification within one year from the date of the MLA, you will be required to re-take the MLA at your additional expense.

To take the MLA, use the following link: [www.academy.cce-global.org](http://www.academy.cce-global.org).

If you experience any issues, please contact the assessment administrator, CCE, Monday thru Friday 8:30am 5pm at 336.482.2856. You may also email for technical support at [support@cce-global.org](mailto:support@cce-global.org). Please do not contact the Board regarding technical support issues.

If you have already taken and passed the previous Maryland Law Exam, this notice does not apply to you and no further action is necessary.

- **Criminal History Records Check** All applicants must complete a criminal history records check (CHRC).

If you are located in Maryland at the time of your application, please use the attached form for the CHRC.

If you will obtain a CHRC in another state, you must contact the Board to receive the required form. The form attached to this application WILL NOT be accepted outside of Maryland.

Applicant must include a copy of the receipt from the CHRC with this application. This allows the Board to access the report online from the Criminal Justice Information System.

***Please note:*** A license will not be issued unless and until the Board determines that the applicant has completed **ALL** requirements including required coursework, examinations, CHRC, and any other requirements set by the Board in accordance with Maryland law.



# MARYLAND Department of Health

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D.,M.P.H., Secretary

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## BOARD OF PROFESSIONAL COUNSELORS AND THERAPISTS

4201 Patterson Avenue, Suite 316, Baltimore, Maryland 21215-2299

### LICENSED CLINICAL PROFESSIONAL COUNSELOR

#### \*\*OUT OF STATE – APPLICATION\*\*

*Please type or print all information.*

#### I. VETERANS AND SPOUSAL PREFERENCE

Are you an active service member or the spouse of any active service member?  Yes  No

Are you a veteran or the spouse of a veteran who was discharged from active duty under circumstances other than dishonorable within one year of filing this application?  Yes  No

#### II. DEMOGRAPHIC INFORMATION

Name: \_\_\_\_\_  
*Last First MI Maiden*

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: \_\_\_\_\_  
*Street City State Zip*

Prior address: \_\_\_\_\_  
*(If less than 3 years at current address) Street City State Zip*

Mailing Address: \_\_\_\_\_  
*(If different than above) Street City State Zip*

Business: \_\_\_\_\_  
*Name Street City State Zip*

Gender and Ethnicity: *This information is optional and may be used for statistical purposes by authorized personnel.*

Gender:  Male  Female

Ethnicity: Are you of Hispanic or Latino origin?  Yes  No

*Check all that apply:*

American Indian or Alaska Native

Asian  White

Black or African American

Native Hawaiian or Pacific Islander

### III. INFORMATION REGARDING BACKGROUND

*Please answer Yes or No to each question.*

**YES    NO**

1. Has any state licensing or disciplinary board ever taken any disciplinary action against your license or certification, including, but not limited to, charges, admonishment, reprimand, revocation, or suspension?

*If yes, attach a separate page with a complete explanation of each occurrence (include date, time, location, disposition, etc.) and a copy of the disciplinary/court document from the issuing agency, if applicable.*

2. Have you pled guilty, nolo contendere, or been convicted of, received probation before judgment or had a conviction set aside for any criminal act in any state, territory, or jurisdiction (excluding minor traffic violations)?

*If yes, attach a separate page with a complete explanation of each occurrence (include date, time, location, disposition, etc.) and a certified copy of the disciplinary/court document from the issuing agency.*

*Please note that if you do not answer this question or fail to disclose and provide the requested information your application will be administratively closed without further review. You will be required to submit a new application and pay the required fee. In addition, you may be required to appear before the Board regarding your failure to provide the required information.*

3. Are you currently on parole, probation or under any other court ordered supervision in any state, territory, or jurisdiction related to a criminal conviction? If so, you must submit official documentation indicating the terms and conditions, start and end dates, compliance and/or completion of the parole, probation or court ordered supervision with your application.

*Please note that if you fail to disclose and provide the requested information your application will be administratively closed without further review. You will be required to submit a new application and pay the required fee.*

**IV. EDUCATION:** List colleges or universities attended to satisfy academic requirements for licensure or certification. Do not list degrees unrelated to counseling. Please list the most recent colleges/universities first and provide **official** transcripts. Attach additional sheets, if necessary.

A. \_\_\_\_\_  
*Name of School* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_  
Dates attended: From (mo./yr.) \_\_\_\_\_ To (mo./yr.) \_\_\_\_\_  
Degree awarded: \_\_\_\_\_ Date awarded: \_\_\_\_\_  
Major field of study: \_\_\_\_\_

B. \_\_\_\_\_  
*Name of School* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_  
Dates attended: From (mo./yr.) \_\_\_\_\_ To (mo./yr.) \_\_\_\_\_  
Degree awarded: \_\_\_\_\_ Date awarded: \_\_\_\_\_  
Major field of study: \_\_\_\_\_

C. \_\_\_\_\_  
*Name of School* \_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_  
Dates attended: From (mo./yr.) \_\_\_\_\_ To (mo./yr.) \_\_\_\_\_  
Degree awarded: \_\_\_\_\_ Date awarded: \_\_\_\_\_  
Major field of study: \_\_\_\_\_

**V. COURSES:** Complete the chart below. If the title of your course differs from those listed, you must include a catalog course description or syllabus for each course. A course applied to one topic area **may not** be used to fulfill another topic area. Each course must be 3 semester or 5 quarter credit hours. Official transcript(s) must be attached to this application. You may attach separate sheet(s) for additional relevant coursework.

Topic Area	Course Title and Number (Must appear on transcript)	Credits Earned	College/Univ.	Date	Grade
Prof., Legal, Ethical Resp.					
Diagnosis and Psychopathology					
Psychotherapy/ treatment of mental and emotional disorders					

**VI. EXAMINATIONS**

- A. Have you passed the NCE OR NCMHCE?  Yes  No If yes, please include a copy of test score.
- B. Have you passed the Maryland law exam?  Yes  No If yes, please include a copy of test score.

**VII. PROFESSIONAL REFERENCES (3):** List at least 3 professional references who can attest to your counseling skills, professional standards of practice and supervised clinical work. You must include three (3) Professional Reference assessment forms in their original sealed envelopes with the application. Forms are attached.

A. Name of Reference: \_\_\_\_\_

Degree: \_\_\_\_\_ Certification/License: \_\_\_\_\_

Position: \_\_\_\_\_ Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Will this reference be verifying some or all of your supervised clinical experience?  Yes  No

B. Name of Reference: \_\_\_\_\_

Degree: \_\_\_\_\_ Certification/License: \_\_\_\_\_



Position: \_\_\_\_\_ Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Will this reference be verifying some or all of your supervised clinical experience?  Yes  No

C. Name of Reference: \_\_\_\_\_

Degree: \_\_\_\_\_ Certification/License: \_\_\_\_\_

Position: \_\_\_\_\_ Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Will this reference be verifying some or all of your supervised clinical experience?  Yes  No

**VIII. PROFESSIONAL CLINICAL EXPERIENCE:** Applicant must include a completed Professional Experience Verification(s) with this application. Forms are attached to application.

**IX. NATIONAL CREDENTIALS REGISTRY:** If applicable, applicant must provide proof of registration with NCR or its successor as meeting the out of State applicant requirements for Maryland.

**X. AFFIDAVIT**

In making this application to the Maryland Board of Professional Counselors and Therapists (the “Board”) for the issuance of a Licensed Clinical Professional Counselor credential:

- I agree to abide by the rules and regulations of the Board and to take all examinations necessary for the processing of my application;
- Upon issuance of certification, I agree to abide by the Code of Ethics as set forth in COMAR;
- I understand that the fee submitted with this application is **NON-REFUNDABLE**;
- I agree to hold the Board, its members, officers, agents, and examiners free from any damage or claim of damage or complaint by reason of any action taken in connection with this application, the attendant examination, the grades with respect to any examination, and/or the failure or refusal of the Board to issue me a license or certificate.
- I grant permission to the Board to seek any information or references it deems appropriate or necessary in verifying my credentials as it pertains to this application.
- I understand, by law, it is my responsibility to notify the Board, in writing, of any change of contact information including address, phone number, and/or email address.

I do hereby affirm that all of the statements made herein are true and correct to the best of my knowledge and belief. I voluntarily consent to a thorough review of the information in this application and other activities for the purpose of verifying my qualifications for certification or licensure.

\_\_\_\_\_  
Applicant’s Signature                                  Date

ATTACH  
APPLICANT PHOTO  
  
(Recent 2”x2”)

**NOTARY**

State of \_\_\_\_\_

City/County of \_\_\_\_\_

I HEREBY CERTIFY that on this \_\_\_\_\_ day of \_\_\_\_\_, before me, a

Notary Public of the State and City/County aforesaid, personally appeared \_\_\_\_\_ and

made oath in due form that the contents of the foregoing Affidavit are true.

Notary Public \_\_\_\_\_ Commission Expires: \_\_\_\_\_.

## PROFESSIONAL REFERENCE ASSESSMENT

Applicant's Name: \_\_\_\_\_

The above-named individual has applied to the Maryland State Board of Professional Counselors and Therapists to become a licensed professional counselor. Your assessment will help determine the applicant's eligibility for licensure. Please answer all questions to the best of your knowledge, information, and belief.

***PLEASE RETURN THE COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPE.***

Reference's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_

Degree: \_\_\_\_\_ Title: \_\_\_\_\_

Professional Certification/License: \_\_\_\_\_ State/Certifying Org.: \_\_\_\_\_

Relationship to Applicant:  Educator  Prof. Colleague  Supervisor (must sign Supervision Verification form)  Other: \_\_\_\_\_

Length of time you have known Applicant: From (mo./yr.) \_\_\_\_\_ To (mo./yr.) \_\_\_\_\_

Please rate the Applicant on the following skills/characteristics. Place a check $\checkmark$ in each category. <i>(Applicants who are counselor educators should be evaluated on the basis of their ability to train students in counseling skill areas).</i>	<i>Outstanding</i>	<i>Above Avg.</i>	<i>Average</i>	<i>Below Avg.</i>	<i>Poor</i>	<i>Cannot evaluate</i>
<i>Individual counseling skills</i>						
<i>Appropriate referral making skills</i>						
<i>Group counseling skills</i>						
<i>Personal integrity</i>						
<i>Consulting skills</i>						
<i>Insight to client's problems</i>						
<i>Ability to relate to co-workers</i>						
<i>Objectivity on the job</i>						
<i>Ethical conduct</i>						
<i>Concern for welfare of clients</i>						
<i>Sense of responsibility</i>						
<i>Recognition of own limits</i>						
<i>Supervisory ability</i>						
<i>Ability to keep material confidential</i>						

Additional Comments (optional): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I recommend this Applicant for licensure as a clinical professional counselor:  Yes       No

The information provided above is based on my best knowledge, information, and belief. I agree to answer additional questions regarding this evaluation if requested by the Board.

\_\_\_\_\_  
Reference's signature

\_\_\_\_\_  
Date

**PROFESSIONAL REFERENCE ASSESSMENT**

Applicant's Name: \_\_\_\_\_

The above-named individual has applied to the Maryland State Board of Professional Counselors and Therapists to become a licensed professional counselor. Your assessment will help determine the applicant's eligibility for licensure. Please answer all questions to the best of your knowledge, information, and belief.

***PLEASE RETURN THE COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPE.***

Reference's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_

Degree: \_\_\_\_\_ Title: \_\_\_\_\_

Professional Certification/License: \_\_\_\_\_ State/Certifying Org.: \_\_\_\_\_

Relationship to Applicant:  Educator  Prof. Colleague  Supervisor (must sign Supervision Verification form)  Other: \_\_\_\_\_

Length of time you have known Applicant: From (mo./yr.) \_\_\_\_\_ To (mo./yr.) \_\_\_\_\_

Please rate the Applicant on the following skills/characteristics. Place a check $\checkmark$ in each category. <i>(Applicants who are counselor educators should be evaluated on the basis of their ability to train students in counseling skill areas).</i>	<i>Outstanding</i>	<i>Above Avg.</i>	<i>Average</i>	<i>Below Avg.</i>	<i>Poor</i>	<i>Cannot evaluate</i>
<i>Individual counseling skills</i>						
<i>Appropriate referral making skills</i>						
<i>Group counseling skills</i>						
<i>Personal integrity</i>						
<i>Consulting skills</i>						
<i>Insight to client's problems</i>						
<i>Ability to relate to co-workers</i>						
<i>Objectivity on the job</i>						
<i>Ethical conduct</i>						
<i>Concern for welfare of clients</i>						
<i>Sense of responsibility</i>						
<i>Recognition of own limits</i>						
<i>Supervisory ability</i>						
<i>Ability to keep material confidential</i>						

Additional Comments (optional): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

I recommend this Applicant for licensure as a clinical professional counselor:  Yes       No

The information provided above is based on my best knowledge, information, and belief. I agree to answer additional questions regarding this evaluation if requested by the Board.

\_\_\_\_\_  
Reference's signature

\_\_\_\_\_  
Date

**PROFESSIONAL REFERENCE ASSESSMENT**

Applicant's Name: \_\_\_\_\_

The above-named individual has applied to the Maryland State Board of Professional Counselors and Therapists to become a licensed professional counselor. Your assessment will help determine the applicant's eligibility for licensure. Please answer all questions to the best of your knowledge, information, and belief.

***PLEASE RETURN THE COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPE.***

Reference's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_

Degree: \_\_\_\_\_ Title: \_\_\_\_\_

Professional Certification/License: \_\_\_\_\_ State/Certifying Org.: \_\_\_\_\_

Relationship to Applicant:  Educator  Prof. Colleague  Supervisor (must sign Supervision Verification form)  Other: \_\_\_\_\_

Length of time you have known Applicant: From (mo./yr.) \_\_\_\_\_ To (mo./yr.) \_\_\_\_\_

Please rate the Applicant on the following skills/characteristics. Place a check <input checked="" type="checkbox"/> in each category. (Applicants who are counselor educators should be evaluated on the basis of their ability to train students in counseling skill areas).	<i>Outstanding</i>	<i>Above Avg.</i>	<i>Average</i>	<i>Below Avg.</i>	<i>Poor</i>	<i>Cannot evaluate</i>
<i>Individual counseling skills</i>						
<i>Appropriate referral making skills</i>						
<i>Group counseling skills</i>						
<i>Personal integrity</i>						
<i>Consulting skills</i>						
<i>Insight to client's problems</i>						
<i>Ability to relate to co-workers</i>						
<i>Objectivity on the job</i>						
<i>Ethical conduct</i>						
<i>Concern for welfare of clients</i>						
<i>Sense of responsibility</i>						
<i>Recognition of own limits</i>						
<i>Supervisory ability</i>						
<i>Ability to keep material confidential</i>						

Additional Comments (optional): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I recommend this Applicant for licensure as a clinical professional counselor:  Yes       No

The information provided above is based on my best knowledge, information, and belief. I agree to answer additional questions regarding this evaluation if requested by the Board.

\_\_\_\_\_  
Reference's signature

\_\_\_\_\_  
Date





## STATE VERIFICATION OF LICENSE

**To be completed by Applicant:**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Address: \_\_\_\_\_

SSN: \_\_\_\_\_ Lic. Title & Number: \_\_\_\_\_

Graduate School: \_\_\_\_\_ Degree: \_\_\_\_\_

Date Awarded: \_\_\_\_\_ Total Graduate Credits Earned: \_\_\_\_\_

Yrs. experience practicing as LCPC: \_\_\_\_\_

I authorize the information requested below to be provided to the Maryland Board of Professional Counselors and Therapists.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**To be completed by State of licensure and returned directly to:**

**Maryland Board of Professional Counselors  
4201 Patterson Ave., Suite 316  
Baltimore, MD 21215**

**Please do not return to the Applicant.**

Issuing State: \_\_\_\_\_ Lic. Title: \_\_\_\_\_ Date of Orig. Issuance: \_\_\_\_\_

Issued by:  Examination – Title and date of exam: \_\_\_\_\_

Endorsement/Reciprocity  Grandfather clause

Applicant's License is:  Active, expires: \_\_\_\_\_  Inactive, expired: \_\_\_\_\_.

Has the Applicant's license ever been placed on probation, restricted, suspended, or revoked?

Yes, please provide explanation on reverse side.  No

\_\_\_\_\_  
Name and Title (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**SEAL**



# MARYLAND Department of Health

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D.,M.P.H., Secretary

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## BOARD OF PROFESSIONAL COUNSELORS AND THERAPISTS

4201 Patterson Avenue, Suite 316, Baltimore, Maryland 21215-2299

### NOTICE OF CRIMINAL HISTORY RECORDS CHECK

Effective January 1, 2014, the Maryland Board of Professional Counselors and Therapists (the "Board") requires that all applicants for licensure, certification, and trainee status complete a criminal history records check in accordance with §§17-501 and 17-501.1 of the Health Occupations Article, Annotated Code of Maryland.

A Criminal History Records Check includes a national and state criminal history background search. The criminal history records check requires you to be fingerprinted. In order to be fingerprinted, you will need to complete and present the LiveScan Pre-Registration Form. (Attached).

You must present this form to the fingerprinting site because it provides the Criminal Justice Information System (CJIS) authorization number #**1300005490** and the FBI ORI number #**MD920512Z** assigned specifically to the Board.

This allows the information to be forwarded directly to the Board.

For additional information contact CJIS at 410-764-4501. For current listings of fingerprinting providers please go to <http://www.dpscs.maryland.gov/publicservs/fingerprint.shtml>.

### FOR FAST AND ACCURATE SERVICE

1. When requesting a criminal history records check for licensing purposes you must have an agency name and authorization number (Listed above).
2. Your background check is being sent to the Board.
3. You must bring a valid form of government identification. (Examples: driver's license, Certificate of Naturalization, passport, Alien Registration Card, or Military Identification).
4. Complete the LiveScan Pre-registration Application and bring it to any fingerprinting center/provider.
5. Bring payment as indicated above. The Board will receive the results from the criminal history records check directly from CJIS within 5-7 business days. The Board will contact you if it has any questions regarding the report. Please do not contact the Board to check if the report has been received.
6. Please do not send the LiveScan Pre-registration Application to the Board. You must present it at the fingerprint center/provider location.



**STATE OF MARYLAND**  
**DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES**  
**CRIMINAL JUSTICE INFORMATION SYSTEMS - CENTRAL REPOSITORY**

**LIVESCAN PRE-REGISTRATION APPLICATION**

**APPLICANT INFORMATION** (PLEASE TYPE OR PRINT CLEARLY)

Name:			
Date of birth:	SSN:	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female (Please check)
Height: ft. inches	Weight: lbs.	Eye Color:	Hair Color:
Race: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Other (Please check)			
Place of Birth:	Citizenship:		
Current address:			
City:	State:	ZIP Code: -	
Daytime Phone:	Evening Phone:	Driver's License #:	

**AGENCY INFORMATION**

Agency Authorization #: 1300005490	
ORI # (if required): MD920512Z	Reason fingerprinted? License/Cert.
Position Applied for: N/A	
Request Type: (Choose one ONLY) <input type="checkbox"/> Adult Dependent Care <input type="checkbox"/> Attorney/Client <input type="checkbox"/> Child care <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Gold Seal/ Adoption <input type="checkbox"/> Gold Seal/Letter/VISA <input type="checkbox"/> Government Employment	<input checked="" type="checkbox"/> Government Licensing or Certification <input type="checkbox"/> Immigration/VISA <input type="checkbox"/> Individual Challenge <input type="checkbox"/> Individual Review <input type="checkbox"/> MSP Licensing <input type="checkbox"/> Private Party Petition <input type="checkbox"/> Public Housing

**Mail Response to:**  
(Mailing option only available for Visa Gold Seal and/or Individual Review)

Name:	_____
Address:	_____
City, State, Zip code:	_____

CHECKLIST FOR **Out of State LCPC APPLICATION**

- Official transcript(s) in the sealed envelope sent to you from educational institution.
- NCE and Maryland Law Assessment exam scores (if applicable).
- Three (3) completed Professional Reference Assessment forms in sealed envelopes to you from each professional reference.
- Copy of NCR registration (if applicable).
- Professional Experience Verification(s).
- Application is signed and notarized.
- Recent photo (2"x2").
- Copy of receipt from criminal history records check.
- Check or money order in the amount of \$250 payable to the Board of Professional Counselors and Therapists.
- \*\* Remember to make a copy of completed application and attachments for your records.