Mental Health Counselor Associate Expired Credential Activation Application Packet

Contents:

Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. 42 U.S.C. § 666(a)(13); RCW 26.23.150. It will be used under the state's child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you have questions.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Mental Health Counselor Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

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Application Instructions Checklist

You will be notified in writing if more documentation is needed.

To ensure you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

- ☐ **Pay Late Penalty Fee.**
- ☐ **Pay Current Renewal Fee.**
- ☐ **Pay Expired Credential Reissuance Fee.**
  All fees are non-refundable. You can check the online **fee page** for current fees.
- ☐ **1. Demographic Information.**
  Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360-236-4700 if you do not have one.

  National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

  Legal Name: List your full name: first, middle, and last.

  Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

  Birth date: Provide the month, day, and year of your birth.

  Address: List the address we should use to send any information about your credential. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change. See **WAC 246-12-310**.

  Phone, Fax, and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

  Email: Enter your email address, if you have one.

  Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.
- ☐ **2. Other License, Certification, or Registration.** List **all** credentials you have held since last being credentialed in Washington State. List in date order, most current

first. Include your last active credential in Washington State. Attach additional pages if you need more space.

- ☐ **3. Professional Experience.** List in date order, most recent to later, all your professional work experience since your Washington State credential expired. Attach additional pages if you need more space.
- ☐ **4. Disciplinary Action Attestation.** Required by **WAC 246-12-040**.
- ☐ **5. Declaration Working Toward Licensure.** Required by **WAC 246-809-130**.
- ☐ **6. Continuing Education Attestation.** Required by **WAC 246-12-040.**
- ☐ **7. Applicant's Attestation.** Required to be both signed and dated in order to process the application.

Washington State Department of HEALTH

Background Check Stamp Here

Date Stamp Here

Revenue 0207030000

Mental Health Counselor Associate
Expired Credential Activation Application

Please print clearly. Follow the instructions provided. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so may result in a delay in processing your application.

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	**National Provider Identifier Number (NPI)** (Enter 10 digit number)	☐ Male ☐ Female ☐ Prefer Not to Answer ☐ X

Name First Middle Last

Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address

Mailing address if different from above address of record

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

2. Other License, Certification, or Registration

List in date order, most recent to later, **all** credentials you have held since last being credentialed in Washington State. Include your last active credentials in Washington State.

State/Jurisdiction	Profession	Credential			Method of Credentialing	Currently in force	
		Type	Number	Yr Issued		No	Yes

3. Professional Experience

List in date order, most recent to later, all your professional work experience since your Washington State credential expired.

Type of experience of practice and location	Start (mm/yyyy)	End (mm/yyyy)

4. Disciplinary Action Attestation

I certify that no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify that I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

Applicant's Initials	Date

5. Declaration Working Toward Licensure

I declare that I am working toward licensure as a Mental Health Counselor.

Applicant's Initials	Date

6. Continuing Education Attestation

I certify I have met all continuing education and competency requirements for the past two years.

Applicant's Initials	Date

7. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

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Washington State Department of HEALTH

Mental Health Counselor
Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Out of State Credential Verification

Applicant Name: _____ Birth date: _____

I, _____, Secretary of _____,

hereby certify that _____

was granted state: ☐ Registration ☐ Certificate ☐ License

Number: _____ to practice: _____

in the State of _____ on the _____ day of _____, 20 _____

Legal/Disciplinary Action: ☐ Yes ☐ No If Yes, explain: _____

_____

_____

On the basis of: _____

_____

Did the applicant take and pass the NBCC Exam?

☐ Yes ☐ No Passing Score: _____

☐ Yes ☐ No 100 hours immediate postgraduate supervision with an approved licensed mental health practitioner or equally qualified licensed mental health practitioner.

☐ Yes ☐ No 3000 hours supervised postgraduate experience with approved licensed mental health practitioner or equally qualified licensed mental health practitioner. 1200 hours must be direct counseling with individuals, couples, families, or groups.

☐ Yes ☐ No 36 months full time counseling with a qualified licensed mental health counselor.

Status of License: ☐ Current Expiration Date _____ ☐ Expired Date _____

State Seal

Acting In Behalf of the: _____
Official Name of Board

Phone _____

Secretary _____

Date Certification Prepared _____

Return to address above.

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Washington State Department of HEALTH

Mental Health Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Approved Supervisor Verification
Mental Health Counselor Associate

To the Supervisor:

Please review **WAC 246-809-234**. To supervise a license mental health counselor associate, you must hold a license without restrictions that has been in good standing for at least two years.

You must not be a blood or legal relative or cohabitant of the license associate, license associate's peer, or someone who has acted as the license associate's therapist within the last two years.

Prior to the commencement of any supervision you shall provide the license associate this declaration, stating that you have met the requirements of **WAC 246-809-234** and that you qualify as an approved supervisor.

As an approved supervisor, I attest that I have completed the following:

A minimum of fifteen clock hours of training in clinical supervision obtained through:

- A supervision course; or
- Continuing education credits on supervision; or
- Supervision of supervision; or
- Or any combination of these; and

And twenty-five hours of experience in supervision of clinical practice

I attest that I will gain full knowledge of the supervisor's practice activities including:

- Practice setting
- Record keeping
- Financial management
- Ethics of clinical practice
- A backup plan for coverage

Declaration of Supervision—must be completed by Supervisor and provided to license candidate prior to the commencement of supervision in accordance with **WAC 246-809-234**.

I, _____ a licensed _____ in the
Name of Supervisor Name of License Candidate

State of _____ with license number _____ attests to _____

that I have read and met all the requirements in connection with **WAC 246-809-234**.

_____
Signature of Supervisor

_____
Date

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RCW/WAC and Online Website Links

RCW and WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Licensed Mental Health Counselor Laws, RCW 18.225

Licensed Mental Health Counselor Rules, WAC 246-809

Online

Licensed Mental Health Counselor, Web Page