Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration

BOARD OF PROFESSIONAL COUNSELING

ALLIED AND BEHAVIORAL BOARDS APPLICATION LICENSURE APPLICATION PROCESS

Application and processing fees are non-refundable for any reason after 120 business days

Thank you for submitting an application for a license to practice your profession in the District of Columbia. The application process involves **three distinct phases and may take 30-60 days**.

Please allow, at least, 30 days before inquiring about the status of an application http://doh.dc.gov or Customer service 1-877-672-2174.

Phase one (Processing) The following items and all supporting documents required must be received by the processing unit **within 120 business days** of submission of applications: Or your application will be deemed incomplete and closed.

1. A completed application form*
2. Two (2) Passport sized photos
3. Fees (made payable to DC Treasurer) Forms of Payment Accepted - Cashier Check, Money Order or Personal Check. **No Cash or Credit Cards**
4. Criminal Background Check - **Criminal Background Check Fees are separately payable to L-1 Identity Solutions** to schedule an appointment **or see fee schedule** (Call **1-877-783-4187** or www.L1enrollment.com **A Criminal Background Check IS REQUIRED for EVERYONE.**

*Please ensure that the application is received by the processing unit before any supporting documentation is submitted. We are unable to store loose documents without an associated application form. Loose documents will be discarded.

Requests for submission of missing documentation will be sent via email or letter at 30, 60, and 90-day intervals. When all documents have been received; the application is entered into the system as completed and **pending review** (this does not mean approved) for the **first of three phases** and will be sent to a Health Licensing Specialist (HLS) for analysis.

Phase two (Analysis) The HLS will conduct a more detailed review of all the documents. If further information or documents are necessary the HLS will contact an applicant and the analysis phase may take additional time. **Providing an email address for the Board to correspond speeds the process of notification of deficiencies and request of additional documents.**

When the **second of three phases** is completed, the application is entered into the system as pending board decision. The Board will review the application during their next meeting.

Phase three (Board Review and Decision) Board meetings are held monthly, bi-monthly, or quarterly, depending on the Board. Please visit our web page at http://doh.dc.gov for Board meeting dates. Board decisions may vary; the Board will exercise one of the following options depending on the facts in each application:

1. Determine the applicant meets the criteria for licensure and a license certificate is mailed within 8-10 days;
2. Determine a deferral is necessary to request additional information, or ask the applicant to appear in person to gather relevant information;
3. Determine the application does not meet the criteria at time of application (for reasons such as additional course work or supervision) and request that the applicant withdraw the application; or
4. Determine the applicant does not meet the criteria for licensure and send the applicant a notification of the Board's intent to deny the application and provide the reason.

FOR COPIES OF YOUR PROFESSION'S MUNICIPAL REGULATIONS PLEASE GO TO: http://doh.dc.gov

Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration

BOARD OF PROFESSIONAL COUNSELING

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to ***DC Code 22-2514***. If you have any questions, call HRLA Customer Service at **1-877-672-2174 Monday through Friday, 8:30AM to 4:30PM EST.** **Note: Please refer to application instructions before completing this form because fees are not refundable.**

SECTION 1A. LICENSURE TYPE & FEES

SELECT LICENSURE TYPE:
All Licensure levels cost: $230

- ☐ **Professional Counselor (PC) by examination**
- ☐ **Graduate Counselor (GC) by examination**
- ☐ **Professional Counselor (PC) by endorsement**
- ☐ **Graduate Counselor (GC) by endorsement**
- ☐ **Re-examination** ☐ **PC** ☐ **GC**

☐ **Duplicate licenses (limit 5) _____x $34.00**

Total Enclosed $_____

SECTION 1B. MAILING OF APPLICATION

PLEASE MAIL YOUR APPLICATION TO:

P.O. Box 37802
Washington, D.C. 20013

LICENSURE EXPIRATION: All licenses **expire July 31st** of old numbered years

SECTION 2A. APPLICANT INFORMATION

Note: LEGAL NAME: ***(Do not use any initials unless they are a part of your name)***

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

GENDER: ☐ **MALE** ☐ **FEMALE**

____/_____/_____ _____ _____ _____ - _____ - _____
Date of Birth **Place of Birth : State/Providence/Territory** **Country if not USA** **Social Security Number**

SECTION 2B. OTHER NAMES USED:

If your name on this application is different from the name on any of your supporting documentation, provide a copy of a legal document supporting that name change. Acceptable documents for individuals includes: a copy of a marriage certificate, divorce decree, or court order.

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

SECTION 2C: RACE & ETHNICITY DESIGNATION: (Optional)

- ☐ **American Indian/Alaskan Native** ☐ **Asian/South Asian**
- ☐ **Black or African American** ☐ **Caucasian/White**
- ☐ **Hispanic or Latino** ☐ **Other _____**
- ☐ **Native Hawaiian or other Pacific Islander**

LANGUAGE(S) SPOKEN:

Language(s) spoken other than English:

_____
_____
_____

SECTION 3A. PREFERRED MAILING ADDRESS

Note: A P.O. BOX MAY NOT BE USED FOR AN ADDRESS. PLEASE PROVIDE A STREET ADDRESS.

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

☐ **HOME ADDRESS** ☐ **BUSINESS ADDRESS**

SECTION 3B. HOME ADDRESS

THIS INFORMATION WILL NOT BE MADE AVAILABLE TO THE PUBLIC.

HOME ADDRESS:_____
(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

APARTMENT #_____ **HOME PHONE NUMBER: (**_____**)** _____ **-** _____ **HOME FAX: (**_____**)** _____ **-** _____

EMAIL ADDRESS: _____ **(REQUIRED)**

SECTION 3C. BUSINESS ADDRESS:

THIS INFORMATION WILL NOT BE MADE AVAILABLE TO THE PUBLIC.

BUSINESS NAME:_____

BUSINESS ADDRESS:_____
(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

☐ **SUITE #**_____ ☐ **FLOOR#**_____

BUSINESS PHONE NUMBER: (_____**)** _____ **-** _____ **BUSINESS FAX: (**_____**)** _____ **-** _____

EMAIL ADDRESS: _____

IMPORTANT MESSAGE TO ALL PROFESSIONAL COUNSELORS

PCs are required to update name or address changes within 30 days of the change. It is imperative that you update your information in writing, by email **hpla.doh.dc.gov or fax (202) 724-5145** to the District of Columbia Health Regulation Licensing Administration Processing Department. Submit your request to the Attention of the "Processing Center". Include your name, phone number and any other pertinent information that will assist us in ensuring that the information is updated to the appropriate record/file.

District of Columbia Health Regulation Licensing Administration
Attention: Processing Department - Board of Professional Counseling
899 North Capitol Street, N.E., 1st Floor
Washington, D.C. 20002

SECTION 4A. SCHOOLS ATTENDED

List Professional Counseling schools attended, in reverse chronological order, beginning with the most recent at the top.

School Name, City, State, Country	Date of Graduation mm/yyyy	Degree/Certificate

SECTION 4B. TRAINING AND PRACTICE - POSTGRADUATE EXPERIENCE

List experience covering the five (5) year period prior to the submission of the application (**MONTH & YEAR**) and all training. Include letters from employing facilities, organizations, and training. **For "TRAINING AND PRACTICE DESCRIPTIONS", use the letter key code below**. List experience in reverse chronological order, beginning with the most recent.

Organization/Institution	Start Date mm/yyyy	End Date mm/yyyy	Type of Position *(Use Key Code Below)*

TRAINING AND PRACTICE DESCRIPTIONS/TYPE OF POSITION KEY CODE

A. INTERNSHIP B. EMPLOYMENT C. PRIVATE PRACTICE D. OTHER…(Attach a typed explanation on a separate sheet of paper to this form.)

SECTION 4C. LICENSES IN OTHER STATES/JURISDICTIONS

List all states and jurisdictions in which you have ever held a license (excluding training licenses) and request license verifications to be mailed directly to the Board. Use additional sheet if necessary.

Are you currently applying for licensure in any other jurisdiction? _____ If yes please list those jurisdictions:_____

Jurisdiction	Issue Date mm/yyyy	Expiration Date mm/yyyy	License Number

SECTION 5. REQUIRED SCREENING QUESTIONS

Please answer questions 1 through 15 by placing an X in the appropriate boxes. If you answer "YES" to any question, you must provide full information and complete details **on a separate sheet of paper attaching copies of all relevant documents such as final court orders or panel review decisions.**

1.	Have you ever been charged, arrested, convicted, pled guilty to, or pled no contest (including no lo contendere) to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor (including driving under the influence or while impaired, but excluding minor traffic violations and whether or not sentence was imposed or suspended)?	Yes ☐ No ☐
2.	Have you ever been licensed in any healthcare field in any state or jurisdiction? If yes, please list profession(s) & jurisdiction(s). **HEALTH PROFESSION(S)** _____ _____ **JURISDICTION(S)** _____ _____	Yes ☐ No ☐
3.	Have you ever voluntarily surrendered a license or registration certificate (or allowed it to lapse) after formal charges had been brought against you or while you were under investigation?	Yes ☐ No ☐
4.	Have you ever been terminated or resigned (voluntary or involuntary) from employment or training program in your profession for any reason?	Yes ☐ No ☐
5.	Has any licensing authority taken adverse action against your license or privileges or informed you of any pending charges?	Yes ☐ No ☐
6.	Has any licensing authority, health facility, or peer review board informed you of any pending charge(s) or investigation(s) against you?	Yes ☐ No ☐
7.	Do you have a medical condition or have you become aware of any medical condition that currently impairs or limits your ability to practice medicine safely or that could affect your performance or impact your ability to practice your profession?	Yes ☐ No ☐
8.	Are you currently being treated, or within the past five (5) years have you been treated, for a physical or mental condition that, but for the treatment, could impair your ability to practice your profession?	Yes ☐ No ☐
9.	Have you ever engaged in the excessive use of alcohol, controlled substances or prescription drugs or have you received treatment or therapy for abuse of alcohol or drugs?	Yes ☐ No ☐
10.	Within the last ten (10) years, have you voluntarily resigned, asked to resign, been terminated, or disciplined by any employer due to practice or moral turpitude issues?	Yes ☐ No ☐
11.	Have you ever withdrawn a license application or have you been denied a license or denied the privilege of taking a license examination by any professional licensing board or agency?	Yes ☐ No ☐
12.	Have you ever been pardoned from a felony (or criminal) conviction?	Yes ☐ No ☐
13.	Have you ever had a record expunged from a felony (or criminal) conviction?	Yes ☐ No ☐

SECTION 6A. SUPPORTING DOCUMENTS

Please indicate the supporting documents you have included with this package or requested to be sent to the DC Board of Professional Counseling. Keep a photocopy.

☐ **Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicants name printed on the back.**
The photos must be original photos and cannot be computer-generated copies or paper copies.

☐ **Verification(s) of licensure** ***These should be provided in a sealed envelope from the issuing jurisdiction(s) for each license identified in Section 4C.***

☐ **All undergraduate, graduate, and professional school transcripts.**
Transcripts should be provided in a sealed envelope from the issuing institution for each school that you attended and listed in Section 4A.

☐ **Documentation of work experience covering 3500 hours and two (2) years.**

☐ **Examination Scores** ***In a sealed envelope from the test provider.***

☐ **Criminal Background Check (CBC) -***To access form and instructions go to www.doh.dc.gov/service/criminal-background-check or contact the CBC unit at 1-877-783-4187.*

SECTION 6B. Payment/Mailing Information

Make check or Money order payable to "DC TREASURER"
A charge of $65.00 will be imposed for dishonored checks
(Public Law 89-208)

Mail your application package and check to:
P.O. Box 37802
Washington, D.C. 20013

SECTION 7A. CLEAN HANDS

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit** for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars ($100.00) to the District of Columbia Government as a result of any of the following:

- Fines, penalties, or interest assessed pursuant to ***D.C. Official Code Title 8, Chapter 8*** (Litter Control Administrative Act of 1985);
- Fines or interest assessed pursuant to ***D.C. Official Code Title 8, Chapter 9*** (Illegal Dumping Enforcement Act of 1994);
- Fines, penalties, or interest assessed pursuant to ***D.C. Official Code Title 2, Chapter 18*** (Civil Infractions Act of 1985);
- Past due taxes;
- Past due District of Columbia Water and Sewer Authority service fees; or
- Fines or penalties assessed pursuant to ***D.C. Official Code Title 50, Chapter 23*** (Traffic Adjudication)?

Yes ☐ **No** ☐

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (***D.C. Law 11-118, D.C. Code §47-2861 et seq.***).

SECTION 7B. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

_____	_____	_____
LICENSEE SIGNATURE	***PRINT NAME***	***DATE***