APPLICATION INSTRUCTIONS FOR PROFESSIONAL CLINICAL MENTAL HEALTH COUNSELOR (LPCC), LICENSED MARRIAGE & FAMILY THERAPY (LMFT) AND ART THERAPY (LPAT).

1. Read the entire application before you begin to answer any questions, so you will understand exactly what information is being requested.
2. All questions must be answered. The burden of proof in satisfying the board that you are eligible for licensure is upon you.
3. Type or print your responses in **Black Ink**.
4. Your application fee of $75.00 must accompany your application. Your check or money order should be made payable to the “Counseling and Therapy Practice Board” **Fees ARE NON-REFUNDABLE**.
5. You must contact all colleges or universities you have attended contributing to the required associate, BA or master’s degree. Your official transcripts sent in a **sealed envelope**, to be submitted with your application to the Counseling and Therapy Practice Board.
6. The supervisor must complete attachment B, placed in a sealed envelope, to be submitted with your application.

To assist you in completing your applications please use the enclosed check-off list:

**Licensure by Requirements:**

- 1. Complete the Application;
- 2. Application fee $75.00 (NON-REFUNDABLE);
- 3. Current Color Photo; 2x2 in. (Passport Quality, NO PAPER COPIES);
- 4. Answer all questions to the best of your knowledge (if you answer yes to any questions, please give details on a separate sheet of paper include a certified copy of final judgment papers);
- 5. Application must be signed, dated, and notarized;
- 6. Attachment A (must come directly from your licensure state, sent in a sealed envelope), submitted with your application; and
- 7. Attachment B from supervisor (placed in sealed envelope), submit with your application; and
- 8. Official sealed college or university transcripts, submitted with your application.

**Licensure by Reciprocity:**

- 1. Complete the application;
- 2. Application fee $75.00 (NON-REFUNDABLE);
- 3. Current Color Photo; 2x2 in. (Passport Quality, NO PAPER COPIES);
- 4. Answer all questions to the best of your knowledge (if you answer yes to any questions, please give details on a separate sheet of paper include a certified copy of final judgment papers);
- 5. Application must be signed, dated, and notarized;
- 6. Attachment A (must come directly from your licensure state, sent in a sealed envelope), submitted with your application; and
- 7. Official sealed college or university transcript (graduate transcript only). Must hold a masters or doctoral degree in counseling or a counseling-related field from an accredited institution (sealed envelope), submit with your application.

**FIRST TIME APPLICANTS WITH A RELATED FIELD DEGREE MUST MEET THE CORE CURRICULUM CONTACT THE BOARD OFFICE FOR SPECIFIC INFORMATION. ONLY RELATED FIELD DEGREES.**

Revised 09/2014
# New Mexico Counseling and Therapy Practice Board Application

**LICENSURE BY RECIPROCITY**

$75.00 Application  
(Application Review time is 10-15 business days)

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## PERSONAL INFORMATION

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## PROFESSIONAL EDUCATION:

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**NOTICE**

**CASH IS NO LONGER ACCEPTED** as a form of payment for all business transactions including but not limited to licenses, permits, fees, and penalties. Payment must be made in one of the following methods: Check, Cashier’s Check, Money Order, or Credit Card (where authorized).

When you provide a check as payment, you authorize The State of New Mexico to either use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction.

Application Fee payment method (please mark):  
- check  
- money order  
- credit card

Type:  
- MC  
- Visa

Visa Number:  
Expiration date:  
Security Code:  

**Office Use Only**

Recei t#  
Deposit Date  
Fee Amount  
CK/MO
New Mexico Counseling and Therapy Practice Board

DISCIPLINARY/LEGAL ISSUES
Read the following carefully, check all appropriate boxes: Yes answers required an explanation and a copy of the final judgment paper.

1. Have you ever used another name under which records relating to your application, education, training or experience may be filed?
   _____ Yes  _____ No If yes, please enter names(s) used ________________________________

2. Have you ever received a deferred prosecution or judgment or been convicted of, or pled guilty or nolo contendere to a felony or misdemeanor (not including traffic violations) in any state, territory or district of the United States or a foreign country?
   _____ Yes  _____ No

3. Has any disciplinary action ever been started against you as a result of your counseling or therapy services or any license you hold or have held to practice counseling or therapy? (Note: disciplinary action includes but is not limited to suspension, probation, practice limitations, reprimand, letter admonition, censure, and any allegations currently pending.)
   _____ Yes  _____ No

4. Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such a claim yourself?
   _____ Yes  _____ No

5. Have you ever voluntarily surrendered a license or certification to practice counseling, therapy or any other health related profession in any state, foreign country, territory, or institution?
   _____ Yes  _____ No

6. Do you have any personal or legal problems with alcohol or drugs that in any way affect your ability to be a counselor or therapist?
   _____ Yes  _____ No

7. Have you ever pled guilty or nolo contendere to or been convicted, of driving under the influence of driving while intoxicated?
   _____ Yes  _____ No

8. Have you ever been denied a license or permission to take an examination to practice counseling or therapy in any state, foreign country or territory?
   _____ Yes  _____ No

9. Do you have any mental illness that affects your ability to be a counselor or therapist?
   _____ Yes  _____ No

10. Have you ever had any malpractice claims made against your license in New Mexico or any other state, foreign country or territory?
    _____ Yes  _____ No

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11. Have you had any judgments, or entered into any settlements, in regards to malpractice claims made against you in New Mexico or any other state, foreign country or territory?  
   ___Yes___No

12. Do you now have any pending lawsuits or claims in regard to counseling or therapy services in any capacity?  
   ___Yes___No

13. Are you in violation of compliance with court-ordered child support payments?  
   ___Yes___No

AFFIDAVIT AND NOTARIZATION
The undersigned, being duly sworn, upon his/her oath deposes and says that he/she is the person making the foregoing statements and that they are made in good faith and are true in every respect. By executing this application, the undersigned also acknowledges that he/she has read the Code of Ethics for Counseling and, if issued a license, agrees to conform with and support the Code of Professional Ethics, Rules and Regulations of the New Mexico Counseling and Therapy Practice Board, and the Professional Counseling and Therapy Act. I certify that all of the statements made in this application are true, complete, and correct to the best of my knowledge and belief and are made in good faith.

STATE OF ____________________________
COUNTY OF ____________________________

BEFORE ME on this day of ________, 20____ personally appeared the above named applicant who, being by me duly sworn upon oath, states that all statements and answers contained in this application are true and correct.

____________________________________
Notary Public

____________________________________
My Commission Expires:
Attachment A

STATEMENT OF REGISTRATION, CERTIFICATION OR LICENSURE AS A COUNSELOR OR THERAPIST IN ANOTHER STATE

Applicant completes only the top portion of this form and sends it to the state(s) in which he/she holds, or has held a license.

Section 1: To be completed by applicant:

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<th>Last Name:</th>
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Section 2: to be completed by the state

This certifies that the above individual was licensed as ___________________ (profession) with license number ____________________, issued ____________ (original date of licensure), expired ____________, entitling him/her to practice alcohol and drug abuse counseling or a related occupation.

1. Current license status:  ___Active ___Inactive ___Lapsed

2. Licensed on the basis of:  ___NBCC Examination. Date Taken: __________Score: __________
   ___State Examination
   ___Endorsement. Please identify licensing states: ________________
   ___Credentials. Please attach an explanation.
   ___Other. Please attach an explanation.

3. Was your state the state of original licensure?  ___Yes ___No

4. The educational requirements for the above-referenced title at the time of the applicant's licensure/certification:

   Required Field of Study

   Number of face-to-face supervised hours__________ Number of client contact hours __________

5. At the time this applicant was licensed, what were the licensing requirements with respect to post-degree experience and supervision?

6. Has this license ever been subjected to disciplinary action?  ___Yes ___No
   (e.g. revoked, suspended, surrendered, restricted, limited, placed on probation)?

7. Are there any complaints pending:  ___Yes ___No

I certify that the information I have provided on this application is true and correct to the best of my knowledge.

Seal

Name

Title

Please return this form to:
NM Counseling & Therapy Practice Board PO Box 25101,
Santa Fe, NM 87505

Name of State Board

Address/City/State/Zip

Revised 09/2014
**STATEMENT OF VERIFICATION OF POSTGRADUATE SUPERVISED HOURS**

It is the applicant’s responsibility to send this form to the appropriate supervisors.

**Date:**

To (Name of Supervisor):

In applying for licensure to practice Counseling/Therapy in the State of New Mexico, the Counseling and Therapy Practice Board requires verification of my number of postgraduate supervision hours. I therefore ask that you furnish the requested information and place it in a **sealed envelope, submit with application**.

**Print Applicant's Name:**

**Supervisors Information:**

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License Title: __________ License No: __________ State: __________ Issue Date: __________

Where the supervision/client contact took place: ________________________________

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<th>Beginning Date of Supervision (MM/DD/YYYY)</th>
<th>Ending Date of Supervision (MM/DD/YYYY)</th>
<th>Number of Face to Face Supervision Hours</th>
<th>Number of Direct Clinical Client Contact Hours</th>
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I declare under penalty of perjury under the laws of The State of New Mexico that the above information is true and correct. I further certify that this individual is competent to receive a license in the area in which supervision was given.

**Supervisor’s Signature:**

**Date:**

**AFFIDAVIT AND NOTARIZATION**

The undersigned, being duly sworn, upon his/her oath deposes and says that he/she is the person making the foregoing statements and that they are made in good faith and are true in every respect. By executing this application, the undersigned also acknowledges that he/she has received the above supervision. **I certify that all of the statements made in this application (B) are true, complete, and correct to the best of my knowledge and my belief and are made in good faith.**

**SEAL**

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<th>Supervisors Signature</th>
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**STATE OF**

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BEFORE ME on this _______ day of ________, 20__, personally appeared the above-named applicant who, being by me duly sworn upon oath, states that all statements and answers contained in this application are true and correct.

Notary Public

My Commission Expires: __________________________

Revised 09/2014
REQUEST FOR SPECIAL EXAMINATION ACCOMODATIONS

If you have a disability covered by the Americans With Disabilities Act, please complete this form and the documentation of disability related needs on the reverse side so your examination accommodation can be processed efficiently. The information you provide and any documentation regarding your disability and your need for examination accommodation will be treated with strict confidentiality.

(This section is for board office use only)

Name of applicant: First Name    M.I.    Last Name

Applicant Mailing Address

Social Security Number

SPECIAL ACCOMMODATIONS

I REQUEST SPECIAL ACCOMMODATIONS FOR THE ____________________________ EXAMINATION.

Please provide the board office as to what accommodations you are requesting and attach an official letter from your doctor.

Signature          Date

Revised 09/2014
SERVICE SATISFACTION SURVEY

In response to each question please rate your satisfaction with the service you received from the board office on a scale from 1-5, with 5 being the highest.

1. You were able to reach the board office during state business hours (includes leaving a message). Rating_______

2. The period of time from your initial request of an application packet to its receipt was satisfactory. Rating_______

3. All necessary forms were provided in your application packet. Rating_______

4. If you accessed the board website, you found the information/forms helpful. Rating_______

5. Telephone calls were returned in a timely manner. Rating_______

6. The board staff was courteous. Rating_______

7. Board staff assistance was provided efficiently and accurately. Rating_______

8. Overall, you were satisfied with the service you received from the board office. Rating_______

9. Let us know how we can improve our services:

________________________________________________________________________________________

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Thank you for taking the time to complete and return this survey. It is our endeavor to provide the best service possible to our applicants, licensees and the general public.

Optional: Name______________________________________________________________

Please send this survey with your application.