



Mental Health Counselor Expired Credential Activation Application Packet

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

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

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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 [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.

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.

Birth place: Provide the city, state and country where you were born.

Address: List the address we should use to send any information on 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. Previous Credentialing. List **all** licenses you have held since last being licensed in Washington State. List in date order, most current first. Include your last active license in Washington State. If you need more space, attach a sheet of paper.

- 3. Professional Experience.** In date order, list all your professional work experience since your Washington State credential expired. If you need more space, attach a sheet of paper.
- 4. AIDS Education and Training Attestation.** Required by [WAC 246-12-040](#).
- 5. Disciplinary Action Attestation.** Required by [WAC 246-12-040](#).
- 6. Continuing Education/Continuing Competency Attestation.** Complete 36 hours of continuing education, with six in professional ethics. See [RCW 18.225.090](#).
- 7. Applicant's Attestation.** Required to be both signed and dated in order to process the application.

2. Previous Credentialing (Include Previous Credentials in Washington State)

List **all** licenses you have held since last being licensed in Washington State. List in date order, most current first. Include your last active licensed in Washington State. If you need more space, attach a sheet of paper.

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

3. Professional Experience

In chronological order, list all your professional work experience since your Washington State credential expired. If you need more space, attach a sheet of paper.

Type of experience of practice and location	start (mm/yyyy)	end (mm/yyyy)

4. AIDS Education and Training Attestation

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested.

I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

Applicant's Initials	Date
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5. 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
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6. Continuing Education/Continuing Competency Attestation (If Applicable)

I certify that I have met all continuing education and competency requirements for the past two years. I am enclosing documentation on all classes attended/claimed.

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 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
 P.O. Box 47877
 Olympia, WA 98504-7877
 360.236.4700

Out of State Credential Verification

Applicant Name: _____ Birth date: _____
mm/dd/yyyy

I, _____, Secretary of _____,
Official Name of Board

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 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: _____

S
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A
L

 Official Name of Board Telephone Number

 Secretary

 Date Certification Prepared

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RCW/WAC and Online Web Site Links

RCW and WAC Links

Uniform Disciplinary Act.....	<u>RCW 18.130</u>
Administrative Procedure Act	<u>RCW 34.05</u>
Administrative procedures and requirements	<u>WAC 246-12</u>
Licensed Mental Health Counselor RCW	<u>RCW 18.225</u>
Licensed Mental Health Counselor WAC	<u>WAC 246-809</u>

On-Line

AIDS Training Resources	<u>Reference Page</u>
Licensed Mental Health Counselor	<u>Web Page</u>