



STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
APPLICATION FOR SUPERVISION & PROVISIONAL LICENSE

COMMITTEE FOR PROFESSIONAL COUNSELORS
 3605 MISSOURI BOULEVARD
 PO BOX 1335
 JEFFERSON CITY, MO 65102-1335

INSTRUCTIONS **PLEASE TYPE OR PRINT IN BLACK INK**

This application must be **TYPED** or **PRINTED** in **BLACK INK** and **ALL SECTIONS MUST BE COMPLETED**. An incomplete application will be returned. The completed application must be received in the committee office at least thirty (30) days before an upcoming committee meeting or conference call to be considered for placement on an agenda. **RETURNED APPLICATIONS WILL RESULT IN DELAYING COMMITTEE REVIEW.**

Official Graduate Transcript must be sent to the committee office by school at address listed at the top of the form. Completed application and fee to be sent to the same mailing address.

FEE: Fee information can be obtained at pr.mo.gov/counselors. Click on the icon Regulations and Chapter 1 - General Rules.

If the applicant has passed the National counselor Examination (NCE) please enter month and year mm/yyyy. See Section I item #8.

Pursuant to §620.127, RSMo, disclosure of your social security number (SSN) is mandatory. The committee will not publicly disclose your SSN without your consent, unless such disclosure is permitted by federal or state law. However, state law allows the committee to disclose your SSN in connection with any civil, criminal, administrative or arbitral proceeding, in an investigation in anticipation of litigation, pursuant to a court order, and in the performance of a statutory or constitutional duty or power. The committee can also disclose your SSN to another government agency (federal, state or local) and to a private person or entity acting on behalf of, or in cooperation with, a state entity. State law requires the committee to provide your SSN to child support and tax compliance officials.

TELEPHONE: (573) 751-0018 (VOICE MAIL) **FAX:** (573) 751-0735 **TDD:** 800-735-2966 **EMAIL:** profcounselor@pr.mo.gov

I. APPLICANT INFORMATION

1. NAME (LAST, FIRST, MIDDLE INITIAL, SUFFIX, MAIDEN)		E-MAIL ADDRESS
2. ADDRESS (STREET AND BOX NUMBER, IF APPLICABLE, CITY, STATE, ZIP)		
3. TELEPHONE HOME	4. DATE OF BIRTH	5. SOCIAL SECURITY NUMBER (REQUIRED)
6. GENDER (THIS INFORMATION IS VOLUNTARY)		7. RACE (THIS INFORMATION IS VOLUNTARY)
8. IF THE APPLICANT HAS PASSED THE NATIONAL COUNSELOR EXAMINATION (NCE) PLEASE ENTER MONTH AND YEAR MM/YYYY		

II. SUPERVISOR INFORMATION

8. SUPERVISOR NAME (LAST, FIRST, MIDDLE, MAIDEN)		SUPERVISOR EMAIL ADDRESS	9. IS SUPERVISOR A RELATIVE OF APPLICANT? <input type="checkbox"/> YES <input type="checkbox"/> NO
10. ADDRESS (STREET, CITY, STATE, ZIP CODE)			11. DAYTIME PHONE NUMBER
12. DATE OF EMPLOYMENT	13. IF NOT EMPLOYED BY INSTITUTION, SUBMIT A CONTRACT AFFILIATING SUPERVISOR WITH THE PROPOSED SITE <input type="checkbox"/> CONTRACT OF AFFILIATION INCLUDED WITH APPLICATION <input type="checkbox"/> CONTRACT OF AFFILIATION FORTHCOMING		

14. PLEASE CHECK ALL THAT APPLY TO SUPERVISOR:

<input type="checkbox"/> LICENSED PROFESSIONAL COUNSELOR	LICENSE NUMBER	STATE
<input type="checkbox"/> LICENSED PSYCHOLOGIST	LICENSE NUMBER	STATE
<input type="checkbox"/> LICENSED PSYCHIATRIST	LICENSE NUMBER	STATE
<input type="checkbox"/> OTHER (list credential)	LICENSE NUMBER	STATE

IF REGISTERING MORE THAN ONE SETTING FOR LICENSURE SUPERVISION, PLEASE CHECK HERE.

III. SUPERVISED PRACTICE SITE

15. NAME OF PRACTICE SITE

16. SITE ADDRESS

17. IS SITE A PRIVATE PRACTICE? IF YES, ANSWER QUESTIONS 18 AND 19 BELOW.

18. IDENTIFY INDIVIDUAL(S) WHO HAVE AN OWNERSHIP INTEREST IN THE PRIVATE PRACTICE.

19. LIST ALL INDIVIDUALS EMPLOYED BY OR AFFILIATED WITH THE PRIVATE PRACTICE (attach separate sheet, if necessary.)

NAME	TITLE	LICENSE NUMBER	STATUS

IV. NATURE OF SUPERVISION

T20. CHECK THE APPROPRIATE BOX(ES) THAT DESCRIBE THE DUTIES TO BE PERFORMED BY THE APPLICANT. ATTACH ADDITIONAL SHEETS IF NECESSARY:

- ASSESSMENT/TESTING CRISIS INTERVENTION GROUP COUNSELING
 INDIVIDUAL COUNSELING (Please specify) _____ CHILDREN _____ ADULTS _____ ADOLESCENTS _____ FAMILY
 RESEARCH SCHOOL COUNSELING (See application instructions concerning school counseling)
 SUBSTANCE ABUSE COUNSELING VOCATIONAL/CAREER COUNSELING
 OTHER (Please explain)

20A. BRIEFLY DESCRIBE JOB AND DUTIES

21. APPLICANT'S WORK TITLE

22. DATE OF APPLICANT'S INITIAL EMPLOYMENT

23. ESTIMATED NUMBER OF HOURS PER WEEK APPLICANT WILL BE WORKING. APPLICANT MUST WORK AT LEAST FIFTEEN (15) HOURS PER WEEK PROVIDING COUNSELING OR COUNSELING RELATED DUTIES.

24. THIS SECTION MUST BE COMPLETED BY THE SUPERVISOR. EXPLAIN HOW REPORTS, CASE NOTES, TREATMENT PLANS, ETC. WILL BE REVIEWED BY THE SUPERVISOR AND THE REVIEW DOCUMENTED.

24A. CHECK BOXES THAT APPLY TO FORMS OF SUPERVISORY OVERSIGHT. ATTACH ADDITIONAL SHEET IF NECESSARY.

- REVIEW AUDIO/VISUAL TAPES PROFESSIONAL DEVELOPMENT PERIODIC EVALUATION
 SEMINARS GROUP SUPERVISION SESSIONS OTHER (Please explain) _____
 WORKSHOPS OBSERVE SESSIONS

SUPERVISOR SIGNATURE REQUIRED

V. STATEMENT OF EMPLOYER

I, as a representative of the proposed supervision site, hereby affirm that the supervisor and counselor-in-training are employed at or affiliated with the site requested in Section III. I understand that if both are not employees, a contract must be provided to the committee which will affiliate the supervisor to the practice site.

EMPLOYER SIGNATURE

PRINT NAME AND TITLE

DATE

25. Have you completed an advanced degree with a major in counseling, counseling psychology, clinical psychology, guidance and counseling, or school psychology?

YES NO

If graduate course work is in quarter hours, please check here

If graduate course work is from an online or Internet based program, please check here

26. DEGREE INFORMATION

UNIVERSITY/COLLEGE ATTENDED	CITY AND STATE	DATES ATTENDED				DEGREE TYPE	CONFERRED	
		FROM		TO			MO	YR
		MON	YR	MON	YR			
A.								
B.								
C.								

27. LIST CORE COURSES TAKEN FOR GRADUATE CREDIT THAT APPEAR ON A TRANSCRIPT.

COURSE NO.	COLLEGE/UNIVERSITY	TITLE OF COURSE	CREDIT HOURS	DATE TAKEN
A. COUNSELING THEORY (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
B. HUMAN GROWTH & DEVELOPMENT (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
C. SOCIAL AND CULTURAL DIVERSITY (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
D. HELPING RELATIONSHIP (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
E. GROUP COUNSELING (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
F. CAREER DEVELOPMENT (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
G. APPRAISAL (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
H. RESEARCH METHODS (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
I. PROFESSIONAL ORIENTATION (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
J. DIAGNOSIS (MINIMUM OF 3 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				
K. PRACTICUM / INTERNSHIP / FIELD STUDY (MINIMUM OF 6 SEMESTER HOURS GRADUATE CREDIT REQUIRED)				

VII. APPLICANT HISTORY

28. Please answer the following questions (Yes answers must be explained in writing and accompany application) YES NO
- a. Have you, or any license or right to practice held by you, been restricted, disciplined, such a disciplinary action to include, but not be limited to, revocation, suspension, probation, censure, or reprimand, whether voluntarily agreed to or not, by any US state, territory, federal agency, Canadian province or foreign country?
 - b. Have you ever taken an examination or been licensed by another professional licensing board? If yes, please list the board name, state, and license number.
 - c. Are you presently being investigated or is any disciplinary action pending against any professional license, certification, registration or permit you hold?
 - d. Have you ever been arrested, charged, subject to prosecution, indicted, found guilty, or entered a plea of guilty or nolo condendere, in a criminal prosecution under the laws of any state or of the United States whether or not sentence was imposed? Applicants must answer "yes" even if a suspended imposition of sentence or suspended execution of sentence was received/ordered. **If "yes", are you currently on probation?**
 - e. Have you been charged with or convicted of a violation of any federal or state drug laws or rules whether or not sentence was imposed or suspended?
 - f. Are you now or have you in the last five years been addicted to any drug or chemical substance including alcohol?
 - g. Have you had a judgment rendered against you based upon fraud, misrepresentation, or deception related to your practice as a professional counselor?
 - h. Have you ever been named as a defendant in a civil suit related to counseling?

Pursuant to Section 324.010 RSMo:

CHECK THIS BOX ONLY IF IN ALL OF THE LAST THREE (3) YEARS: YOU WERE NOT A MISSOURI RESIDENT, YOU DID NOT HAVE ANY MISSOURI INCOME, AND YOU ARE NOT SUBJECT TO ANY TYPE OF MISSOURI INCOME TAX.

False statements are subject to criminal penalties and/or license discipline.

Information relating to state income tax compliance must be directed to MO Department of Revenue at 573-751-7200 or e-mail income@dor.mo.gov.

VIII. STATEMENT OF APPLICANT

I understand I must practice professional counseling under the supervision of a licensed professional counselor, psychologist, or psychiatrist approved by the Committee for Professional Counselors, until I am licensed. I further understand that the minimum acceptable supervised experience shall be 3,000 hours and 24 months obtained within 24 - 60 calendar months for master's degree applicants or 1,500 hours and 12 months obtained within 12 - 36 calendar months for applicants with at least 30 hours post-master's degree course work in counseling or a counseling related field. If, for any reason, the approved site or supervisor changes, I will notify the Committee for Professional Counselors and file a change of supervision application. I understand that any supervision obtained without such notification will not be applicable toward licensure. I hereby affirm under penalties of perjury that I am the applicant named in this registration and that all statements and enclosures herein are true and accurate to the best of my knowledge, information and belief. I submit for consideration this application for supervision as required by the Missouri law governing the practice of professional counseling and subject to the regulations of the Missouri Committee for Professional Counselors. I subscribe and agree to abide by all applicable laws and regulations regarding the practice of professional counseling. I hereby certify that I have read the laws and applicable regulations promulgated by the Missouri Committee for Professional Counselors.

Enclosed is the application fee which is not refundable. I understand that the Committee may require further information or evidence that it deems reasonable and proper and that the results of the review of this application will be provided to the licensure supervisor listed on this application.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications.

I authorize all correspondence regarding my application to be emailed to my supervisor and me at the email addresses listed on page 1 of this application. I understand such correspondence will not be sent via regular mail.

APPLICANT SIGNATURE (REQUIRED)

DATE

IX. STATEMENT OF SUPERVISOR (SIGNATURE REQUIRED)

I have reviewed this proposal for supervised professional experience and accept full responsibility for the work this applicant will be performing under my supervision. This work will be performed pursuant to my order, control, oversight and guidance. I have read and understand the law and regulations concerning licensure supervision. If I am unable to complete this supervision arrangement or discontinue supervision I will advise the Committee for Professional Counselors in writing. I hereby affirm under penalties of perjury that I am the supervisor named in this registration and that all the statements and enclosures herein are true and accurate to the best of my knowledge, information and belief.

SUPERVISOR SIGNATURE (REQUIRED)

DATE