

# THE OKLAHOMA APPLICATION PROCEDURE

for

## LICENSURE BY ENDORSEMENT

**SUBMISSION OF APPLICATION:** Your application for licensure must be returned by mail\* to the Professional Counselor Licensing Division in packet form. This means that all forms, university transcript(s) and fee must be submitted together in one envelope. Below is a recommended sequence for completing your application:

1. Study the Act and Regulations included in your materials. These documents describe the particulars of your application and direct your professional behavior as a licensee. The Oklahoma portion of your examination for licensure will cover these documents. Retain these documents for reference and exam preparation.
2. Complete your part of the following documents and distribute them to the appropriate third parties, then retrieve the signed documents from the third party for submission:
  - A. Three documents of recommendation from three professionals.
3. University transcript – **request that an official** copy of your transcript be mailed to you from the university registrar. The transcript must be in a sealed envelope with the registrars stamp over the flap. Include the unopened envelope from the registrar in your application packet.
4. Letter of good standing – request that a letter of good standing from the state of current licensure be mailed to you. The letter of good standing must be in a sealed envelope. Include the unopened envelope from the current state of licensure in your application packet.
5. Licensure verification card – please include a copy of current license card from the state of licensure.
6. Verification of exam score – please include documentation that you have passed the national exam for the license you are applying for:
  - A. LPC – National Counselor Examination
  - B. LMFT – Licensing Examination in Marital and Family Therapy
  - C. LBP – Practitioner’s Exam of Psychological Knowledge
6. Complete the application form and affix your personal check, money order or cashier’s check for the application fee in the area designated.
  - A. Licensed Professional Counselor - \$145
  - B. Licensed Marital and Family Therapist - \$200
  - C. Licensed Behavioral Practitioner - \$275
7. For your own protection:
  - A. Photocopy all the documents you have submitted.
  - B. Submit your documents by certified mail.
  - C. Double check – to ensure that all forms are completed as per instructions, transcript(s) are in a sealed envelope from the registrar and that all forms are signed. Failure to comply with the instructions will cause a delay in the processing of your application and possibly a missed exam deadline.
8. Assemble all the above materials and submit them in one envelope to:

Professional Counselor Licensing  
Protective Health Services  
Oklahoma State Department of Health  
P.O. Box 268823  
Oklahoma City, OK 73126-8823

### **EXAMINATIONS:**

**LPC** – The Oklahoma Legal and Ethical Responsibilities Examination (OLERE)

The OLERE covers the Oklahoma LPC Act and Regulations. Contact the Department for information regarding the OLERE.

**LBP** – Oklahoma Licensed Behavioral Practitioners State Standards Test.

- A. This is a written examination covering the LBP Act and Regulations. Consists of twenty (20) multiple-choice questions.
- B. Please call the PCL office to schedule your examination.

**LMFT** – The Oklahoma LMFT Professional Issues Oral Examination

- A. This is an oral examination administered by the LMFT Advisory Board covering the Oklahoma LMFT Act and Regulations, as well as, abnormal behavior, including the use of the DSM-IV.
- B. The LMFT office will schedule your examination and notify you by mail.

**\*Facsimile or other electronic submission of documents will not be accepted.**



# APPLICATION INVENTORY - ENDORSEMENT

(Please staple this form to the front of your completed application packet)

Applicant's name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please check the line beside the appropriate response:**

I am applying to become licensed as an:       LPC       LBP       LMFT

**Inside this packet I have enclosed the following:**

Notarized application form       The application fee, equaling: \$ \_\_\_\_\_

Sealed transcript. If yes, from which University(s)?  
\_\_\_\_\_

Three (3) Documents of recommendation. PLEASE NOTE: Must be on Department form(s)

Since three (3) recommendation forms are required, if less than three (3) are enclosed, please explain why.  
\_\_\_\_\_

Affidavit of Lawful Presence

Out-of-State Verification From

Licensure Verification Card

Verification of Exam Score

Two, classifiable sets of fingerprints (if fingerprint cards are not included with this packet, contact Carolyn Martin at carolynkm@health.ok.gov)

Please list any additional enclosures in the space below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





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Oklahoma State Department of Health  
Protective Health Services  
Professional Counselor Licensing  
P.O. Box 268823  
Oklahoma City, OK 73126-8823  
Telephone: (405) 271-6030  
FAX: (405) 271-1918  
<http://pcl.health.ok.gov>

## APPLICATION FORM

Please check the license you are applying for:

LPC

LBP

LMFT

(Please Print Legibly or Type)

### 1. Identifying Information:

a) Applicant's Name: \_\_\_\_\_

b) Social Security Number: \_\_\_\_\_ c) Birth date: \_\_\_\_\_ d) Sex:  M  F

e) Preferred Mailing Street Address: \_\_\_\_\_

f) City, State, Zip: \_\_\_\_\_

g) Area code & Telephone: \_\_\_\_\_

h) E-mail Address: \_\_\_\_\_

i) Current Place of Employment: \_\_\_\_\_

j) Telephone at Current Place of Employment: \_\_\_\_\_

**2. Education:** College/University granting the qualifying degree (please print out the full name of the school - do not abbreviate or use initials):

a) Name of Institution: \_\_\_\_\_

b) Graduate Degree: \_\_\_\_\_ c) Year Graduated: \_\_\_\_\_

d) Major: \_\_\_\_\_

e) Name(s) on transcript(s) if different from that listed on item 1.(a) of this application:

**3. Other Credentials:** If you possess professional licenses or certificates issued by Oklahoma or other states, give license or certificate titles, numbers, states issuing and expiration date.

(over)

**4. Professional Misconduct:**

a) Have you ever had your professional membership, registration, certificate or license suspended, revoked, restricted, or denied or has any other disciplinary action been taken against you by any professional organization, federal or state regulatory body or foreign jurisdiction, or are you presently under investigation by any regulatory body, to the best of your knowledge?

Yes  No

b) Have you ever had professional privileges in a hospital, HMO, etc., suspended or restricted or has any other disciplinary action been taken against you on grounds of unprofessional conduct, incompetence, negligence or unsafe practice?

Yes  No

c) Has any claim been made against you in a criminal or a civil suit or any other forum in the past ten years which clearly alleges unethical behavior on your part including but not limited to the following examples: sexual intimacy with a client, a dual relationship with a client, violation of confidentiality, or any other offense which might relate to your professional practice?

Yes  No

d) Have you ever voluntarily given up privileges, registration, certificate or license to practice your profession or agreed to restrict your practice?

Yes  No

*If you answered "yes" to any of the above, provide detailed information on a separate piece of paper.*

e) Have you ever been convicted of a felony or a misdemeanor?

Yes  No

f) If your answer to number 4.(e) is "yes", please provide the following information:

Date of conviction: \_\_\_\_\_ Where convicted: \_\_\_\_\_

Charge: \_\_\_\_\_

If the conviction was set aside, give the date and provide detailed information on a separate piece of paper.

**5. References:**

Separate documents in your application packet call for recommendations from third parties. Three documents must be submitted. The rater must be a **professional who is familiar with your personal character and professional skills**. Do not request a person to act as a reference who is an employee of the Department of Health, a member of the Board of Health or the LPC, LMFT or LBP Advisory Boards or a member of your family.

**6. Proposed Professional Practice:**

Please describe how you plan to use your license including: 1.) type of professional setting (hospital, school, in/out patient, etc.) 2.) client population 3.) client age range 4. type of practice (governmental, private not for profit, private for profit).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE READ CAREFULLY**

I understand that the Oklahoma Open Records Act requires that all records contained in my licensing file, with the exception of my university transcripts and any documents associated with an on-going investigation of my professional conduct, are available for public scrutiny and photocopying.

I hereby grant permission to the Department to seek any information or references deemed fit in securing my credentials pertinent to this application.

I further agree that if issued a license, upon the revocation of the license, I shall return said license.

The information that I have provided in this application is truthful. I understand the giving the Department false information of any kind may result in the voiding of this application and possible disciplinary action.

**I have read the Act and Regulations relevant to the license, for which I am applying, understand them and agree to abide by them.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

**NOTARIZATION**

The State of \_\_\_\_\_ )  
County of \_\_\_\_\_ )

BEFORE ME, the undersigned authority, on this day personally appeared \_\_\_\_\_  
known to me to be the person whose name is subscribed to the foregoing instrument, and having been by me first duly sworn on oath,  
acknowledged that he had executed the same for the purposes and considerations therein expressed and that the foregoing statements  
are true and correct.

GIVEN under my hand and seal of office, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

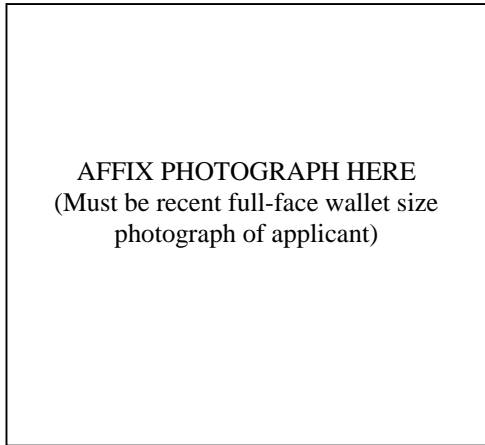
My commission expires \_\_\_\_\_, \_\_\_\_\_.

Notary Public in and for \_\_\_\_\_ County, Oklahoma or \_\_\_\_\_.  
(Please place notary seal on edge of photograph.)

\_\_\_\_\_  
Name of Notary

\_\_\_\_\_  
Signature of Notary

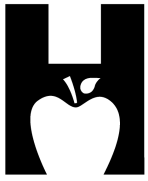
**Return to:**  
**Oklahoma State Department of Health**  
**Protective Health Services**  
**Professional Counselor Licensing – 0504**  
**1000 N.E. 10th Street**  
**Oklahoma City, OK 73117-1299**



Please staple your application fee check made out to the appropriate licensing fund (ie; LPC revolving fund - \$145; LMFT revolving fund - \$200; LBP revolving fund - \$275) in the space below.

Pursuant to the law, this fee , “...shall be retained by the State Department of Health and not returned to the applicant





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Oklahoma State Department of Health  
Protective Health Services  
Professional Counselor Licensing – 0504  
1000 NE 10<sup>th</sup> Street  
Oklahoma City, OK 73117  
Telephone: (405) 271-6030  
Fax: (405) 271-1918  
<http://pcl.health.ok.gov>

**AFFIDAVIT OF LAWFUL PRESENCE BY PERSON  
MAKING APPLICATION FOR A LICENSE, PERMIT OR CERTIFICATE**

I, the undersigned applicant, being of lawful age, state that one of the following statements is true and correct: (Check which one of the following statements apply.)

\_\_\_\_\_ I am a United States citizen.

\_\_\_\_\_ I am a qualified alien under the federal Immigration and Nationality Act and am lawfully present in the United States. (Alien or Admission # \_\_\_\_\_)

I state under penalty of perjury under the laws of Oklahoma that the Foregoing is true and correct and that I have read and understand this form and executed it in my own hand.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

If you are using this form to renew a license, permit, or certificate, please write you license number: \_\_\_\_\_  
(Current license, permit, or certificate #)

**INSTRUCTIONS FOR USE OF THE AFFIDAVIT OF LAWFUL PRESENCE BY  
PERSON MAKING APPLICATION FOR A LICENSE, PERMIT OR CERTIFICATE**

**The person signing this form must read these instructions carefully.**

1. If the person executing this form is receiving services and not making an application for a license, permit or certificate, this form should **not** be used but rather, either the form titled, "*Affidavit of Lawful Presence by Parent or Guardian of Person Receiving Services*" or the form titled "*Affidavit of Lawful Presence by Person Receiving Services*" should be used.
2. If the person executing this form is a citizen of the United States then that person should check the box to the left of the statement, "*I am a citizen of the United States.*" If the person executing this form is not a citizen of the United States but is a qualified alien under the federal Immigration and Nationality Act and is lawfully present in the United States then that person should check the box to the left of the statement, "*I am a qualified alien under the federal Immigration and Nationality Act and am lawfully present in the United States.*"
3. In the space after the word "*Date*" the person executing this form should write today's date. The person executing this form should indicate the city and state where they are actually located when they sign this form.
4. Within the context of the execution of this form, the term "penalty of perjury" means the willful assertion of the fact of either United States citizenship or lawful presence in the United States as a qualified alien, and made upon one's oath or affirmation and knowing such assertion to be false. Making such a willful assertion on this form knowing it to be false is a crime in Oklahoma and may be punishable by a term of incarceration of not more than five (5) years in prison. Additionally, one who procures another to commit perjury is guilty of the crime of subornation of perjury and may be punished in the same manner, as he would be if personally guilty of the perjury so procured.





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**OUT-of-STATE LICENSE VERIFICATION FORM**

**SECTION 1: APPLICANT INFORMATION (This section is to be completed by the applicant)**

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Type of credential held in other state: \_\_\_\_\_ License Number: \_\_\_\_\_

Date Issued: \_\_\_\_\_ Date of Expiration: \_\_\_\_\_

**SECTION 2: CURRENT STANDING (To be completed by the State Board)**

Name of credential held (Licensure/Certificate): \_\_\_\_\_

Licensure/Certificate #: \_\_\_\_\_

Date of Issue: \_\_\_\_\_ Date of Expiration: \_\_\_\_\_

Is the license in good standing? Yes \_\_\_\_\_ No \_\_\_\_\_

**If "no", please state reason(s):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the Licensee/Certificated have a record of disciplinary action(s)? Yes \_\_\_\_\_ No \_\_\_\_\_

**If "yes", please state the nature of the disciplinary action(s):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION 3: TEST**

Did the applicant complete an examination in order to receive licensure? Yes \_\_\_\_\_ No \_\_\_\_\_

**If "yes" please complete the following:**

Name of Exam: \_\_\_\_\_

Date of Exam: \_\_\_\_\_ Pass \_\_\_\_\_ Fail \_\_\_\_\_

Applicants Score: \_\_\_\_\_ Passing Score: \_\_\_\_\_

**SECTION 4: SUPERVISION**

Did the applicant accrue supervised experience to become licensed/certified? Yes \_\_\_\_\_ No \_\_\_\_\_

**If “yes” please complete the following:**

Number of hours of supervised experience: \_\_\_\_\_

Number of months: \_\_\_\_\_

Number of face-to-face direct client contact hours: \_\_\_\_\_

Number of face-to-face hours with supervisor: \_\_\_\_\_

Supervisor qualifications: \_\_\_\_\_

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

Print name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of State Board: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Please return this form - in a sealed envelope - to the applicant listed in SECTION 1.**



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**DOCUMENT OF RECOMMENDATION**

Please check the appropriate license:     LPC         LBP         LMFT

This document is to be completed by a **professional person who has knowledge of the applicant's personal character and professional competence.** Please rate the applicant in comparison to other professionals at a similar level of training and experience. Raters shall not be Health Department employees or members of the Board of Health or Advisory Board or members of the applicant's family.

**(To be completed by Applicant)**

Applicant's Name: \_\_\_\_\_

Applicant's Address: \_\_\_\_\_

\_\_\_\_\_

Applicant's place of employment: \_\_\_\_\_

Applicant's telephone number: \_\_\_\_\_

----- **(To be completed by rater)** -----

Please rate the applicant in the following categories:

**No Observation      Below Average      Average      Above Average**

Personal Character: \_\_\_\_\_

Professional Ethics: \_\_\_\_\_

Professional Training: \_\_\_\_\_

Treatment Skills: \_\_\_\_\_

Assessment Skills: \_\_\_\_\_

Consulting Skills: \_\_\_\_\_

Research Skills: \_\_\_\_\_

**(over)**





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Applicant's Address: \_\_\_\_\_

\_\_\_\_\_

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Consulting Skills: \_\_\_\_\_

Research Skills: \_\_\_\_\_

**(over)**

