

# OKLAHOMA STATE DEPARTMENT OF HEALTH

## Instructions for Submitting an Application for Licensure

Below is a recommended sequence for completing and submitting your application for Licensed Professional Counselor (LPC), Licensed Marital and Family Therapist (LMFT) and Licensed Behavioral Practitioner (LBP):

1. Request fingerprint cards from the Professional Counselor Licensing Division by contacting Carolyn Martin at [CarolynKM@health.ok.gov](mailto:CarolynKM@health.ok.gov) with your name and mailing address.

Each applicant for licensure must have a background check completed by the Oklahoma State Bureau of Investigation (OSBI). Fingerprint cards take four (4) to six (6) weeks to process. The process time is determined by the OSBI and cannot be expedited by this office. Therefore, we thank you in advance for your patience.

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:

- Three (3) Document of Recommendation Forms.
- Internship/Practicum Documentation Form.

3. Request that an **official copy of your university transcript** (graduate coursework only) be mailed to you from the university registrar. The transcript must be in a sealed envelope with the registrar's stamp over the flap. Include the unopened envelope from the registrar in your application packet.

Please be aware that transcripts cannot be reviewed and fingerprint cards cannot be processed unless they are submitted along with your application form and application fee.

4. Complete the application form and affix your personal check, money order or cashier's check for the application fee. The application fee for each license type is:

- Licensed Professional Counselor - \$145.00 (Made payable to the LPC Revolving Fund)
- Licensed Marital and Family Therapist - \$200.00 (Made payable to the LMFT Revolving Fund)
- Licensed Behavioral Practitioner - \$275.00 (Made payable to the LBP Revolving Fund)

5. Assemble all the above materials and if possible, submit them in one envelope to:

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

### Supervised Experience Forms:

Enclosed in your application packet are a Supervision Agreement, Statement of Professional Disclosure and On-Site Supervisor Verification Form. You may begin to accrue supervision hours only after you have submitted application and have been approved by the Department.

### For Your Own Protection:

- Photocopy all the documents you have submitted.
- Submit your documents by certified mail.
- Double check – to ensure that all forms are completed as per instructions, official transcript(s) are in a sealed envelope from the registrar and that all forms are signed and each signature is dated.

**\*\*Failure to comply with the instructions may cause a delay in the processing of your application.\*\***



# APPLICATION INVENTORY

(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.

\_\_\_\_\_  
 Internship/Practicum documentation form

Supervision agreement (if applicable at the time of application)  
THE SUPERVISION AGREEMENT WILL NOT BE APPROVED IF NOT ACCOMPANIED BY THE CANDIDATE'S STATEMENT OF PROFESSIONAL DISCLOSURE AND THE ON-SITE SUPERVISOR VERIFICATION FORM.

Candidate Statement of Professional Disclosure Form (does not apply for LMFT)

Affidavit of Lawful Presence

On-Site Supervisor Verification Form

Academic worksheet

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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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



**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 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.

Date \_\_\_\_\_ Signature \_\_\_\_\_  
City & State \_\_\_\_\_ Print Name \_\_\_\_\_

If applying to renew a license, permit, or certificate, please write the 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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FAX: (405) 271-1918  
<http://pcl.health.ok.gov>

**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 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:

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

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

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

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

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

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

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

**(over)**





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**(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:

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

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

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

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

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

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

**(over)**





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**INTERNSHIP/PRACTICUM DOCUMENTATION FORM**

Please check the appropriate license:

LPC

LBP

LMFT

(To be completed by applicant)

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

Name and address of agency where practicum was taken:

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

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

City, State \_\_\_\_\_ Zip: \_\_\_\_\_

Inclusive dates of practicum: From: \_\_\_\_\_ To: \_\_\_\_\_

Total number of clock hours accrued in practicum: \_\_\_\_\_

Name of school arranging practicum: \_\_\_\_\_

Type of treatment done: \_\_\_\_\_

(To be completed by supervisor or school official)

I verify that the above information is true and correct:

Name of person verifying: \_\_\_\_\_

Address of person verifying: \_\_\_\_\_

Telephone number of person verifying: \_\_\_\_\_

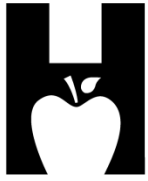
Title/position of person verifying: \_\_\_\_\_

Do you recommend this person to pursue licensure?  Yes  No

Signature of person verifying: \_\_\_\_\_

(Please copy this form if more than one practicum was taken)





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**ON-SITE SUPERVISOR VERIFICATION**

I the undersigned have read and agree to comply with the requirements set forth in Subchapter 11 of the LPC Regulations or Subchapter 15 of the LBP Regulations or Subchapter 11 of the LMFT Regulations.

Printed Name of Candidate: \_\_\_\_\_

Candidate's Application for Licensure Type (please check one):  LPC  LMFT  LBP

Candidate's Current Place of Employment: \_\_\_\_\_

Address of Current Place of Employment: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Candidate's Phone #: \_\_\_\_\_

Candidate's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of On-Site Supervisor: \_\_\_\_\_

License Type: \_\_\_\_\_ License #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

On-Site Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

..... (For Oklahoma State Department of Health use only) .....

Notes: \_\_\_\_\_

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





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**SUPERVISION AGREEMENT**

Please check appropriate license:                     LPC                     LBP

I the undersigned have read and agree to comply with the requirements set forth in Subchapter 11 of the LPC Regulations or Subchapter 15 of the LBP Regulations. I understand that a violation of these requirements may result in a loss of supervision hours and/or disciplinary action against both the candidate and the supervisor.

Name of Candidate: \_\_\_\_\_

Candidate's Current Place of Employment: \_\_\_\_\_

Address of Place of Supervision: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Candidate's Phone #: \_\_\_\_\_ Candidate's Email Address: \_\_\_\_\_

Candidate's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Supervisor: \_\_\_\_\_ License #: \_\_\_\_\_

Supervisor's Current Place of Employment: \_\_\_\_\_

Supervisor's Phone #: \_\_\_\_\_ Supervisor's Email Address: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

..... (For office use only).....

Approved: Yes No Date Approved/Disapproved: \_\_\_\_\_ PCL Staff Initials: \_\_\_\_\_

Reason for Disapproval/Notes: \_\_\_\_\_

\_\_\_\_\_  
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**LMFT SUPERVISION AGREEMENT**

I the undersigned have read and agree to comply with the requirements set forth in Subchapter 11 of the LMFT Regulations. I understand that a violation of these requirements may result in a loss of supervision hours and/or disciplinary action against both the candidate and the supervisor.

Name of Candidate: \_\_\_\_\_

Candidate's Current Place of Employment: \_\_\_\_\_

Address of Place of Supervision: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Candidate's Phone #: \_\_\_\_\_ Candidate's Email Address: \_\_\_\_\_

Candidate's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Supervisor: \_\_\_\_\_ License #: \_\_\_\_\_

Supervisor's Current Place of Employment: \_\_\_\_\_

Supervisor's Phone #: \_\_\_\_\_ Supervisor's Email Address: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

..... (For office use only).....

Approved: Yes No Date Approved/Disapproved: \_\_\_\_\_ PCL Staff Initials: \_\_\_\_\_

Reason for Disapproval/Notes: \_\_\_\_\_

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

## SUBCHAPTER 11. SUPERVISED EXPERIENCE REQUIREMENTS

### 310:400-11-1. Supervisor and supervisee responsibilities

Supervisor and Supervisee shall be jointly responsible for:

- (1) insuring the requirements under this subchapter are fulfilled. Any failure to comply may result in the loss of supervision hours, denial of licensure, initiation of formal complaint procedures, and/or loss of approved supervisor status.
- (2) insuring the client's right to confidentiality is protected and the rules of the supervisor's and supervisee's respective employers are adhered to during the course of supervision.

### 310:400-11-2. Acceptable supervised experience

Supervised experience is acceptable when:

- (1) it begins after all applicable academic requirements as stated in Subchapter 7 have been completed, and supervision agreement has been approved by the Department.
- (2) official application for licensure has been made. This includes Application, application fee, Internship/Practicum Documentation Form, official graduate transcript, three (3) Document of Recommendation Forms, completed criminal background check, On-Site Supervisor Verification Form, and Supervision Agreement. Applicants who have met part or all of supervision experience requirements for clinical membership in AAMFT will be considered to have met part or all of the supervision requirements for licensure in Oklahoma.
- (3) it consists of the performance of therapy activities as described in Section 1925.2, subsection 7 and 9 of the LMFT Act and contains the following characteristics:
  - (A) supervision focuses on the raw data from a supervisee's continuing clinical practice, which may be available to the supervisor through a combination of direct observation, co-therapy, written clinical notes, and audio and video recordings and the LMFT Act and Regulations.
  - (B) supervision is a process clearly distinguishable from personal psychotherapy, and is contracted in order to serve professional/vocational goals.
  - (C) individual supervision shall be face-to-face with one supervisor and one or two supervisees.
  - (D) group supervision may be done with up to six supervisees and a supervisor.
- (4) supervised experience hours may be accrued in academic, governmental, or private practice settings.
- (5) supervised experience may be accrued in a private for-profit or private not-for-profit therapy setting, only if:
  - (A) The LMFT Candidate works at the same location as a person licensed in the State of Oklahoma as a Licensed Marital and Family Therapist, Licensed Professional Counselor, Licensed Behavioral Practitioner, Psychologist, Clinical Social Worker or Psychiatrist who directs and is responsible for the professional duties of the LMFT Candidate; and
  - (B) The LMFT Candidate is receiving supervision for licensure from an approved LMFT supervisor who is not required to work at the same location as the LMFT Candidate.

### 310:400-11-3. Supervisor qualifications

(a) In order to be approved as a supervisor for therapists seeking MFT licensure, an individual must:

- (1) be an American Association for Marriage and Family Therapy approved Supervisor familiar with Oklahoma LMFT Act and Rules duly promulgated, or
- (2) be an LMFT
  - (A) with two (2) years of experience in marital and family therapy beyond the number of years of experience required for licensure and
  - (B) who has successfully completed a graduate course in therapist supervision (at least 45 contact hours) or equivalent course of study acceptable to the Department. This equivalent course of study should consist of workshops in marriage and family therapy supervision in combination with directed study of the marriage and family therapy supervision literature. Fifteen (15) of the 45 clock hours should be in a class or workshop format which includes a minimum of four supervisors-in-training; the other 30 clock hours should be reserved for the directed study. Directed study must be approved and monitored by an Approved Supervisor.

(b) Approved LMFT Supervisors are required to complete a minimum of three (3) clock hours, every three (3) years, of continuing education in therapy supervision specific to Oklahoma law provided by the LMFT Advisory Board, or its designee.

### 310:400-11-4. Duration of supervised experience

- (a) Work experience under supervision must extend over a minimum of 24 months. This marital and family therapy related experience must include a minimum of 1000 hours of direct client contact.
- (b) Supervision sessions:
  - (1) should be scheduled weekly and shall be no less than 6.25 hours of supervision for each 42 hours of direct client contact. No more than 42 hours of direct client contact can be counted in a one month period of time, or
  - (2) may be arranged on a different schedule upon:
    - (A) written request of the supervisor and supervisee in advance, and
    - (B) approval of the schedule by the Department.
- (c) Total number of face-to-face supervision hours must be at least 150. Supervision in group sessions shall equal no more than 75 hours of the total requirement.
- (d) Supervisors shall perform at least two (2) observations, (live or tape) per each six (6) month evaluation period for each supervisee.
- (e) Approved supervisors shall consult with on-site supervisor at least once per supervisee during each reporting period.

### 310:400-11-5. Documentation of supervised experience

- (a) An LMFT Supervision Agreement between supervisor and supervisee as well as the On-Site Supervisor Verification form must be received and approved by the Department prior to the accrual of supervision hours.
- (b) Semi-annual documentation of supervision hours, evaluation of competence, date of observations (live or tape), and date of consultation between approved supervisor and on-site supervisor must be submitted by the supervisor and co-signed by the supervisee on official Supervision Evaluation Forms.



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**STATEMENT OF PROFESSIONAL DISCLOSURE - CANDIDATE**

I am required by regulation to furnish this document to you. It requires that I inform you of my professional training, orientation/techniques, fees and credentials. I am working toward licensure as a Professional Counselor or Behavioral Practitioner (check the appropriate license above) under the auspices of the Oklahoma State Department of Health. I am in the process of accruing 3000 hours of supervised experience, which are required for licensure. Until that time, the supervising licensee listed below shall supervise me.

I will be happy to discuss this information with you and/or furnish you with printed material concerning the licensing process. You may contact (without giving your name), the Professional Counselor Licensing Division listed on the masthead of this document.

Printed Name of Candidate: \_\_\_\_\_

Candidate's Application for Licensure Type (please check one):     LPC     LBP

Candidate's Current Place of Employment: \_\_\_\_\_

Address of Current Place of Employment: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Candidate's Work Phone #: \_\_\_\_\_

Candidate's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Supervisor: \_\_\_\_\_ License #: \_\_\_\_\_

Supervisor's Current Place of Employment: \_\_\_\_\_

Address of Current Place of Employment: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Supervisor's Work Phone #: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

..... (For client use only).....

The above-designated Licensee Candidate has satisfactorily supplied me with information and/or printed material regarding his/her practice, licensure and professional development.

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

..... (For Oklahoma State Department of Health use only) .....

Notes: \_\_\_\_\_



# LPC ACADEMIC WORKSHEET

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

University: \_\_\_\_\_ Degree: \_\_\_\_\_

## **CORE COURSES – All courses must be 3 hours\* (total at least 27 hours)**

**A. Human growth and development – at least 1 course.** Any course which deals with the process stages of human intellectual, physical, social and emotional development of any of the stages of life from prenatal through old age.

1. \_\_\_\_\_

**B. Abnormal human behavior – at least 1 course.** Any course which offers a study of the principles of understanding dysfunction in human behavior or social disorganization.

1. \_\_\_\_\_

**C. Appraisal/assessment techniques – at least 2 courses.** Any course which deals with the principles, concepts and procedures of systematic appraisal, assessment, or interpretation of client needs, abilities, and characteristics, which may include the use of both testing and non-testing approaches.

1. \_\_\_\_\_ 2. \_\_\_\_\_

**D. Counseling theories/methods – at least 2 courses.** Any course which surveys the major theories and/or techniques of counseling.

1. \_\_\_\_\_ 2. \_\_\_\_\_

**E. Professional orientation/ethics – at least 1 course.** Any course which deals primarily with the objectives of professional counseling organizations, codes of ethics, legal aspects of practice, standards of preparation and the role of persons providing direct counseling services.

1. \_\_\_\_\_

**F. Research – at least 1 course.** Any course which deals with the methods of social science or mental health research which includes the study of statistics or a thesis in an area relevant to the practice of counseling.

1. \_\_\_\_\_

**G. Practicum/internship - at least 1 course equaling at least 300 clock hours.** An organized practicum with planned experiences providing classroom and field experience with clients under the supervision of college or university approved counseling professionals.

1. \_\_\_\_\_

## **ELECTIVE COURSES – at least 5 courses of at least 3 hours each (total at least 15 hours)**

**H. Group dynamics**

\_\_\_\_\_

**I. Life style & career development**

\_\_\_\_\_

**J. Social & cultural foundations**

\_\_\_\_\_

**K. Personality theories**

\_\_\_\_\_

**L. Crisis intervention**

\_\_\_\_\_

**M. Marriage/family counseling**

\_\_\_\_\_

**N. Addictions counseling**

\_\_\_\_\_

**O. Rehabilitation counseling**

**P. Gerontology**

\_\_\_\_\_

**Q. Human sexuality**

\_\_\_\_\_

**R. Counseling with children/adolescents**

\_\_\_\_\_

**S. Clinical supervision**

\_\_\_\_\_

**T. Psychopharmacology**

\_\_\_\_\_

**U. Consultation**

\_\_\_\_\_

**V. Physical & Emotional Health**

\_\_\_\_\_

**W. Specialty areas (none established)**

\_\_\_\_\_

## ADDITIONAL COURSES

Using the key below, please use the corresponding letter beside each academic category to document the remaining graduate courses on your transcript in order to reach the **60-hour requirement** (ex. B. Abnormal human behavior = Academic Category: B).

### Academic category Key:

- |                                    |                                    |                               |   |
|------------------------------------|------------------------------------|-------------------------------|---|
| A. Human growth and development    | E. Professional orientation/ethics | K. Personality theories       | R. Counseling with children/adolescents |
| B. Abnormal human behavior         | F. Research                        | L. Crisis intervention        | S. Clinical supervision                 |
| C. Appraisal/assessment techniques | G. Practicum/internship            | M. Marriage/family counseling | T. Psychopharmacology                   |
| D. Counseling theories/methods     | H. Group dynamics                  | N. Addictions counseling      | U. Consultation                         |
|                                    | I. Life style/career development   | O. Rehabilitation counseling  | V. Physical & emotional health          |
|                                    | J. Social and cultural foundations | P. Gerontology                | W. Specialty areas (none established)   |
|                                    |                                    | Q. Human Sexuality            |   |

1. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
2. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
3. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
4. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
5. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
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14. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
15. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
16. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
17. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
18. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
19. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
20. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
21. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
22. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
23. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_

# LMFT ACADEMIC WORKSHEET

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

University: \_\_\_\_\_ Degree: \_\_\_\_\_

**Theoretical Foundations of Marital and Family Systems** – any course which deals primarily in areas such as family life cycle; theories of family development; marriage and/or the family; sociology of the family; families under stress; the contemporary family; family in a social context; the cross-cultural family; youth/adult/aging and the family; family subsystems; individual, interpersonal relationships (marital, parental, sibling). 3 – 3 hr. courses

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Assessment and Treatment in Marital and Family Therapy** – any course which deals in areas such as family therapy methodology; family assessment; treatment and intervention methods; overview of major clinical theories of marital and family therapy such as: communications, contextual, experiential, object relations, strategic, structural, systemic, transgenerational. 3 – 3 hour courses

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Human Development** – any course which deals primarily in areas such as human development; personality theory; human sexuality; psychopathology; at least one of which in psychopathology or abnormal human behavior. 3 – 3 hr. courses.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Ethics and Professional Studies** – any course which deals primarily in areas such as professional socialization and the role of the professional organization; legal responsibilities and liabilities; independent practice and inter-professional cooperation; ethics and family law. 1-3 hour course

1. \_\_\_\_\_

**Research** – any course which deals primarily in areas such as research design, methods, statistics, research in marital and family therapy. 1-3 hour course

1. \_\_\_\_\_

**Practicum/internship** – At least 300 clock hours

1. \_\_\_\_\_



# LBP ACADEMIC WORKSHEET

(Effective January 1, 2008)

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

University: \_\_\_\_\_ Degree: \_\_\_\_\_

**A. Assessment and Diagnosis – at least 6 semester hours.** Courses teaching the measurement and assessment of an individual's behavioral or psychological functioning such as the assessment of psychopathology, personality characteristics, intellectual functioning, skills and interests and neuropsychological functioning.

1. \_\_\_\_\_ 2. \_\_\_\_\_

**B. Intervention – at least 9 semester hours.** Courses teaching empirically validated treatment modalities for the remediation, treatment or prevention of behavior disorders, adjustment problems and psychopathology or other disturbances in psychological functioning.

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_

**C. Experimental Foundations – at least 6 semester hours.** Courses teaching the design, conduct, analysis and interpretation of psychological research or concerning the general principles and processes for the core areas of experimental psychology.

1. \_\_\_\_\_ 2. \_\_\_\_\_

**D. Psychopathology – at least 6 semester hours.** Courses teaching the psychological diagnosis and etiology of psychopathology or mental and behavioral disorders of children and adults.

1. \_\_\_\_\_ 2. \_\_\_\_\_

**E. Personality and Social Psychology – at least 6 semester hours\*.** Courses teaching the psychological or behavioral development and functioning of the individual and group differences. **\*Three of these hours shall be in a course in multicultural issues or cultural bases of behavior.**

1. \_\_\_\_\_ 2. \_\_\_\_\_

**F. Professional orientation/ethics – at least 3 semester hours.** Courses teaching the objectives of professional behavioral health services organizations, codes of ethics, legal aspects of practice, standards of preparation and the role of persons providing direct behavioral health services.

1. \_\_\_\_\_

**G. Biological bases of behavior – at least 3 semester hours.** Courses teaching the biological, physiological, genetic underpinnings of behavior.

1. \_\_\_\_\_

**H. Practicum/internship – at least 300 clock hours.** Organized learning experiences in behavioral health services with classroom and field experience with clients under the supervision of college/university approved behavioral health services professionals.

\_\_\_\_\_

**I. Elective courses.** The remaining courses needed to meet the 60 graduate hour requirement shall be in any of the knowledge areas listed above.

## ADDITIONAL COURSES

Using the key below, please use the corresponding letter beside each academic category to document the remaining graduate courses on your transcript in order to reach the **60-hour requirement** (ex. B. Intervention = Academic Category: B).

### Academic category key:

- A. Assessment
- B. Intervention
- C. Experimental foundations

- D. Psychopathology
- E. Personality and Social Psychology
- F. Professional orientation/ethics

- G. Biological bases of behavior

1. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
2. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
3. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
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23. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_
23. Name of Course: \_\_\_\_\_ Number of Hours: \_\_\_\_\_ Academic Category: \_\_\_\_\_

**National Counselor Examination (NCE)  
State Specific Insert  
Oklahoma Licensure Candidates**

**\*\*This is a supplement to the NCE Candidate Handbook. You can download the handbook from the NBCC Web site at [www.nbcc.org/stateboardmap](http://www.nbcc.org/stateboardmap) \*\***

**CONTACT INFORMATION**

All questions and requests for information about the **Oklahoma licensure process** should be directed to:

Professional Counselor Licensing Division  
Oklahoma State Department of Health  
1000 N.E. 10<sup>th</sup> Street  
Oklahoma City, OK 73117-1299  
Phone: 405-271-6030  
Fax: 405-271-1918  
Web site: <http://pcl.health.ok.gov>

All questions and requests for information regarding the **National Counselor Examination** program should be directed to:

NBCC Assessment Dept.  
3 Terrace Way  
Greensboro, NC 27403  
Phone: 336-547-0607  
Web site: [www.nbcc.org/stateboardmap](http://www.nbcc.org/stateboardmap)

**ELIGIBILITY REQUIREMENTS**

Candidates must receive approval from the Oklahoma State Department of Health (OSDH) before testing. Once approved, candidates will receive an eligibility letter and Licensure Examination Registration Form from the OSDH. The registration form should be completed with **original ink signature** and sent by U.S. postal mail to NBCC with the \$195 examination fee. This fee is in addition to the \$145 licensure application fee you submitted to the OSDH.

**(Fees are subject to change.)**

**REGISTRATION DEADLINES**

Candidates will need to allow 4 weeks processing time from the date your fee clears. Candidates can submit registration materials described above at any time after being approved by the OSDH but be aware that space is limited. The fees are good for 6 months.

**TESTING SCHEDULE**

Testing is normally the first two full weeks of each month, Monday thru Saturday at 9:00am and 1:30pm, with four hours allowed for the examination. However, only certain sites offer Saturday testing; candidates should contact AMP for particular locations and dates. Candidates are scheduled on a first-come, first-served basis. Two testing locations are in Oklahoma; however, a candidate may test at any of the over 170 AMP assessment centers across the U.S. The two sites in Oklahoma are Oklahoma City and Tulsa.

**\*\*The NBCC NCE preparation guide may be purchased for \$44.95 by going to [www.nbcc.org/study](http://www.nbcc.org/study). Print the order form and fax or mail it to NBCC. If you do not have internet access, fax or mail a written request to NBCC for the study guide.**

**Examination schedule for 2011/2012:**

❖ July '11	07/05 – 07/16
❖ August '11	08/01 – 08/13
❖ September '11	09/06 – 09/17
❖ October '11	10/03 – 10/15
❖ November '11	11/07 – 11/19
❖ December '11	12/05 – 12/17
❖ January '12	01/02 – 01/14
❖ February '12	02/06 – 02/18
❖ March '12	03/05 – 03/17
❖ April '12	04/02 – 04/07
❖ April '12	04/17 – 04/21
❖ May '12	05/07 – 05/19
❖ June '12	06/04 – 06/16
❖ July '12	07/02 – 07/14
❖ August '12	08/06 – 08/18
❖ September '12	09/04 – 09/15
❖ October '12	10/01 – 10/13
❖ November '12	11/05 – 11/17
❖ December '12	12/05 – 12/15

**After the candidate receives from NBCC, the postcard confirming registration**, the desired examination date should be scheduled by the candidate through AMP's Web site or by calling AMP's toll-free customer service line.

AMP Phone number: 888-519-9901  
AMP Web site: [www.goAMP.com](http://www.goAMP.com)

**RE-REGISTRATION**

Candidates who fail the examination must wait at least 3 months from their test date before they can retest. The actual retest date will depend on the monthly testing schedule and site availability. Candidates will need to send a new registration form and \$195 examination fee.

They may get the registration form by calling the OSDH.

**SPECIAL ACCOMMODATIONS**

Requests for special accommodations should be sent to and approved by the OSDH, including supporting documentation from a qualified professional. NBCC must receive confirmation of approval from the OSDH prior to notifying AMP of the needed accommodations. Special accommodation requests must be made for each examination. Candidates sitting for the examination with approved special accommodations should schedule their examination via the toll-free number to ensure accommodation confirmation.

**AFTER PASSING THE EXAM**

Once a candidate has successfully passed the National Counselor Examination, the candidate must contact the OSDH for information regarding the Oklahoma Legal and Ethical Responsibilities Exam.



## **Oklahoma Legal and Ethical Responsibilities Examination (OLERE):**

The OLERE is a paper/pencil exam consisting of 20 multiple choice questions. You are allowed thirty (30) minutes to complete the exam and the OLERE has a cut score of 60%. There is no fee to take the OLERE.

The OLERE exam covers the LPC Act and Regulations. To download a copy of the LPC Act and Regulations, [click here](#)

The OLERE is administered in the Professional Counselor Licensing Division office. The address is:

Oklahoma State Department of Health  
Professional Counselor Licensing – Room 154A  
1000 NE 10<sup>th</sup> St.  
Oklahoma City, OK 73117

The OLERE may be taken Monday through Thursday, from 9:00AM to 4:00PM.

Once you have received your test eligibility letter you may schedule a time to sit for the exam by emailing Carolyn Martin the time in which you would to take the exam at [carolynkm@health.ok.gov](mailto:carolynkm@health.ok.gov)

Please be aware of LPC Regulation **310:405-15-8. Failure to apply**, which states:

The application of a person who fails to apply for, sit for, and successfully pass the National Counselor Examination and the Oklahoma Legal and Ethical Responsibilities Examination, within the two-year eligibility period, after the applicant has been mailed notification at last known address in writing of his/her eligibility for examination, shall be voided and the applicant shall be mailed notification at last known address.

Please refer to [Subchapter 15](#) of the LPC Regulations for complete information pertaining to the LPC examination requirements.



**LICENSED BEHAVIORAL PRACTITIONERS (LBP)  
EXAMINATION INFORMATION**

**ELIGIBILITY REQUIREMENTS**

An LBP applicant is eligible to take the licensing examination following the submission and approval of:

- Application form and fee
- Practicum/Internship Documentation Form
- Official transcript(s) showing completion of all academic requirements listed in Subchapter 13, section
- Three (3) Document of Recommendation forms
- Two (2) classifiable sets of fingerprints; and
- Examination fee

**PRACTITIONER'S EXAMINATION OF PSYCHOLOGICAL KNOWLEDGE (PEPK)**

For questions regarding Practitioner's Examination of Psychological Knowledge (PEPK), please contact the Northamerican Association of Masters in Psychology. You may contact NAMP by phone at (405) 329-3030 or by email at [namp@att.net](mailto:namp@att.net)

**TESTING SCHEDULE**

The Department shall administer the licensure examination at least one (1) time each year or more often if necessary.

**LBP STATE STANDARDS TEST**

Prior to licensure, you will be required to sit for and pass the LBP State Standards Test, which covers the Oklahoma LBP Act and Regulations. Contact the Department at (405) 271-6030 for information regarding the LBP State Standards Test.