



Creating
a State
of Health

PROTECTIVE
HEALTH
SERVICES

Oklahoma State Department of Health
Protective Health Services
Professional Counselor Licensing
1000 NE 10th Street
Oklahoma City, OK 73117-1299
Telephone: (405) 271-6030
FAX: (405) 271-1918
www.health.ok.gov/program/lpc

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 _____, _____.

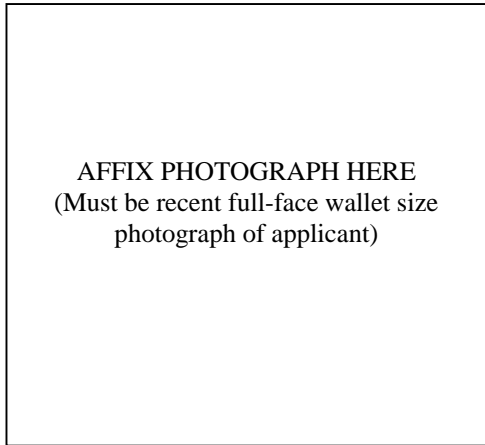
Notary Public in and for _____ County, Oklahoma or _____.
(Please place notary seal on edge of photograph.)

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

Web Address: www.health.ok.gov/program/lpc



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