PUBLIC PROTECTION CABINET
Kentucky Department of Professional Licensing
500 Mero Street, 2SC32
Frankfort, KY 40601
Phone: (502) 564-3296
Fax: (502) 564-4818

Andy Beshear
GOVERNOR

Jacqueline Coleman
LIEUTENANT GOVERNOR

Ray A. Perry
SECRETARY

DJ Wasson
DEPUTY SECRETARY

Kristen Lawson
COMMISSIONER

February 16, 2024

Applications are available online here: KBLPC Applications.

If you require a paper application, please choose from the list below. Please be advised that paper applications are processed slower than online applications due to the availability of the online system.

DPL-LPC-02 LPCA Supervision Agreement

DPL-LPC-03 LPCC-S Application

DPL-LPC-04 LPCC Application

DPL-LPC-05 LPCA Application

DPL-LPC-06 LPCC Application by Reciprocity

DPL-LPC-07 LPCC Renewal

DPL-LPC-08 LPCA Renewal

DPL-LPC-09 LPCC Reinstatement

DPL-LPC-10 LPCA Reinstatement

KENTUCKY BOARD OF LICENSED PROFESSIONAL COUNSELORS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING
P.O. Box 1360, Frankfort, Kentucky 40602
500 Mero Street 2SC32 Frankfort, Kentucky 40601 (Overnight Delivery Only)
Phone: (502) 782.8803 | Fax: (502) 564.4818 | Website: lpc.ky.gov | Email: LPC@KY.GOV

LPCA SUPERVISION AGREEMENT

SECTION 1: APPLICANT INFORMATION

Last Name:	First Name:	Middle Initial	Previous Name:
Mailing Address: Street	City	State	Zip Code
Business Address: Street	City	State	Zip Code
( ) Telephone Number:	Email Address:		

SECTION 2: SUPERVISOR INFORMATION

Last Name:	First Name:	Middle Initial	Previous Name:
Mailing Address: Street	City	State	Zip Code
Business Address: Street	City	State	Zip Code
( ) Telephone Number:	Email Address:		
License Type:	License No.:	Date of Issue:	Expiration Date:

Attach a copy of the license.

Do you hold a designation as a licensed professional clinical counselor supervisor? ☐ Yes ☐ No

Current Number of LPCA Supervisees:

SECTION 3: SUPERVISED EXPERIENCE

Position Title:		
Name of organization or agency where you will be supervised. (Attach additional sheets, if necessary.)		
City:	State:	Zip Code:

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Average number of hours expected to be gained per week:

SECTION 3: SUPERVISED EXPERIENCE (Cont.)	
TYPE OF SETTING	
☐ Government Agency	☐ Hospital
☐ Non-Profit	☐ Private Practice
☐ School (Describe:)	☐ Volunteer
TYPE OF COUNSELING EXPERIENCE (CHECK ALL THAT APPLY):	
☐ Rehabilitation	☐Career & Vocational
☐ Child & Adolescent	☐Drug & Alcohol
☐ General	☐Group
☐ Marriage & Family	☐Other (Describe):

Describe specifically, and in detail, what experience will be obtained to meet the criteria for: Direct responsibility for a specific individual or group of clients; and broad exposure and opportunity for skill enhancement with a variety of developmental issues, dysfunctions, diagnoses, acuity levels and population groups. 201 KAR 36:060

Describe specifically, and in detail, how supervision will focus on: (a) the appropriate diagnosis of a client problem leading to proficiency in applying professionally recognized clinical nomenclature; the development and modification of the treatment plan; the development of treatment skills suitable to each phase of the therapeutic process; ethical problems in the practice of professional counseling; and the development and use of the professional self in the therapeutic process. 201 KAR 36:060.

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Describe specifically, and in detail, how the supervisor will manage, oversee, and direct supervision and take responsibility for the professional clinical counseling practice of the supervisee, including the supervisor's plan for reviewing clinical documentation, viewing the supervisee's client sessions in face-to-face format, recorded format, or both if available; and communicating with the supervisee's administrative supervisor, if applicable, regarding the supervisee's performance. 201 KAR 36:060. Section 2.

APPLICANT VERIFICATION

I, _____,the applicant, affirm that all information provided by me on this form is true and accurate and I affirm the following:

- I have read the Board's statutes and regulations related to supervised experience and that all supervised experience will be completed in accordance with board rules.
- I will meet with my supervisor approximately one hour each week with a minimum of three hours per month of documented supervised experience.
- I will abide by all rules of the board, including the ethics requirements.
- I understand the associate license is only valid while I practice under supervision.
- I will notify the board if this supervisory arrangement is terminated; and
- I understand any additional supervisors and settings shall be approved by the board in advance.

Signature of Applicant:	Date:
Printed Name:	

SUPERVISOR VERIFICATION

I, _____, the board approved supervisor of the above-named applicant, affirm that all information provided by me on this form is true and accurate and I affirm the following:

- All supervised experience will be completed in accordance with the statues and regulations related to supervised experience and all subsequent board rules.
- I will provide supervision to the above name applicant at least one hour during each week of documented experience.
- I understand the full professional responsibility for services of the supervisee shall rest with the supervisor.

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- I understand the supervisory arrangement is only valid while my license remains active.
- I will notify the board if the supervisory arrangement is terminated.
- I understand that I shall not serve as a supervisor of record for more than nine (9) persons obtaining experience for LPCC licensure at the same time.

Signature of Supervisor:	Date:
Printed Name:	

APPLICANT/SUPERVISEE AGENCY VERIFICATION FOR OFF-SITE SUPERVISION ONLY

I, _____, agency representative of the above-named applicant/supervisee, having proper authorization to agree on behalf of the agency, agree that the above-named supervisor shall have access to the following information relating to the applicant/supervisee:

- The applicant/supervisee's clinical documentation and records
- The applicant/supervisee's client sessions in face-to-face format, recorded format, or both, if available.
- The name and contact information for the applicant/supervisee's administrative supervisor, if applicable.
- Open communication with the applicant/supervisee's administrative supervisor, if applicable, regarding the supervisee's performance.

Signature of Agency Representative:	Date:
Printed Name:	

<u>This agreement shall not be effective until the board has issued a letter of approval of this agreement.</u>

THE APPLICANT AND SUPERVISOR MUST KEEP A COPY OF THIS FORM FOR RECORDS.

A FEE MAY BE APPLICABLE IF COPIES ARE REQUESTED FROM THE BOARD.

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LPCC-S APPLICATION

The following form shall be completed and returned to board to qualify as a supervisor of a licensed professional clinical counselor or licensed professional counselor associate and, hold a designation as an LPCC-S.

Last Name:	First Name:	Middle Initial:	License Number:
Street Address:	City:	State:	Zip Code:
( ) Telephone Number:	Email Address:		

I have satisfied at least one of the following (please check):

☐	I have taught or completed a three (3) hour graduate level course in counseling supervision.
☐	I have taught or completed a board-approved fifteen (15) hour course on supervision.
☐	I have five (5) years' experience as a board-approved, active supervisor.
☐	If applying for reinstatement as an LPCC-S after discipline, I have completed a board-approved supervision training in compliance with 201 KAR 36:065. Section 3.

I affirm that all information provided by me on this form is true and accurate, and I meet the following requirements of 201 KAR 36:065:

☐	Be licensed by the board as a licensed professional clinical counselor.
☐	**FOR ALL APPLICANTS. Not have:** ▪ An unresolved complaint filed against the applicant by this board or another board that licenses or certifies a profession. ▪ A suspended or probated license or certificate; ▪ Been under discipline by the board within the last two (2) years preceding the application; or ▪ An order from any board under which the applicant is licensed or certified prohibiting the applicant from providing supervision.
☐	**FOR OUT OF STATE APPLICANTS.** Show proof of the following: ▪ That you have been in the practice for at least two (2) years following licensure as a professional clinical counselor or its licensure equivalent issued by another state's regulatory professional counseling board. ▪ Show proof of supervisory status in the other state ▪ Show proof of completion of a three (3) hour board-approved training on Kentucky LPC law.
☐	▪ Have taught or completed a three (3) hour graduate level course in counseling supervision. ▪ Have taught or completed a fifteen (15) hour board-approved supervisor training course; or ▪ Any supervisor who is a clinical counseling supervisor as a part of a board- approved supervisory agreement or a supervisor of a graduate-level counseling student who is providing services in a mental health setting with five (5) years of experience shall be deemed to satisfy the requirement of 201 KAR 36:065, Section 1(1)(e).

Attach supporting documentation to your application. This includes a copy of the transcript for the graduate level course or the certificate(s) documenting the completion of a 15-hour board-approved supervision course.

Signature (Required) :	Date:

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APPLICATION FOR LICENSED PROFESSIONAL CLINICAL COUNSELOR

INSTRUCTIONS

1. A payment to the Kentucky State Treasurer for the application fee of $150.
2. A background check performed within the last ninety (90) days by the Federal Bureau of Investigation.
3. If applying for licensure by endorsement, an official sealed transcript reflecting graduate coursework earned to fulfill the requirements of Section 3 of the Application.

Please Type or Print All Information

Please check one:

☐	I am currently a LPCA in KY.
☐	I am independently licensed in another state (for at least 5 years) and am applying for endorsement licensure per KRS 335.527.
☐	I am currently licensed in a state that has a reciprocal licensure agreement with KY and am applying for reciprocity.
☐	I have completed the licensing requirements per KRS 335.525(1).

SECTION 1: APPLICANT INFORMATION

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
Business Address: Street	City:	State:	Zip Code:
( ) Telephone Number:	Email Address:	/ / D.O.B.	SSN (Last 4):
	Race:	Gender:	Citizenship:
Present Place of Employment Telephone Number:	Present Place of Employment E-mail Address:		

GENERAL QUESTIONS

1. Are you credentialed as a professional counselor in another state or jurisdiction? If yes, list the state(s): _____ If yes, submit licensure verification from each state in which you hold or have held a license.	☐ YES	☐ NO
2. Do you or have you ever held any other license, certificate, or registration from a state board in Kentucky or any other state? If "Yes", list the license(s) and state(s) and attach a letter of good standing from each state:	☐	☐
3. Have you held a certification/license/registration in Kentucky or any other state that has ever been suspended or revoked? If "Yes", give details and attach supporting documentation:	☐ YES	☐ NO
4. Have you committed fraud or misrepresentation in applying for a license in this state or another state?		
5. Have you been convicted of a felony or a misdemeanor (other than minor traffic violations) in any state?	☐	☐

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	If "Yes", give details and attach supporting documentation:	YES	NO
6.	Are you a member of the military or a military spouse? If yes, please attach proof of the following: (1) proof of issuance of a valid license, permit, certificate or other document issued by another state that is active or has been expired for < 2 years and that it is in good standing or was upon the date of expiration; DD-214 form or other proof of active or prior military service with an honorable discharge, discharge under honorable conditions, or a general discharge under honorable conditions; proof of marriage to an active duty member of the Armed Forces of the U.S., if applicable; and proof that the military spouse is assigned to a duty station in this state and that the applicant is also assigned to a duty station in this state pursuant to the spouse's active duty military orders.	☐ YES	☐ NO
7.	Are you a Respondent in a case with an active order of protection pursuant to KRS Chapter 403 or Chapter 456 following notice and an opportunity to be heard?	☐ YES	☐ NO
8.	Have you been declared incompetent by a court of competent jurisdiction?	☐ YES	☐ NO
9.	Have you engaged in fraud, dishonesty, or corruption on a certification of examination in this state or another state?	☐ YES	☐ NO
10.	Do you have a substantiated charge of child abuse and neglect pursuant to KRS Chapter 620, or adult abuse, neglect, or exploitation pursuant to KRS Chapter 209?	☐ YES	☐ NO
11.	Are you under an adjudication or other diversion agreement which suspends or defers sentencing for a crime?	☐ YES	☐ NO

SECTION 2: EXPERIENCE

Begin with your most recent counseling position and list, fully and accurately, the details of each job you have held relating to the professional experience you wish to document. You must have completed a minimum of 4,000 hours of experience in the practice of counseling, which must have been obtained since obtaining the master's degree and must be under approved supervision and shall include, but not be limited to, a minimum of 1,600 hours of direct counseling with individuals, couples, families, or groups and a minimum of 100 hours of individual, face-to-face clinical supervision with an approved supervisor. The total hour of professional experience includes all hours, both direct and indirect.

Dates Employed	Company Name:	Job Title:
Total Hours of Professional Experience:		
Total Hours of Direct Counseling:		
Total Hours of Individual, Face-to-Face Clinical Supervision:		
Name of Clinical Supervisor:		
Describe your duties:		

Dates Employed	Company Name:	Job Title:
Total Hours of Professional Experience:		
Total Hours of Direct Counseling:		
Total Hours of Individual, Face-to-Face Clinical Supervision:		
Name of Clinical Supervisor:		
Describe your duties:		

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Dates Employed	Company Name:	Job Title:
Total Hours of Professional Experience:		
Total Hours of Direct Counseling:		
Total Hours of Individual, Face-to-Face Clinical Supervision:		
Name of Clinical Supervisor:		
Describe your duties:		

Attach additional sheets if necessary.

SECTION 3: VERIFICATION OF SUPERVISED PROFESSIONAL COUNSELING EXPERIENCE
(Each Clinical Supervisor must complete a separate Section 3 Verification)

SUPERVISEE INFORMATION

Name of LPCA Supervisee:	
LPCA's License Number:	
Date Supervision Began:	Date Supervision Ended:
Date Board Approved Supervision Training Completed:	
☐ **Copy of Board Approved Supervision Training Attached**	

SUPERVISOR INFORMATION

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
( ) Telephone Number:	Email Address:		

Professional Credential of Supervisor. Check the one that applies.

____ Licensed Professional Counselor
____ Licensed Psychologist
____ Licensed Psychiatrist
____ Licensed Clinical Social Worker
____ Licensed Marriage & Family Therapist
____ Nurse with M.A. Degree & Psychiatric Certification

License Number: _____

Graduate Degree(s) Held (Check all that apply):

	Major Emphasis:	Institution:	Year Awarded:
___ Master's Degree			
___ Specialist Degree in:			
___ Doctorate			

How many hours of professional counseling (direct and indirect) experience has the applicant named above completed while under your supervision? (This is total working time and includes all professional activities.)	

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How many hours of direct counseling experience with individuals, groups, families, etc. has the applicant named above completed while under your supervision?	
How many hours of individual, face-to-face, weekly clinical supervision has the applicant named above completed while under your general supervision?	
Do you know of any reason why this person should not be issued a certificate as a professional counselor? If yes, please provide details:	__ Yes __ No
Please comment on applicant's therapeutic competence and ethial behavior:	
I, the clinical supervisor named in the above, do hereby certify under penalty of law that the information contained is true, correct, and complete to the best of my knowledge and belief.	
Signature:	Date:

SECTION 4 AND 5 ARE NOT REQUIRED IF YOU ARE AN LPCA IN KENTUCKY OR ARE APPLYING BY ENDORSEMENT

SECTION 4: CERTIFICATION/VERIFICATION OF CLINICAL INTERNSHIP/PRACTICUM

INSTRUCTIONS: COMPLETE ONE FORM FOR EACH SEMESTER OF INTERNSHIP/PRACTICUM.		
Name of Student/Candidate:		
School:	Department:	
Degree Program:	CACREP: ☐ Yes ☐ No	
Supervisor:		
Supervisor's Licensing Credential:	License Number:	
Year of Internship:	Semester:	Quarter
Agency(s) Internship Completed:		
Name of Onsite Clinical Supervisor:		
Degree & Discipline of Onsite Clinical Supervisor:		
Onsite Clinical Supervisor's Licensing Credential:	License Number:	
Briefly describe the nature of practice/experience including populations worked with:		

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Direct Experience Hours:	Indirect Experience Hours:	
Individual Supervision Hours:	Group Supervision Hours:	Total Hours:
University/College Supervision Hours:		
Individual Supervision Hours:	Group Supervision Hours:	
Supervisor/Instructor Signature:	Date:	

VERIFICATION

I, the applicant named above, do hereby certify under penalty of law, that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected, or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

Signature (Required) :	Date:
Printed Name:	

SECTIONS 5 & 6 ARE NOT REQUIRED IF YOU ARE AN LPCA IN KENTUCKY

SECTION 5: EDUCATION

Please request an official transcript to be ~~mailed from the~~ school to the Board office.

School Name	Degree	CACREP Accredited	Regionally Accredited	Graduation Date (mo./yr.)	Number of Hours	Major/Concentration
		☐	☐			
		☐	☐			
		☐	☐			
		☐	☐			

SECTION 6: CURRICULUM STANDARD

Please Enter **GRADUATE LEVEL** Courses Only. Each Graduate Level Course may only be used in ***One Area***.

1. The helping relationship including counseling theory and practice.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

2. **Human growth & development**.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

3. Lifestyle & Career Development.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

4. Group dynamics, process, counseling, and consulting.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

5. Assessment, appraisal, and testing of individuals.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

6. Social and cultural foundations, including multicultural issues.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

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7. Principles of etiology, diagnosis, treatment planning, and prevention of mental and emotional disorders and dysfunctional behavior.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

8. Research and evaluation.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

9. Professional Orientation: Per 201 KAR 36:070 Section 1(2) requires a three (3) semester hour course, at the minimum, on Professional Orientation and Ethics that is concentrated on the American Counseling Association Code of Ethics. (Studies that provide an understanding of all aspects of professional counseling including counseling history, counseling roles, organizational structures, professional counseling ethics, professional counseling standards, and licensing and credentialing in professional counseling. Example Courses: Introduction to Counseling, Professional Orientation, Legal and Ethical Issues in Counseling.)

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

Practicum/Internship – All applicants shall complete an organized practicum or internship in counseling consisting of at least 600 clock hours.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

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APPLICATION FOR LICENSED PROFESSIONAL COUNSELOR ASSOCIATE

INSTRUCTIONS

1. A payment to the Kentucky State Treasurer for the application fee of $150.
2. A background check performed within the last ninety (90) days by the Federal Bureau of Investigation.
3. A completed, signed Supervision Agreement. Note: The application can be submitted without a signed Supervision Agreement but will remain pending until a signed agreement is reviewed and approved by the Board.
4. An official sealed transcript reflecting graduate coursework earned to fulfill the requirements of Section 3 of the Application.
5. **Please Type or Print All Information**

SECTION 1: APPLICANT INFORMATION

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
Business Address: Street	City:	State:	Zip Code:
( ) Telephone Number:	Email Address:	/ / D.O.B.	SSN (Last 4):
	Race:	Gender:	Citizenship:

Present Place of Employment:

Work Telephone Number:	Work E-mail Address:

GENERAL QUESTIONS

1. Are you credentialed as a professional counselor in another state or jurisdiction? If yes, list the state(s): _____ If yes, submit licensure verification from each state in which you hold or have held a license.	☐ YES	☐ NO
2. Do you or have you ever held any other license, certificate, or registration from a state board in Kentucky or any other state? If "Yes", list the license(s) and state(s) and attach a letter of good standing from each state:	☐ YES	☐ NO
3. Have you held a certification/license/registration in Kentucky or any other state that has ever been suspended or revoked? If "Yes", give details and attach supporting documentation:	☐ YES	☐ NO
4. Have you committed fraud or misrepresentation in applying for a license in this state or another state?	☐ YES	☐ NO
5. Have you been convicted of a felony or a misdemeanor (other than minor traffic violations) in any state? If "Yes", give details and attach supporting documentation:	☐ YES	☐ NO
6. Are you a member of the military or a military spouse? If yes, please attach proof of the following: (1) proof of issuance of a valid license, permit, certificate or other document issued by another state that is active or has been expired for < 2 years and that it is in good standing	☐ YES	☐ NO

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	or was upon the date of expiration; DD-214 form or other proof of active or prior military service with an honorable discharge, discharge under honorable conditions, or a general discharge under honorable conditions; proof of marriage to an active duty member of the Armed Forces of the U.S., if applicable; and proof that the military spouse is assigned to a duty station in this state and that the applicant is also assigned to a duty station in this state pursuant to the spouse's active duty military orders.		
7.	Are you a Respondent in a case with an active order of protection pursuant to KRS Chapter 403 or Chapter 456 following notice and an opportunity to be heard?	☐ YES	☐ NO
8.	Have you been declared incompetent by a court of competent jurisdiction?	☐ YES	☐ NO
9.	Have you engaged in fraud, dishonesty, or corruption on a certification of examination in this state or another state?	☐ YES	☐ NO
10.	Do you have a substantiated charge of child abuse and neglect pursuant to KRS Chapter 620, or adult abuse, neglect, or exploitation pursuant to KRS Chapter 209?	☐ YES	☐ NO
11.	Are you under an adjudication or other diversion agreement which suspends or defers sentencing for a crime?	☐ YES	☐ NO

SECTION 2: EDUCATION

Please request an official transcript to be mailed from the school to the Board office.

School Name	Degree	CACREP Accredited	Regionally Accredited	Graduation Date (mo./yr.)	Number of Hours	Major/Concentration
		☐	☐			
		☐	☐			
		☐	☐			
		☐	☐			
		☐	☐			

SECTION 3: CURRICULUM STANDARD

Please Enter **GRADUATE LEVEL** Courses Only. Each Graduate Level Course may only be used in ***One Area***.

1. The helping relationship including counseling theory and practice.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

2. **Human growth & development**.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

3. Lifestyle & Career Development.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

4. Group dynamics, process, counseling, and consulting.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

5. Assessment, appraisal, and testing of individuals.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

6. Social and cultural foundations, including multicultural issues.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

7. Principles of etiology, diagnosis, treatment planning, and prevention of mental and emotional disorders and dysfunctional behavior.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

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8. Research and evaluation.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

9. Professional Orientation: Per 201 KAR 36:070 Section 1(2) requires a three (3) semester hour course, at the minimum, on Professional Orientation and Ethics that is concentrated on the American Counseling Association Code of Ethics. (Studies that provide an understanding of all aspects of professional counseling including counseling history, counseling roles, organizational structures, professional counseling ethics, professional counseling standards, and licensing and credentialing in professional counseling. Example Courses: Introduction to Counseling, Professional Orientation, Legal and Ethical Issues in Counseling.)

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

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Practicum/Internship – All applicants shall complete an organized practicum or internship in counseling consisting of at least 600 clock hours.

Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours

SECTION 4: CERTIFICATION/VERIFICATION OF CLINICAL INTERNSHIP/PRACTICUM

INSTRUCTIONS: COMPLETE ONE FORM FOR EACH SEMESTER OF INTERNSHIP/PRACTICUM.		
Name of Student/Candidate:		
School:	Department:	
Degree Program:	CACREP: ☐ Yes ☐ No	
Supervisor:		
Supervisor's Licensing Credential:	License Number:	
Year of Internship:	Semester:	Quarter
Agency(s) Internship Completed:		
Name of Onsite Clinical Supervisor:		
Degree & Discipline of Onsite Clinical Supervisor:		
Onsite Clinical Supervisor's Licensing Credential:	License Number:	
Briefly describe the nature of practice/experience including populations worked with:		

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Direct Experience Hours:	Indirect Experience Hours:	
Individual Supervision Hours:	Group Supervision Hours:	Total Hours:
University/College Supervision Hours:		
Individual Supervision Hours:	Group Supervision Hours:	
Supervisor/Instructor Signature:	Date:	

VERIFICATION

I, the applicant named above, do hereby certify under penalty of law, that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected, or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

Signature (Required) :	Date:
Printed Name:	

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APPLICATION FOR LICENSED PROFESSIONAL CLINICAL COUNSELOR BY RECIPROCITY

Instructions

1. A payment to the Kentucky State Treasurer for the application fee of $150.
2. A letter of good standing from each jurisdiction where you are certified or licensed; and
3. A background check performed within the last ninety (90) days by the Federal Bureau of Investigation.
4. **Please Type or Print All Information**

SECTION 1: APPLICANT INFORMATION

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
Business Address: Street	City:	State:	Zip Code:
( ) Telephone Number:	Email Address:	/ / D.O.B.	SSN (Last 4):
	Race:	Gender:	Citizenship:
Present Place of Employment:			
Work Telephone Number:	Work E-mail Address:		

GENERAL QUESTIONS

1. Are you credentialed as a professional counselor in another state or jurisdiction? If yes, list the state(s): _____ If yes, submit licensure verification from each state in which you hold or have held a license.	☐ YES	☐ NO
2. Do you or have you ever held any other license, certificate, or registration from a state board in Kentucky or any other state? If "Yes", list the license(s) and state(s) and attach a letter of good standing from each state:	☐ YES	☐ NO
3. Have you held a certification/license/registration in Kentucky or any other state that has ever been suspended or revoked? If "Yes", give details and attach supporting documentation:	☐ YES	☐ NO
4. Have you committed fraud or misrepresentation in applying for a license in this state or another state?	☐ YES	☐ NO
5. Have you been convicted of a felony or a misdemeanor (other than minor traffic violations) in any state? If "Yes", give details and attach supporting documentation:	☐ YES	☐ NO
6. Are you a member of the military or a military spouse? If yes, please attach proof of the following: (1) proof of issuance of a valid license, permit, certificate or other document issued by another state that is active or has been expired for < 2 years and that it is in good standing or was upon the date of expiration; DD-214 form or other proof of active or prior military service with an honorable discharge, discharge under honorable conditions, or a general discharge under honorable conditions; proof of marriage to an active duty member of the Armed Forces of the U.S., if applicable; and	☐ YES	☐ NO

DPL-LPC-06
Rev. December 2023
KRS 12.245 and 12:357, KRS 335.515(1), (3), (5)
and 201 KAR 36:072

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	proof that the military spouse is assigned to a duty station in this state and that the applicant is also assigned to a duty station in this state pursuant to the spouse's active duty military orders.		
7.	Are you a Respondent in a case with an active order of protection pursuant to KRS Chapter 403 or Chapter 456 following notice and an opportunity to be heard?	☐ YES	☐ NO
8.	Have you been declared incompetent by a court of competent jurisdiction?	☐ YES	☐ NO
9.	Have you engaged in fraud, dishonesty, or corruption on a certification of examination in this state or another state?	☐ YES	☐ NO
10.	Do you have a substantiated charge of child abuse and neglect pursuant to KRS Chapter 620, or adult abuse, neglect, or exploitation pursuant to KRS Chapter 209?	☐ YES	☐ NO
11.	Are you under an adjudication or other diversion agreement which suspends or defers sentencing for a crime?	☐ YES	☐ NO

SECTION 2: EDUCATION

Please request an official transcript to be mailed from the school to the Board office.

School Name	Degree	CACREP Accredited	Regionally Accredited	Graduation Date (mo./yr.)	Number of Hours	Major/Concentration
		☐	☐			
		☐	☐			
		☐	☐			
		☐	☐			

VERIFICATION

I, theapplicant named above, do hereby certify underpenalty of law, that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected, or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

Signature (Required) :

Date:

Printed Name:

DPL-LPC-06
Rev. December 2023
KRS 12.245 and 12:357, KRS 335.515(1), (3), (5)
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LPCC RENEWAL APPLICATION

INSTRUCTIONS

Your Licensed Professional Clinical Counselor credential renewal date is October 31st. In accordance with KRS 335.535 and 201 KAR 36:020 governing this profession, a Licensed Professional Clinical Counselor is required to renew their license annually with the transmittal of this form and a renewal fee of $150.00, (check or money order) made payable to the **Kentucky State Treasurer.** Please return this completed form with the fee to the address above prior to the deadline date of October 31st. The fee for renewals received during the 60-day grace period is $175.00. Credentials not renewed prior to December 31st, will be terminated and you must immediately **CEASE AND DESIST PRACTICING** (no exceptions) and the use of the title Licensed Professional Clinical Counselor.

SECTION 1: LICENSEE INFORMATION

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
Business Address: Street	City:	State:	Zip Code:
( ) Telephone Number:	Email Address:	License Number:	
Present Place of Employment:			
Work Telephone Number:	Work E-mail Address:		

GENERAL QUESTIONS

1.	Are you credentialed as a professional counselor in another state or jurisdiction? If yes, list the state(s): _____ If yes, submit licensure verification from each state in which you hold or have held a license.	☐ YES	☐ NO
2.	Do you or have you ever held any other license, certificate, or registration from a state board in Kentucky or any other state? If "Yes", list the license(s) and state(s) and attach a letter of good standing from each state:	☐ YES	☐ NO
3.	Have you held a certification/license/registration in Kentucky or any other state that has ever been suspended or revoked? If "Yes", give details and attach supporting documentation:	☐ YES	☐ NO
4.	Have you committed fraud or misrepresentation in applying for a license in this state or another state?	☐ YES	☐ NO
5.	Have you been convicted of a felony or a misdemeanor (other than minor traffic violations) in any state? If "Yes", give details and attach supporting documentation:	☐ YES	☐ NO
6.	Are you a member of the military or a military spouse? If yes, please attach proof of the following: (1) proof of issuance of a valid license, permit, certificate or other document issued by another state that is active or has been expired for < 2 years and that it is in good standing or was upon the date of expiration; DD-214 form or other proof of active or prior military service with an honorable discharge, discharge under honorable conditions, or a general discharge under honorable conditions; proof of marriage to an active duty member of the Armed Forces of the U.S., if applicable; and proof that the military spouse is assigned to a duty station in this state and that the applicant is also assigned to a duty station in this	☐ YES	☐ NO

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	state pursuant to the spouse's active duty military orders.		
7.	Are you a Respondent in a case with an active order of protection pursuant to KRS Chapter 403 or Chapter 456 following notice and an opportunity to be heard?	☐ YES	☐ NO
8.	Have you been declared incompetent by a court of competent jurisdiction?	☐ YES	☐ NO
9.	Have you engaged in fraud, dishonesty, or corruption on a certification of examination in this state or another state?	☐ YES	☐ NO
10.	Do you have a substantiated charge of child abuse and neglect pursuant to KRS Chapter 620, or adult abuse, neglect, or exploitation pursuant to KRS Chapter 209?	☐ YES	☐ NO
11.	Are you under an adjudication or other diversion agreement which suspends or defers sentencing for a crime?	☐ YES	☐ NO

SECTION 2: CONTINUING EDUCATION COMPLIANCE

Please request an official transcript to be mailed from the school to the Board office.

Course Name	Date Completed MM/DD/YYYY	Course Hours Earned

Total Course Hours Earned: _____

Suicide Assessment, Treatment, and Management Exemption:

Do you qualify for the exemption under 201 KAR 36:030 Section 1 (4) as a licensee who teaches the board-approved training on suicide assessment, treatment, and management?

☐ Yes ☐ No

Course Title: _____ **Date Taught:** _____

Law for Regulating Professional Counseling Exemption:

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Do you qualify for the exemption under 201 KAR 36:030 Section 1 (5) as a licensee who teaches the board-approved training on the law for regulating professional counseling, KRS Chapter 335.500 to 335.599 and 201 KAR Chapter 36?

☐ **Yes** ☐ **No**

Course Title: _____ **Date Taught:** _____

VERIFICATION

I, the applicant named above, do hereby certify under penalty of law, that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected, or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

Signature (Required) :	Date:
Printed Name:	

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LPCA RENEWAL APPLICATION

INSTRUCTIONS
Your Licensed Professional Counselor Associate credential renewal date is October 31st. In accordance with KRS 335.535 and 201 KAR 36:020 governing this profession, a Licensed Professional Counselor Associate is required to renew their license annually with the transmittal of this form and a renewal fee of $50.00, (check or money order) made payable to the **Kentucky State Treasurer.** Please return this completed form with the fee to the address above prior to the deadline date of October 31st. The fee for renewals received during the 60-day grace period is $60.00. Credentials not renewed prior to December 31st, will be terminated and you must immediately **CEASE AND DESIST PRACTICING** (no exceptions) and the use of the title Licensed Professional Counselor Associate. **IF APPLICABLE, PLEASE SUBMIT A COPY OF YOUR PROPOSED SUPERVISORY AGREEMENT FOR A NEW SUPERVISOR WITH THIS APPLICATION**.

SECTION 1: LICENSEE INFORMATION

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
Business Address: Street	City:	State:	Zip Code:
( ) Telephone Number:	Email Address:	License Number:	
Present Place of Employment:			
Work Telephone Number:	Work E-mail Address:		

SUPERVISOR INFORMATION

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
( ) Telephone Number:	Email Address:		
License Type:	License Number:		

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GENERAL QUESTIONS		
1. Have you been convicted of a felony or a misdemeanor (other than minor traffic violations) since your last application or renewal? "Conviction" including all instances in which a plea of no contest is the basis of the conviction. If "Yes", give details and attach supporting documentation:	☐ YES	☐ NO
2. Have you been subject to disciplinary action by a mental health credentialing board since your last application or renewal? If "Yes", give details and attach supporting documentation:	☐ YES	☐ NO
3. Have you become licensed or certified in any state since your last application or renewal? If "Yes", list the state(s), type of license or certification, the number of the certification or license and attach a letter of good standing from each state:	☐ YES	☐ NO
4. Are you currently serving in the military?	☐ YES	☐ NO
5. How many hours of client contact did you earn in the current licensure year?		
6. How many hours of individual face-to-face supervision did you earn in the current licensure year?		
7. Does your supervision include the appropriate diagnosis of a client problem leading to proficiency in applying professionally recognized clinical nomenclature, **201 KAR 36:060 Section 5 (1)(a)?** If No, please explain on a separate sheet of paper.	☐ YES	☐ NO
8. Does your supervision include the development and modification of the treatment plan, **201 KAR 36:060 Section 5 (1)(b)?** If No, please explain on a separate sheet of paper.	☐ YES	☐ NO
9. Does your supervision include the development of treatment skills suitable to each phase of the therapeutic process, **201 KAR 36:060 Section 5 (1)(c)?** If No, please explain on a separate sheet of paper.	☐ YES	☐ NO
10. Does your supervision include ethical problems in the practice of professional counseling, **201 KAR 36:060 Section 5 (1)(d)?** If No, please explain on a separate sheet of paper.	☐ YES	☐ NO
11. Are you working as a counselor at least 25 hours per week, and minimally seeing your supervisor at least 3 times per month?	☐ YES	☐ NO
12. Are you working as a counselor less than 25 hours per week, and minimally seeing your supervisor at least 1 hour of face-to-face supervision for every thirty hours of client contact?	☐ YES	☐ NO
13. Have you committed fraud or misrepresentation in applying for a license in this state or another state?	☐ YES	☐ NO
14. Are you a Respondent in a case with an active order of protection pursuant to KRS Chapter 403 (DVO) or KRS Chapter 456 (IPO) following notice and an opportunity to be heard?	☐ YES	☐ NO
15. Have you been declared incompetent by a court of competent jurisdiction?	☐ YES	☐ NO
16. Have you engaged in fraud, dishonesty, or corruption on a certification of examination in this state or another state?	☐ YES	☐ NO

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17. Do you have a substantiated charge of child abuse and neglect pursuant to KRS Chapter 620, or adult abuse, neglect, or exploitation pursuant to KRS Chapter 209?	☐ YES	☐ NO
18. Are you under an adjudication or other diversion agreement which suspends or defers sentencing for a crime?	☐ YES	☐ NO

If you answered "No" to both questions 11 and 12, please explain below.

Supervisor Signature (Required) :	Date:

SECTION 2: CONTINUING EDUCATION COMPLIANCE

Please request an official transcript to be mailed from the school to the Board office.

Course Name	Date Completed MM/DD/YYYY	Course Hours Earned

Total Course Hours Earned: _____

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VERIFICATION

I, the applicant named above, do hereby certify under penalty of law, that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected, or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

Further, as an LPCA, I affirm the following:

- That I have read the board Law and Regulations related to supervised experience and that all supervised experience will be completed in accordance with board rules;
- That I will meet with my supervisor approximately one (1) hour each week with a minimum of three (3) hours per month of documented supervised experience;
- That I will abide by all rules of the board, including ethics requirements;
- That I understand the associate license does not give me authority to engage in the independent practice of counseling;
- That I understand the associate license is only valid while I practice under supervision;
- That I notify the board if this supervisory arrangement is terminated; and
- That I understand any additional supervisors and settings shall be approved by the board in advance.

Signature (Required) :	Date:
Printed Name:	

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LPCC REINSTATEMENT APPLICATION

INSTRUCTIONS
In accordance with KRS 335.535 (4) after the sixty (60) day grace period, individuals with terminated credentials may reinstate their credential upon payment of the renewal fee and a reinstatement fee. To reinstate your license, please return this form along with the reinstatement fee of $250.00, a background check and completion certificates of at least 10 hours of continuing education in accordance with 201 KAR 36:075 Section 3(2)(a)3 and 4.

SECTION 1: LICENSEE INFORMATION

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
Business Address: Street	City:	State:	Zip Code:

( ) Telephone Number:	Email Address:
License Number:	License Expiration Date:
Present Place of Employment:	
Work Telephone Number:	Work E-mail Address:

GENERAL QUESTIONS

1. Have you been convicted of a felony or a misdemeanor (other than minor traffic violations) since your last application or renewal? "Conviction" including all instances in which a plea of no contest is the basis of the conviction. If "Yes", give details and attach supporting documentation:	☐ YES	☐ NO
2. Have you been subject to disciplinary action by a mental health credentialing board since your last application or renewal? If "Yes", give details and attach supporting documentation:	☐ YES	☐ NO
3. Have you become licensed or certified in any state since your last application or renewal? If "Yes", list the state(s), type of license or certification, the number of the certification or license and attach a letter of good standing from each state:	☐ YES	☐ NO
4. Are you currently serving in the military?	☐ YES	☐ NO
5. Have you committed fraud or misrepresentation in applying for a license in this state or another state?	☐ YES	☐ NO
6. Are you a Respondent in a case with an active order of protection pursuant to KRS Chapter 403 (DVO) or KRS Chapter 456 (IPO) following notice and an opportunity to be heard?	☐ YES	☐ NO

KENTUCKY BOARD OF LICENSED PROFESSIONAL COUNSELORS

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7. Have you been declared incompetent by a court of competent jurisdiction?	☐ YES	☐ NO
8. Have you engaged in fraud, dishonesty, or corruption on a certification of examination in this state or another state?	☐ YES	☐ NO
9. Do you have a substantiated charge of child abuse and neglect pursuant to KRS Chapter 620, or adult abuse, neglect, or exploitation pursuant to KRS Chapter 209?	☐ YES	☐ NO
10. Are you under an adjudication or other diversion agreement which suspends or defers sentencing for a crime?	☐ YES	☐ NO

SECTION 2: CONTINUING EDUCATION COMPLIANCE

Please request an official transcript to be mailed from the school to the Board office.

Course Name	Date Completed MM/DD/YYYY	Course Hours Earned

Total Course Hours Earned: _____

Suicide Assessment, Treatment, and Management Exemption:

Do you qualify for the exemption under 201 KAR 36:030 Section 1 (4) as a licensee who teaches the board-approved training on suicide assessment, treatment, and management?

☐ Yes ☐ No

Course Title: _____ **Date Taught:** _____

Law for Regulating Professional Counseling Exemption:

Do you qualify for the exemption under 201 KAR 36:030 Section 1 (5) as a licensee who teaches the board-approved training on the law for regulating professional counseling, KRS Chapter 335.500 to 335.599 and 201 KAR Chapter 36?

☐ **Yes** ☐ **No**

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Course Title: _____ **Date Taught:** _____

VERIFICATION

I, the applicant named above, do hereby certify under penalty of law, that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected, or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

Signature (Required) :	Date:
Printed Name:	

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LPCA REINSTATEMENT APPLICATION

INSTRUCTIONS
In accordance with KRS 335.535 (4) after the sixty (60) day grace period, individuals with terminated credentials may reinstate their credential upon payment of the renewal fee and a reinstatement fee. To reinstate your license, please submit this form along with the reinstatement fee of $90.00, an updated Supervision Agreement, a background check and completion certificates of at least 10 hours of continuing education in accordance with 201 KAR 36:075 Section 2.

SECTION 1: LICENSEE INFORMATION

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
Business Address: Street	City:	State:	Zip Code:

( ) Telephone Number:	Email Address:
License Number:	License Expiration Date:
Present Place of Employment:	
Work Telephone Number:	Work E-mail Address:

GENERAL QUESTIONS

1.	Have you been convicted of a felony or a misdemeanor (other than minor traffic violations) since your last application or renewal? "Conviction" including all instances in which a plea of no contest is the basis of the conviction. If "Yes", give details and attach supporting documentation:	☐ YES	☐ NO
2.	Have you been subject to disciplinary action by a mental health credentialing board since your last application or renewal? If "Yes", give details and attach supporting documentation:	☐ YES	☐ NO
3.	Have you become licensed or certified in any state since your last application or renewal? If "Yes", list the state(s), type of license or certification, the number of the certification or license and attach a letter of good standing from each state:	☐ YES	☐ NO
4.	Are you currently serving in the military?	☐ YES	☐ NO
5.	Have you committed fraud or misrepresentation in applying for a license in this state or another state?	☐ YES	☐ NO
6.	Are you a Respondent in a case with an active order of protection pursuant to KRS Chapter 403 (DVO) or KRS Chapter 456 (IPO) following notice and an opportunity to be heard?	☐ YES	☐ NO

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7. Have you been declared incompetent by a court of competent jurisdiction?	☐ YES	☐ NO
8. Have you engaged in fraud, dishonesty, or corruption on a certification of examination in this state or another state?	☐ YES	☐ NO
9. Do you have a substantiated charge of child abuse and neglect pursuant to KRS Chapter 620, or adult abuse, neglect, or exploitation pursuant to KRS Chapter 209?	☐ YES	☐ NO
10. Are you under an adjudication or other diversion agreement which suspends or defers sentencing for a crime?	☐ YES	☐ NO

SECTION 2: CONTINUING EDUCATION COMPLIANCE

Please request an official transcript to be mailed from the school to the Board office.

Course Name	Date Completed MM/DD/YYYY	Course Hours Earned

Total Course Hours Earned: _____

VERIFICATION

I, the applicant named above, do hereby certify under penalty of law, that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected, or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

Signature (Required) :

Date:

Printed Name: