

Andy Beshear GOVERNOR

Jacqueline Coleman
LIEUTENANT GOVERNOR

# PUBLIC PROTECTION CABINET

Kentucky Department of Professional Licensing 500 Mero Street, 2SC32

Frankfort, KY 40601 Phone: (502) 564-3296 Fax: (502) 564-4818 Ray A. Perry SECRETARY

**DJ Wasson**DEPUTY SECRETARY

Kristen Lawson

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** 





PUBLIC PROTECTION CABINET — DEPARTMENT OF PROFESSIONAL LICENSING
P.O. Box 1360, Frankfort, Kentucky 40602
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# 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:				
SEC	CTION 2: SUPERVISOR INFOR	MATION			
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: Attach a copy of the license.	License No.:	Date of Issue:	Expiration Date:		
Actually a copy of the license.					
Do you hold a designation as a licensed professional	clinical counselor supervisor?	☐ Yes ☐ No			
Current Number of LPCA Supervisees:					
·					
S	ECTION 3: SUPERVISED EXPER	RIENCE			
Position Title:					
Name of organization or agency where yo	u will be supervised. (Attach add	itional sheets, if nec	essary.)		
City:		State:	Zip Code:		

DPL-LPC-02 Rev. July 2023 KRS 335.515(1), (3) and 201 KAR 36:060



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Average number of hours expected to be gained per week	:				
SECTION 3: SUPERVISED EXPERIENCE (Cont.)					
	OF SETTING				
Government Agency	☐ Hospital				
Non-Profit	☐ Private Practice				
☐ School (Describe:)	□ Volunteer				
	ERIENCE (CHECK ALL THAT APPLY):				
☐ Rehabilitation	☐ Career & Vocational				
Child & Adolescent	□ Drug & Alcohol				
☐ General	□Group				
☐ Marriage & Family	☐ Other (Describe):				
	e obtained to meet the criteria for: Direct responsibility for a ure and opportunity for skill enhancement with a variety of s and population groups. 201 KAR 36:060				
to proficiency in applying professionally recognized clinic treatment plan; the development of treatment skills suitab	us on: (a) the appropriate diagnosis of a client problem leading cal nomenclature; the development and modification of the le to each phase of the therapeutic process; ethical problems in ent and use of the professional self in the therapeutic process.				
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for the professional clinical counseling practice of the documentation, viewing the supervisee's client sessions	vill manage, oversee, and direct supervision and take responsibility supervisee, including the supervisor's plan for reviewing clinical in face-to-face format, recorded format, or both if available; and pervisor, if applicable, regarding the supervisee's performance. 201
I,, the applicant, a accurate and I affirm the following:  I have read the Board's statutes and regular experience will be completed in accordance where will make the supervisor approximately documented supervised experience.  I will abide by all rules of the board, including the landerstand the associate license is only valid will notify the board if this supervisory arrangements.	one hour each week with a minimum of three hours per month of the ethics requirements.  while I practice under supervision.
Signature of Applicant:	Date:
Printed Name:	
SUPERV	ISOR VERIFICATION
	ved supervisor of the above-named applicant, affirm that all
information provided by me on this form is true and ac	
All supervised experience will be completed in	accordance with the statues and regulations related to
supervised experience and all subsequent boa	rd rules.
<ul> <li>I will provide supervision to the above name a</li> </ul>	pplicant at least one hour during each week of documented

- 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.

Si	gnature of Supervisor:	Date:
Pı	rinted Name:	
	APPLICANT/SUPERVISEE AGENCY VERIFICATION FOR OFF-SITE SU	PERVISION ONLY
I,	,, agency representative of the above-named applicant/s	
	outhorization to agree on behalf of the agency, agree that the above-named supervisor	shall have access to the
f	ollowing information relating to the applicant/supervisee:	
	<ul> <li>The applicant/supervisee's clinical documentation and records</li> </ul>	
	<ul> <li>The applicant/supervisee's client sessions in face-to-face format, recorded form</li> </ul>	
	The name and contact information for the applicant/supervisee's administrative	• • • • • • • • • • • • • • • • • • • •
	Open communication with the applicant/supervisee's administrative supervisor	, if applicable, regarding the
	supervisee's performance.	
Si	gnature of Agency Representative:	Date:
Pı	rinted Name:	
	This agreement shall not be effective until the board has issued a letter of a	pproval of this agreement.
	THE APPLICANT AND SUPERVISOR MUST KEEP A COPY OF THIS	FORM FOR RECORDS.
	A FEE MAY BE APPLICABLE IF COPIES ARE REQUESTED FR	OM 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.

CIIII	ical counselor of licensed profession	iai couriseior associate ariu, rio	iu a uesignation a	s all LPCC-3.		
Last N	ame:	First Name:	Middle Initial:	License Number:		
Street	Address:	City:	State:	Zip Code:		
( ) Teleph	none Number:	Email Address:				
	ve satisfied at least one of the follow	ring (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.					
	irm that all information provided by	me on this form is true and accu	rate, and I meet the	e following requirements of		
201	KAR 36:065:  Be licensed by the board as a licens	ed professional clinical counsel	or.			
	FOR ALL APPLICANTS. Not have:					
	<ul> <li>a profession.</li> <li>A suspended or probated li</li> <li>Been under discipline by th</li> <li>An order from any board unfrom providing supervision</li> <li>FOR OUT OF STATE APPLICANTS. S</li> <li>That you have been in the p</li> </ul>	ne board within the last two (2) nder which the applicant is licen	years preceding to sed or certified pr following licensure	he application; or rohibiting the applicant eas a professional clinical		
	<ul> <li>Show proof of supervisory s</li> </ul>	-	5 . oga.a.o. , p. o. o.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
		f a three (3) hour board-approve				
	<ul> <li>Have taught or completed a three (3) hour graduate level course in counseling supervision.</li> <li>Have taught or completed a fifteen (15) hour board-approved supervisor training course; or</li> <li>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).</li> </ul>					
	ach supporting documentation to yorse or the certificate(s) documenting	• •	• •			
Signatu	re (Required) :		Date:			

DPL-LPC-03 Rev. December 2023 KRS 335.515(1), (3), (5) and 201 KAR 36:065



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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 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** State: City: Zip Code: Telephone Number: **Email Address:** D.O.B. SSN (Last 4): Race: Gender: Citizenship: Present Place of Employment E-mail Address: Present Place of Employment Telephone Number: **GENERAL QUESTIONS** Are you credentialed as a professional counselor in another state or jurisdiction? NO If yes, list the state(s): YES If yes, submit licensure verification from each state in which you hold or have held a license. 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: Have you held a certification/license/registration in Kentucky or any other state that has ever been suspended NO YES If "Yes", give details and attach supporting documentation: Have you committed fraud or misrepresentation in applying for a license in this state or another state? 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 att	ach supporting documentation:		YES	NO			
6.	Are you a member of the m	ilitary or a military spouse?						
	If yes, please attach proof o	of the following: (1) proof of issuance of a valid license, pe	ermit, certificate or other	YES	40,			
	document issued by another	er state that is active or has been expired for < 2 years an	d that it is in good standing					
	or was upon the date of exp	piration; DD-214 form or other proof of active or prior mi	litary service with an					
		arge under honorable conditions, or a general discharge u	•					
		ge to an active duty member of the Armed Forces of the						
		se is assigned to a duty station in this state and that the a						
		ursuant to the spouse's active duty military orders.						
7.	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?							
8.	Have you been declared inc	YES	NO					
9.	9. Have you engaged in fraud, dishonesty, or corruption on a certification of examination in this state or another state?							
10	10. Do you have a substantiated charge of child abuse and neglect pursuant to KRS Chapter 620, or adult abuse,							
	neglect, or exploitation pur			YES	NO			
11.	Are you under an adjudicati	on or other diversion agreement which suspends or defe	rs sentencing for a crime?					
				YES	NO			
		SECTION 2: EXPERIENCE						
Begin v	vith your most recent couns	eling position and list, fully and accurately, the details of	of each job you have held re	lating to th	e professional			
experie	ence you wish to document. Y	ou must have completed a minimum of 4,000 hours of ex	perience in the practice of co	unseling, wh	nich must have			
		naster's degree and must be under approved supervision						
		rith individuals, couples, families, or groups and a mini			o-face clinical			
supervi		visor. The total hour of professional experience includes	all hours, both direct and ind	irect.				
	Dates Employed	Company Name:	Job T	itle:				
	ours of Professional Experien	ce:						
	ours of Direct Counseling:							
	ours of Individual, Face-to-Fa	ce Clinical Supervision:						
Name o	of Clinical Supervisor:							
Describ	e your duties:							
	Data Family 1	Campan N	T	tal				
	Dates Employed	Company Name:	Job T	ιτιe:				
Total	ours of Professional Experien	co.						
	ours of Direct Counseling:	ice.						
	ours of Individual, Face-to-Fa	ica Clinical Suponician:						
	of Clinical Supervisor:	ice cirrical supervision.						
	or chilical supervisor:							
	o vous dutios							
Describ	e your duties:							
Describ	e your duties:							
Describ	e your duties:							



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Dates Employed		Company Name	•		וווו מטנ	с.
Total Hours of Professional Times	rionco:					
otal Hours of Professional Expe						
otal Hours of Individual, Face-to		ervision:				
lame of Clinical Supervisor:						
Describe your duties:						
tach additional sheets if necessa	ary.					
cı	ECTION 2. VEDIEIC	ATION OF CUREDVICE	D DDOFFCCIONA	I COLINICELINIC EVI	DEDIENCE	
31		ATION OF SUPERVISE Supervisor must comp			_	
	(200 0		INFORMATION		,	
lame of LPCA Supervisee:						
.PCA's License Number:						
ate Supervision Began:			Date Supervision Ended:			
ate Board Approved Supervisio	on Training Complet	ed:				
☐ Copy of Board Approved Sup	nervision Training	Attached				
_ copy of board Approved Sup	pervision framing		INFORMATION			
ast Name:		First Name:		Middle Initial:	Previous N	ame:
Mailing Address: Street		City:		State:	Zip Code:	
		Email Address:				
ofessional Credential of Superv	isor. Check the on					
Licensed Professional Cour		••	Licensed Psychologist			
Licensed Psychiatrist			Licensed Clinical Social Worker			
Licensed Marriage & Famil	ly Therapist		Nurse with M.A. Degree & Psychiatric Certification			
cense Number:						
aduato Dograpo(s) Hold (Chack a	all that apply):					
aduate Degree(s) Held (Check a		sis:	Institution:			Year Awarded:
	all that apply): Major Empha	sis:	Institution:			Year Awarded:
Master's Degree		sis:	Institution:			Year Awarded:
aduate Degree(s) Held (Check a  Master's Degree  Specialist Degree in:  Doctorate		sis:	Institution:		<u></u>	Year Awarded
Master's DegreeSpecialist Degree in:Doctorate	Major Empha			int named above co	mmleted	Year Awarded
Master's Degree Specialist Degree in:	Major Empha	and indirect) experienc	e has the applica		ompleted	Year Awarded:

Rev. December 2023

KRS 12.245 and 12:357, KRS 335.515(1), (3), (5)

and 201 KAR 36:070



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How many hours of direct counseling experience with in completed while under your supervision?	dividuals, groups, familie	es, etc. has the a	pplicant nam	ed above		
How many hours of individual, face-to-face, weekly clinic	cal supervision has the ap	oplicant named a	above comple	ted while		
under your general supervision?	- :		Cueleen			
Do you know of any reason why this person should not be If yes, please provide details:	e issued a certificate as a	professional cou	inseior?		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 I	aw that the info	mation conta	ained is true.	correct, and	1 complete
to the best of my knowledge and belief.	eertiny and er penanty er i					
Signature:				Date:		
				L		
*SECTION 4 AND 5 ARE NOT REQUIRED IF YOU	OU ARE AN LPCA IN	KENTUCKY (	OR ARE AP	PLYING BY	ENDORS	EMENT
SECTION 4: CERTIFICATION	I/VERIFICATION OF	CLINICAL IN.	FRNSHIP/	PRACTICUM	Л	
Instructions: Complete one form for each semeste					<u>'                                    </u>	
	N OF INVENTORIES	0.00				
Name of Student/Candidate:						
School:		Department	!			
Degree Program:		CACREP:	☐ Yes	□ No	)	
Supervisor:						
Supervisor's Licensing Credential:			Lice	nse 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 Nu	mber:	
Briefly describe the nature of practice/experienc	e including population	ns worked with	n:			
DPL-LPC-04						·
Rev. December 2023						



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Direct Experience Hours:		Indired	t Experience	e Hours:			
Individual Supervision Hours:	Gro	oup Supervision H	lours:		Total Hou	rs:	
University/College Supervision	n Hours:						
Individual Supervision Hours:		Group	Supervision	Hours:			
Supervisor/Instructor Signatur	e:			Date:			
I, the applicant named above, and complete to the best of such misrepresentation or for furthermore, I agree to abide signature (Required):	my knowledge and be alsification, my applic	lief. I am aware cation could be	that the ir that, shou rejected, o	ld an investiga or my certifica	ation at any ation revol	y time di	sclose any
	~ -	CTION 5: EDUC	ATION		_		
Please i	<b>SE</b> orequest an official transc	CTION 5: EDUCA	ATION from the sch	ool to the Board	d office.	Maior/0	Concentration
	SE	CTION 5: EDUC	ATION from the sch Regionally Accredited		_	Major/(	Concentration
Please i	<b>SE</b> orequest an official transc	CTION 5: EDUCA ript to be mailed CACREP Accredited	ATION from the sch Regionally Accredited	ool to the Board Graduation	d office.	Major/0	Concentration
Please i	<b>SE</b> orequest an official transc	CTION 5: EDUCA	ATION from the sch Regionally Accredited	ool to the Board Graduation	d office.	Major/0	Concentration
Please i	<b>SE</b> orequest an official transc	CTION 5: EDUCA ript to be mailed CACREP Accredited	ATION from the sch Regionally Accredited	ool to the Board Graduation	d office.	Major/0	Concentration
Please I	SECTION DUATE LEVEL Courses On hip including counseling	CTION 5: EDUCA  ript to be mailed  CACREP Accredited  D  COURRICULUM  COURRICULUM	ATION  from the sch  Regionally Accredited	ool to the Board Graduation Date (mo./yr.)  Date may only be	d office.  Number of Hours  used in <i>One</i>		Concentration  Credit  Hours



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2. Human growth & developme	nt.			
Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours
3. Lifestyle & Career Developme				
Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours
4. Group dynamics, process, cou	unseling, and co	onsulting.		



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	2 6 0	2 711 (2) 11 11		0 1
<b>Educational Institution</b>	Prefix &	Course Title (No abbreviations)	Semester &	Credit
	Number		Year	Hours
5. Assessment, appraisal, and	testing of individuals	<u> </u>		
Educational Institution	Prefix &		Compartano	C!:
Educational institution		Course Title (No abbreviations)	Semester &	Credi
	Number		Year	Hour
6. Social and cultural foundat	ions including multic	cultural issues		
			1.	
<b>Educational Institution</b>	Prefix &	Course Title (No abbreviations)	Semester &	Credi
	Number		Year	Hour



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7.	Principles of etiology, diagnos behavior.	is, treatment	planning, and prevention of mental and emotional	disorders and d	ysfunctional	
	Educational Institution Prefix & Course Title (No abbreviations) Semester & Year					
		Number		Year	Hours	
8.	Research and evaluation.	1	L			
	Educational Institution	Prefix &	Course Title (No abbreviations)	Semester &	Credit	
		Number		Year	Hours	
9.	Professional Orientation: Per	201 KAR 36:07	70 Section 1(2) requires a three (3) semester hour o	ourse, at the m	inimum, on	
			oncentrated on the American Counseling Association			
			s of professional counseling including counseling hi			
			nseling ethics, professional counseling standards, a			
	credentialing in professional c Ethical Issues in Counseling.)	ounseling. Ex	ample Courses: Introduction to Counseling, Profess	sional Orientatio	on, Legal and	
	Educational Institution	Prefix &	Course Title (No abbreviations)	Semester &	Credit	
		Number		Year	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 & Credit Hours  Hours Hours Prefix & Course Title (No abbreviations) Semester & Credit Hours					
clock hours.       Educational Institution     Prefix & Course Title (No abbreviations)     Semester & Credit					
clock hours.       Educational Institution     Prefix & Course Title (No abbreviations)     Semester & Credit					
clock hours.       Educational Institution     Prefix & Course Title (No abbreviations)     Semester & Credit					
clock hours.       Educational Institution     Prefix & Course Title (No abbreviations)     Semester & Credit					
clock hours.       Educational Institution     Prefix & Course Title (No abbreviations)     Semester & Credit					
clock hours.       Educational Institution     Prefix & Course Title (No abbreviations)     Semester & Credit					
· · · · · · · · · · · · · · · · · · ·		shall complete	an organized practicum or internship in counseling	g consisting of a	t least 600
	Educational Institution		Course Title (No abbreviations)		



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Phone: (502) 782.8803 | Fax: (502) 564.4818 | Website: <a href="lpc.ky.gov">lpc.ky.gov</a> | Email: <a href="LPC@KY.GOV">LPC@KY.GOV</a>

#### 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:		
	Face! Address	/ /	CCN (I - + A)		
Telephone Number:	Email Address:	D.O.B.	SSN (Last 4):		
	Race:	Gender:	Citizenship:		
Present Place of Employment:					
Work Telephone Number:	Work E-mail A	ddrocci			
Work relephone Number.	GENERAL QUESTIONS	uui ess.			
Are you credentialed as a professional co	· · · · · · · · · · · · · · · · · · ·				
If yes, list the state(s):  If yes, submit licensure verification from		d a license.	YES NO		
Do you or have you ever held any other li	· · · · · · · · · · · · · · · · · · ·		y or any		
other state?			YES NO		
If "Yes", list the license(s) and state(s) and					
<ol><li>Have you held a certification/license/regi or revoked?</li></ol>	stration in Kentucky or any other state tr	nat nas ever been susp	ended     NO		
If "Yes", give details and attach supportin	g documentation:		11.5		
4. Have you committed fraud or misreprese					
			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:					
6. Are you a member of the military or a mi	, ,				
If yes, please attach proof of the followin					
document issued by another state that is	document issued by another state that is active or has been expired for < 2 years and that it is in good standing				



PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING

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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 sta						olicant is also assi	gned to			
7.	Are you a Respondent in						pter 403 or Chapt	ter 456			
	following notice and an			•	•				YES	NO	
8.	Have you been declared	incompetent	by a court of c	ompet	ent jurisdictio	n?					_
									YES	NO	
9.	Have you engaged in fra	ud, dishonest	y, or corruption	n on a	certification o	t examination	in this state or ar	nother	<u></u>		
10	state?  Do you have a substanti	atad charge o	f child abuse a	nd nog	lost nursuant	to VDC Chanto	r 620 or adult ab	1160	YES	NO	
10.	neglect, or exploitation	-		_	iect pursuant	to KKS Chapte	i 020, or addit ab	use,	YES	NO NO	
11.					nt which suspe	ends or defers	sentencing for a	crime?	1 1		_
									YES	NO	
								I			
			0-								
					N 2: EDUC						
		e request ar		cript t			ool to the Board				
	School Name		Degree		CACREP	Regionally	Graduation	Number	-	r/Concentration	J
					Accredited	Accredited	Date	of Hours	5		
							(mo./yr.)				
					Ш						
			SECTION	1 3: Cl	JRRICULUN	/ STANDAR	D				
	Please Enter <b>GF</b>	RADUATE LE	<b>VEL</b> Courses (	Only. E	ach Graduat	e Level Cour	se may only be	used in <u>O</u>	ne Area.		
1.	The helping relations	hip includin	g counseling t	heory	and practice	e					
	Educational Institution	ı	Prefix &		Course <sup>-</sup>	Title (No abbi	reviations)	S	emester a	& Credit	
			Number						Year	Hours	
											_
											_



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				-	
2.	Human growth & development.				
۷.			T		
	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, counse	eling, and con	sulting.		
	Educational Institution	Prefix &	Course Title (No abbreviations)	Semester &	Credit
		Number		Year	Hours
				<u> </u>	



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5. Assessment, appraisal, a	and testing of individu	als.		
Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours
6. Social and cultural found	dations, including mul	ticultural issues.		
Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours
<ol><li>Principles of etiology, di dysfunctional behavior.</li></ol>	agnosis, treatment pl	anning, and prevention of mental and emo	tional disorders and	
Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours
	1			



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8. Research and evaluation.				
et a trans	D (; 0	C Till (N 11 : .: )		6 12
Educational Institution	Prefix & Number	Course Title (No abbreviations)	Semester & Year	Credit Hours
on Professional Orientation (Studies that provide an unc counseling roles, organization	and Ethics that derstanding of onal structure in professiona	070 Section 1(2) requires a three (3) semester hour of the section 1(2) requires a three (3) semester hour of the section of t	ciation Code of unseling history seling standard	Ethics. /, ls, and
Educational Institution	Prefix &	Course Title (No abbreviations)	Semester &	Credit
Eddedtonarmstration	Number	course ritle (No absreviations)	Year	Hours



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Practicum/Internship – All applicants clock hours.	shall complete	an organized praction	cum or interr	nship in c	ounse	ling consisting of at le	east 600
Educational Institution	Prefix & Number	Course	Title (No abb	reviation	s)	Semester & Year	Credit Hours
SECTION 4: CEI	 RTIFICATION/	 VERIFICATION OF	CLINICAL II	NTERNS	HIP/PI	RACTICUM	
INSTRUCTIONS: COMPLETE ONE FORM FOR	EACH SEMESTER (	OF INTERNSHIP/PRACTIC	UM.				
Name of Student/Candidate:			T				
School:			Departmer	nt:			
Degree Program:			CACREP:	☐ Yes		□ No	
Supervisor:							
Supervisor's Licensing Credential:	1				Licens	se Number:	
Year of Internship:		Semester:				Quarter	
Agency(s) Internship Completed:							
Name of Onsite Clinical Supervisor:							
Degree & Discipline of Onsite Clinica	al Supervisor:						
Onsite Clinical Supervisor's Licensing	g Credential:					License Number:	
Briefly describe the nature of practi	ce/experience i	ncluding population	ns worked wi	th:			
DPL-LPC-05 Rev. December 2023							
KRS 12.245 and 12:357, KRS 335.515(1), (3), (5) and 201 KAR 36:070							



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Direct Experience Hours:		Indirect Experience Hours:		
Individual Supervision Hours: Group Superv		vision 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			
Are you credentialed as a professional co     If yes, list the state(s):     If yes, submit licensure verification from	unselor in another state or jurisdiction?	d a license.	YES NO	
<ol> <li>Do you or have you ever held any other li- other state?</li> <li>If "Yes", list the license(s) and state(s) and</li> </ol>	, , ,		y or any YES NO	
3. Have you held a certification/license/region revoked?  If "Yes", give details and attach supporting	stration in Kentucky or any other state th		ended YES NO	
4. Have you committed fraud or misreprese		tate or another state?	YES NO	
5. Have you been convicted of a felony or a If "Yes", give details and attach supporting	? 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				
			Page 1 of 2	



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		pouse is assigned to a duty station te pursuant to the spouse's active			plicant is also assi	gned to				
7.		n a case with an active order of pro opportunity to be heard?	tection pursua	nt to KRS Cha	pter 403 or Chap	ter 456	YES	S S	NO	
8.	Have you been declared	incompetent by a court of compe	tent jurisdictio	n?			YE:	]	NO	
9.	Have you engaged in fra state?	ud, dishonesty, or corruption on a	certification o	f examination	in this state or ar	nother	YE:	S S	NO	
10.		ated charge of child abuse and neg	glect pursuant	to KRS Chapte	r 620, or adult ab	use,	YES	S S	NO NO	
11.	Are you under an adjudi	cation or other diversion agreeme	nt which suspe	ends or defers	sentencing for a	crime?	YES	S	NO	
		SECTION	ON 2: EDUC	ATION						
	Pleas	se request an official transcript	to be mailed	from the sch	ool to the Board	d office.				
	School Name	Degree	CACREP Accredited	Regionally Accredited	Graduation Date (mo./yr.)	Number of Hours		Major/C	oncenti	ration
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 Na	ame:									



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

DPL-LPC-07 Rev. December 2023 KRS 12.245 and 12:357, KRS 335.515(1), (6) and 201 KAR 36:030, 201 KAR 36:075



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state pursuant to the spouse's active of	duty military orders.							
7. Are you a Respondent in a case with a following notice and an opportunity to	pter 403 or Chapter 456 YES NO							
Have you been declared incompetent								
9. Have you engaged in fraud, dishonest state?	in this state or another YES NO YES NO 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 Kl  11. Are you under an adjudication or other	er diversion agreement which suspends or defers	sentencing for a crime?  YES  NO  YES  NO  NO						
	ON 2: CONTINUING EDUCATION CON official transcript to be mailed from the scho							
Course Name	Date Completed  MM/DD/YYYY	Course Hours Earned						
	, ,							
Total Course Hours Earned:								
Suicide Assessment, Treatment, and Mana	gement Exemption:							
Do you qualify for the exemption under 2 suicide assessment, treatment, and manage		who teaches the board-approved training on						
Yes No								
Course Title:	Date	Taught:						
Law for Regulating Professional Counseling	g Exemption:							
DPL-LPC-07 Rev. December 2023								

Rev. December 2023 KRS 12.245 and 12:357, KRS 335.515(1), (6) and 201 KAR 36:030, 201 KAR 36:075



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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 correct, and complete to the best of my knowledge and belief. I am disclose any such misrepresentation or falsification, my application cou Board. Furthermore, I agree to abide by the standards of practice and contact the standards of practice and conta	aware that, should an investigation at any time ld be rejected, or my certification revoked by the			
Signature (Required) :	Date:			
Printed Name:				
DPL-LPC-07				



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

DPL-LPC-08
Rev. December 2023
KRS 12.245 and 12:357, KRS 335.515(1), (6)
and 201 KAR 36:030, 201 KAR 36:075



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Г		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 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, <b>201 KAR 36:060 Section 5 (1)(a)?</b> 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, <b>201 KAR 36:060 Section 5 (1)(b)?</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
		Does your supervision include ethical problems in the practice of professional counseling, <b>201 KAR 36:060 Section 5 (1)(d)?</b> 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 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 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 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 NO



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17. Do you have a substantiated charge of adult abuse, neglect, or exploitation p		RS Chapter 620, or	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	d 12. please explain below.		123 110
in you unswered the to bein questions 11 am	a 12, picuse explain below.		
Supervisor Signature (Required) :		Date:	
	2: CONTINUING EDUCATION CO		
	cial transcript to be mailed from the sch		
Please request an offic  Course Name	cial transcript to be mailed from the sch  Date Completed  MM/DD/YYYY		e Hours Earned
	Date Completed		
	Date Completed MM/DD/YYYY		

# THE MENT OF SECULATION OF SECURITIES OF SECU

#### KENTUCKY BOARD OF LICENSED PROFESSIONAL COUNSELORS

PUBLIC PROTECTION CABINET — DEPARTMENT OF PROFESSIONAL LICENSING
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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:	

DPL-LPC-08
Rev. December 2023
KRS 12.245 and 12:357, KRS 335.515(1), (6)
and 201 KAR 36:030, 201 KAR 36:075



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: <a href="lpc.ky.gov">lpc.ky.gov</a> | Email: <a href="LPC@KY.GOV">LPC@KY.GOV</a>

#### 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 Nam	ne.	First Name:		Middle Initial:	Previou	s Name:	
Last Ivali	ic.	Til st ivallie.		Wildule IIIItiai.	FTEVIOU	is ivallie.	
Mailing <i>A</i>	Address: Street	City:		State:	Zip Cod	e:	
Rusiness	Address: Street	City:		State:	Zip Cod	e·	
( )	ne Number:	- Oicy.	Email Address		_ Lip cou	<u>c.                                    </u>	
· ·							
License N	Number:		License Expira	tion Date:			_
Present	Place of Employment:						
Work Te	elephone Number:		Work E-mail	Address:			
		GENERAL	QUESTIONS				
1.	Have you been convicted of a felony	·					
	your last application or renewal? "Co	onviction" including al	l instances in w	hich a plea of no c	ontest is	YES	NO
	the basis of the conviction.  If "Yes", give details and attach supporting documentation:						
2.	Have you been subject to disciplinar			aling board since v	our last		$\top$
	application or renewal?	,		,		YES	NO
	If "Yes", give details and attach supp						
3.	Have you become licensed or certifie	· · · · · · · · · · · · · · · · · · ·					
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:					ense and	YES	NO
4.						YES	NO
5.	Have you committed fraud or misrep state?	presentation in applyir	ng for a license	in this state or and	ther	YES	NO NO
6.	Are you a Respondent in a case with	an active order of pro	tection pursua	nt to KRS Chapter	403		
(DVO) or KRS Chapter 456 (IPO) following notice and an opportunity to be heard?					YES	NO	

DPL-LPC-09 Rev. December 2023 KRS 12.245 and 12:357, KRS 335.515(1), (5) and 201 KAR 36:030, 201 KAR 36:075



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P.O. Box 1360, Frankfort, Kentucky 40602 500 Mero Street 2SC32 Frankfort, Kentucky 40601 (Overnight Delivery Only)

7. Have you been declared incompetent	by a court of competent jurisdiction?				
			YES	NO	
O Have you appeared in freed dish appear	tu a saumuntina an a contification of aversion	tion in this state		<del> </del>	
8. Have you engaged in fraud, dishones or another state?	ty, or corruption on a certification of examina	tion in this state	YES	NO NO	
	of child abuse and neglect pursuant to KRS Cha	apter 620, or			
adult abuse, neglect, or exploitation	· · · · · · · · · · · · · · · · · · ·		YES	NO	
10. Are you under an adjudication or oth	fers sentencing				
for a crime?			YES	NO	
SECTION	1.2. CONTINUUNC EDUCATION COMP	LANCE			
	I 2: CONTINUING EDUCATION COMPL ficial transcript to be mailed from the school t				
Course Name	Date Completed		Hours Earne	 ed	
	MM/DD/YYYY				
Total Course Hours Earned:					
Suicide Assessment, Treatment, and Manage	ement Exemption:				
Do you qualify for the exemption under 201 K	AR 36:030 Section 1 (4) as a licensee who teac	hes the board-appr	oved trainin	g on suicide	
assessment, treatment, and management?					
YesNo					
Course Title: Date Taught:					
Law for Regulating Professional Counseling E	exemption:				
Do you qualify for the exemption under 201 l		aches the hoard-an	nroved trair	ning on the	
law for regulating professional counseling, KF		•	proved train	mig on the	
Yes No		•			
DPL-LPC-09					
Rev. December 2023 KRS 12.245 and 12:357, KRS 335.515(1), (5)					
and 201 KAR 36:030, 201 KAR 36:075				Dr 2 C2	



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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:	Previou	s Name:		
Last Name.		THSC Name.		Wildule Hillial.	Fieviou	3 Ivallie.		-
Mailing Addre	ess: Street	City:		State:	Zip Cod	e:		
Business Add	ress: Street	City:		State:	Zip Cod	e:		_
( ) Telephone Ni	umber:		Email Address	:				
· · · · · · · · · · · · · · · · · · ·								_
License Numb	oer:		License Expira	tion Date:				
Present Plac	e of Employment:							
								_
Work Telephone Number: Work E-mail Address:								
		GENERAL	QUESTIONS					
1. Ha	ive you been convicted of a felony	or a misdemeanor (o	ther than mind	r traffic violations)	since			
-	ur last application or renewal? "Co	nviction" including all	instances in w	hich a plea of no c	ontest is	YES	NO	
	the basis of the conviction.							
	'Yes", give details and attach suppo			- U In I - I			+—	_
	ive you been subject to disciplinary plication or renewal?	action by a mental n	eaith credentia	aling board since y	our last	YES		
	Yes", give details and attach suppo	orting documentation:				TES	NO	
	ive you become licensed or certifie			tion or renewal?			$+\Box$	_
	'Yes", list the state(s), type of licens	·	• •		ense and	YES	NO	
attach a letter of good standing from each state:								
4. Ar	4. Are you currently serving in the military?					YES	NO	
	ve you committed fraud or misrep	resentation in applyin	g for a license	in this state or ano	ther			
	ate?					YES	NO	_
	e you a Respondent in a case with a	· ·	· · · · · · · · · · · · · · · · · · ·		403	L		
(D'	(DVO) or KRS Chapter 456 (IPO) following notice and an opportunity to be heard?							

DPL-LPC-10 Rev. December 2023 KRS 12.245 and 12:357, KRS 335.515(1), (5) and 201 KAR 36:030, 201 KAR 36:075



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7. Have you been declared incompetent		YES	NO	
8. Have you engaged in fraud, dishonest or another state?	tion in this state	YES	NO NO	
<ol> <li>Do you have a substantiated charge of adult abuse, neglect, or exploitation;</li> </ol>	f child abuse and neglect pursuant to KRS Chapursuant to KRS Chapter 209?	apter 620, or	YES	NO NO
10. Are you under an adjudication or other for a crime?	ers sentencing	YES	NO NO	
	I 2: CONTINUING EDUCATION COMPL		1	1
Please request an official transcript to be mailed from the school to the Board office.  Course Name  Date Completed  Course  MM/DD/YYYY				ed
Total Course Hours Earned:				
	VERIFICATION			
I, the applicant named above, do hereby c and complete to the best of my knowled such misrepresentation or falsification,	ge and belief. I am aware that, should an my application could be rejected, or m	n investigation at ny certification re	any time devoked by	isclose any
Furthermore, I agree to abide by the stan	dards of practice and code of ethics appr	oved by the Boar	d.	
Signature (Required) :		Date:		
Printed Name:				
DPL-LPC-10				

DPL-LPC-10 Rev. December 2023 KRS 12.245 and 12:357, KRS 335.515(1), (5) and 201 KAR 36:030, 201 KAR 36:075