Board of Behavioral Sciences
1625 North Market Blvd., Suite S200, Sacramento, CA 95834
Telephone: (916) 574-7830 TTY: (800) 326-2297
www.bbs.ca.gov

LICENSED PROFESSIONAL CLINICAL COUNSELOR

REQUEST FOR CONFIRMATION OF QUALIFICATIONS TO ASSESS AND TREAT COUPLES AND FAMILIES

INSTRUCTIONS

- Type or print clearly in ink.
- Please do not contact the Board to check the status of your request. If you would like to know whether the Board has received your forms, mail them in a manner that includes tracking.
- Processing time will vary depending on the volume of applications received.
- **This form will not be accepted unless you currently hold an LPCC license in California.**

ENCLOSE ALL OF THE FOLLOWING IN ADDITION TO THE COMPLETED FORMS *(unless otherwise specified on the request form)*:

- Official transcripts verifying that you have met the educational qualifications, in an envelope sealed by the educational institution
- A course description or course syllabus if the course title does not clearly indicate the content
- Documentation of your supervised experience working with couples, families and/or children

NOTE: New Requirement Effective January 1, 2017:

Effective January 1, 2017, an LPCC who wishes to treat couples or families **must** obtain written confirmation from the Board that he or she meets the requirements to treat couples and families, and must provide a copy of this written confirmation to:

- Couple or family clients prior to commencement of treatment

AND

- The types of supervisees listed below, prior to commencement of supervision:
    - A marriage and family therapist trainee or intern
    - An LPCC or PCC Intern who is gaining the supervised experience necessary to treat couples or families

For more information on “couples and families” requirements, including FAQs, see the Board’s website.

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A. APPLICANT INFORMATION

LPCC License Number:	BBS File Number (if known):	
Legal name*: Last	First	Middle
Maiden name and any other AKA		
Address of Record**: Number and Street		
City	State	Zip Code
Is this a new address? ☐ Yes ☐ No **If YES**, we will update our records accordingly		
Business Telephone:	Residence Telephone:	E-Mail Address (OPTIONAL):

** You must use your legal name. Your "legal name" is the name established legally by your birth certificate, marriage or domestic partnership certificate, or divorce decree (for example). If you have changed your legal name without notifying the Board, submit a Notification of Name Change form with your request along with the required documentation.*

*** The address you provide is public information and will be placed on the Internet pursuant to BPC section 27. All correspondence from the Board will be sent to this address. If you don't want your home or work address to be public, use an alternate mailing address such as a post office box.*

Applicant Name: Last		

Do you currently hold a license as a Licensed Marriage and Family Therapist (LMFT)?

☐ Yes ☐ No

If YES: ➔ Enter your LMFT license number: _____ State: _____ AND

➔ SKIP TO SECTION D

Do you hold a LPCC license in another jurisdiction? ☐ Yes ☐ No

If YES: ➔ Enter your LPCC license number: _____ State: _____ AND

➔ Does the scope of practice in that jurisdiction clearly state that LPCCs are permitted to assess and treat couples, families or children? ☐ Yes ☐ No

If YES: o SKIP TO SECTION C

If NO: o Submit documentation of experience as described in Section B and complete Sections C and D.

B. EXPERIENCE REQUIREMENT

To qualify, you must have a minimum of 500 hours of documented supervised experience working directly with couples, families and/or children under the supervision of one of the following, who has been licensed for at least two (2) years:

- A Licensed Professional Clinical Counselor who, at the time of supervision, had met the education and experience requirements to treat couples and families;
- A Licensed Marriage and Family Therapist; **or**
- Any of the following licensed persons who have sufficient education and experience to competently practice couples and family therapy:
  - o Licensed Clinical Social Worker
  - o Licensed Clinical Psychologist
  - o Licensed Physician Board-Certified in Psychiatry by the American Board of Psychiatry and Neurology

TO VERIFY SUPERVISED EXPERIENCE:

Attach a completed *Supervised Experience with Couples, Families or Children* form signed by your supervisor. If your supervisor is not available, your employer at the time you gained your experience may complete the form.

Applicant Name: Last	First	Middle

C. EDUCATION REQUIREMENT

I. A minimum of six (6) semester units or nine (9) quarter units of graduate coursework specifically focused on the theory and application of marriage and family therapy

OR

II. A named specialization or emphasis area on the qualifying degree in one of the following:

- o Marriage and family therapy
- o Marital and family therapy
- o Marriage, family and child counseling
- o Couple and family therapy

TO VERIFY, COMPLETE ONE OF THE FOLLOWING SECTIONS (I or II) AND ATTACH OFFICIAL, SEALED TRANSCRIPTS

I. ☐ **Coursework focused on the theory and application of marriage and family therapy:**

School	Course Number	Course Title	Units

OR

II. ☐ **Degree Title/Specialization:**

Degree Title:	Named Specialization or Emphasis: ☐ Marriage and family therapy ☐ Marital and family therapy ☐ Marriage, family and child counseling ☐ Couple and family therapy
Name of School, College or University:	

D. APPLICANT SIGNATURE

NOTE: Knowingly providing false information or omitting pertinent information may be grounds for denial of this application. The Board may take disciplinary action on a licensee or registrant who misrepresents his or her education or professional qualifications.

_____ _____

Applicant Signature ***Date***

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SUPERVISED EXPERIENCE WITH COUPLES, FAMILIES OR CHILDREN

NOTE: This form will NOT be accepted as verification for purposes of a LPCC licensing application.

The supervisor* of your experience working directly with couples, families and/or children must complete this form as follows:

- Use a separate form for each supervisor and employer.
- An original signature in ink is required. Have the signer initial any changes.
- Submit with your *Request for Confirmation of Qualifications to Assess and Treat Couples and Families* form.

APPLICANT INFORMATION

LPCC License Number:	BBS File Number (if known):	
Legal name: Last	First	Middle

EMPLOYER INFORMATION

Applicant's Employer's Name	Employer Telephone

SUPERVISOR INFORMATION

Supervisor's Name			Supervisor's Telephone
Supervisor's License Type	License Number	Issue Date	State
Do you have sufficient education and experience to competently practice couples and family therapy?			☐ No ☐ Yes
Have you received professional training in supervision?			☐ No ☐ Yes

** If your supervisor is not available, your employer may sign*

Applicant Name: Last	First	Middle

SUPERVISOR INFORMATION (Continued)

Physicians: Were you certified in Psychiatry by the American Board of Psychiatry and Neurology during this supervision?	☐ No ☐ Yes: Certificate number: _____
California-licensed LPCCs: Did you meet California's qualifications to treat couples and families during this supervision?	☐ No ☐ Yes: Date you met the qualifications: _____

APPLICANT'S SUPERVISED EXPERIENCE

Dates (mm/dd/yyyy): From _____ to _____

Total supervised hours working directly with couples, families and/or children: _____ hours

NOTE: Knowingly providing false information or omitting pertinent information may be grounds for denial of the application. The Board may take disciplinary action on a licensee who helps an applicant obtain a license by fraud, deceit or misrepresentation. All information on this form is subject to verification.

Signature of Supervisor: _____ Date: _____