Clear Form

UTAH DEPARTMENT OF COMMERCE

Division of Professional Licensing

Request to Extend: Associate Clinical Mental Health Counselor License

APPLICANT INFORMATION

Full Legal Name: _____
First *Middle* *Last*

All Previous Legal Names: _____

Other DOPL Licenses Held: _____

SSN: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

_____
City *State* *ZIP Code*

Phone: _____ **Email:** _____

Please Select ONE:

- ☐ I am a United States citizen OR a non-citizen of the United States who is lawfully present.
- ☐ I am a foreign national not physically present in the United States.
- ☐ None of the above, please explain: _____

Driver License or State ID Card _____
State of Issue *License Number* *Expiration Date*

NOTE: If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of lawful presence in the United States.

CHECKLIST

You must include the following items with this request:

1. Narrative explaining why you are requesting the extension and your plan to complete the outstanding license requirements, including the length of the extension you are requesting.
2. Verification of Hours (see attached form) completed by your supervisor attesting to the hours you have completed thus far. Only hours used while licensed as an ACMHC can be counted. Use a separate form for each supervisor and/or location.
3. Completed Extension Request Worksheet (see attached)
4. Documentation of Continuing Education. Copies of certificates must include your name, date of the course, name of the course provider, name of the instructor, course title, and number of hours of continuing education credit.

Submit the above items with your completed application to:

In person or via express delivery:
Division of Professional Licensing
Heber M Wells Building, 1st Floor Lobby
160 E 300 S
Salt Lake City, UT 84111

US Postal Service:
Division of Professional Licensing
PO BOX 146741
Salt Lake City, UT 84114-6741

If you have questions, please contact the Division via our direct email address, b8@utah.gov, or via the phone or fax listed below.

Extension Request Worksheet

APPLICANT INFORMATION

Full Legal Name: _____
First *Middle* *Last*

Mailing Address: _____
Street/PO Box *City* *State/Zip*

I am requesting and extension in order to complete (check all that apply): ☐ Hours ☐ Exam ☐ Other: _____

EXPERIENCE

In addition to completed Verification of Hours forms from each supervisor, please provide the following information:

Have you completed the 3000-hour POST-GRADUATE experience?

☐ Yes Date Completed: _____

☐ No Overall Amount Completed: _____

Total in Mental Health: _____

Total Direct: _____

EXAM HISTORY

Have you taken and passed the required exams?

NCE

☐ Yes Date Completed (Include score report): _____

☐ No Please check all that apply and provide the appropriate information for each question:

☐ I have attempted on the following dates (include score reports):

_____, _____, _____

☐ I am scheduled to take the exam on (date): _____

☐ I am not scheduled. I anticipate taking the exam on (date): _____

NCMHCE

☐ Yes Date Completed (Include score report): _____

☐ No Please check all that apply and provide the appropriate information for each question:

☐ I have attempted on the following dates (include score reports):

_____, _____, _____

☐ I am scheduled to take the exam on (date): _____

☐ I am not scheduled. I anticipate taking the exam on (date): _____

Supervisor Verification

A supervisee may not count any post-graduate supervised training towards their supervision requirements until the division notifies the supervisor listed below of receipt of this form

SUPERVISEE INFORMATION

To be completed by the supervisee.

Full Legal Name: _____
First *Middle* *Last*

Mailing Address: _____
Street / PO Box *City* *State / Zip*

Email Address: _____
*Note: **REQUIRED** All Division notices and communication regarding supervision will be sent to this email.*

CSW License Number if Issues: _____

SUPERVISOR INFORMATION

To be completed by the Supervisor.

Full Legal Name: _____
First *Middle* *Last*

Mailing Address: _____
Street / PO Box *City* *State / Zip*

Email Address: _____
*Note: **REQUIRED** All Division notices and communication regarding supervision will be sent to this email.*

License Number: _____ **License Type:** _____

Proposed Supervisors Must Have Been Actively Engaged in Licensed Practice For at Least 2 Years Before Supervising Post-Graduate Hours

☐ **Yes** ☐ **No** Supervisee is a W-2 employee of a public or private mental health agency.

☐ **Yes** ☐ **No** Written supervision contract meets the requirements outlined in R156-60-302.

☐ **Yes** ☐ **No** Supervisor and Supervisee have both signed a written supervision contract.

Date Written Supervision Contract Was Signed: _____

I certify I have read Utah Admin. Code R156-60-302. Supervised Training Requirements-Supervision Contract-Duties and Responsibilities of Supervisor and Supervisee. I understand that hours MUST be documented using the Division-provided Supervision Record of Post-Graduate Mental Health Practice Hours form.

Signature of Supervisor: _____ **Date:** _____

Signature of Supervisee: _____ **Date:** _____

EMAIL THIS COMPLETED FORM TO B8@UTAH.GOV

SUPERVISION RECORD OF POST-GRADUATE MENTAL HEALTH PRACTICE HOURS

Use this form to report your supervision after obtaining licensure as an Associate Clinical Mental Health Counselor. Each Supervisor must complete a separate form. The hours from all forms must total 3,000.

APPLICANT INFORMATION

To be completed by the supervisee.

Full Legal Name: _____
First *Middle* *Last*

License Number: _____ License Type: _____

SUPERVISION INFORMATION

To be completed by the Supervisor.

Name of Establishment: _____

Name of Supervisor: _____
First *Middle* *Last*

Email Address: _____

Note: (REQUIRED) All Division notices and communication regarding supervision will be sent to this email.

License Number: _____ License Type: _____

Date of Supervision as a W-2 Employee: _____ to _____

Note: Intern/Practicum hours cannot be counted. *MM/DD/YYY* *MM/DD/YYY*

	Documented hours of supervised mental health therapy with clients *As defined in Utah Code 58-60-102(7) and 58-60-405(1)(e)*
	Documented hours of mental health training gathered under Direct Supervision *As defined in Utah Code 58-60-205(1)(e), 58-60-305(1)(e), 58-60-405(1)(e), and 58-60-502(3)*
	Documented hours of mental health therapy training
	TOTAL HOURS of documented training under this supervisor *As defined in Utah Code 58-60-405(1)(e)*

☐ Yes ☐ No **Did the supervisee meet the expectations of supervision outlined in the written plan, with regards to the quality of work performed? If no, submit a written statement regarding the performance to the Division at B8@utah.gov.**

☐ Yes ☐ No **Did the supervisor and supervisee work at the same place of employment? If no, describe how you were able to perform supervision:** _____

_____

I certify that the applicant for licensure as a clinical social worker has successfully completed the above hours of post-graduate supervised experience as a W-2 employee of the facility listed above and that the experience meets the requirements outlined in Utah Admin. Code R156-60a-302c, and Utah Admin. Code R156-60-302. I further certify that the applicant is qualified and competent to practice as a clinical social worker.

Signature of Supervisor: _____ **Date:** _____