SOUTH DAKOTA STATE BOARD OF EXAMINERS FOR COUNSELORS & MARRIAGE AND FAMILY THERAPISTS
Via Teleconference
Friday, August 21, 2020 – 10:00 AM CDT

Proposed Meeting Agenda

1) Call to Order
2) Approval of Agenda
3) Open Forum: 5 minutes for the public to address the Board
4) Approval of Minutes: June 12, 2020
5) Financial Report as of July 31, 2020
6) Executive Session (Pursuant to SDCL 1-25-2 (3) for consideration of proposed contested cases or contractual matters)
7) Old Business
   a. Database Update
   b. COVID-19 Implications and Updates
8) New Business
   a. DSS Update
   b. Office Update
   c. Implementation of administrative rule changes
   d. Application Forms
      a. Application for Plan of Supervision – LPC
      b. Application for Plan of Supervision – LPC-MH
      c. Application for Plan of Supervision – LMFT
      d. Application for Approved Supervisor
      e. Application for License – LPC, LPC-MH and LMFT
      f. Application for License by Endorsement – LPC, LPC-MH and LMFT
      g. Application for Temporary License by Endorsement – LPC, LPC-MH and LMFT
      h. Application for Inactive License – LPC, LPC-MH and LMFT
      i. Application to Reinstatement License – LPC, LPC-MH and LMFT
      e. Council of State Governments Interstate Licensing Compact
9) Announcements
   a. Upcoming Meeting Dates: September 18, 2020 (teleconference)
      November 20, 2020 (Pierre)
10) Adjourn
South Dakota Board of Examiners for Counselors & Marriage and Family Therapists
Via Videoconference
June 12, 2020

Vice President Butler called the meeting to order at 10:04 am central and determined a quorum.

Board Members Present via Videoconference: Tiffany Butler, Sherry Bartels, Roswitha Konz, Cheryl Hartman, Bobbi Brown, Jeff Wangen and Jay Trenhaile

Board Members Absent: Lynell Rice Brinkworth, Woody Schrenk

Others Present via Videoconference: Jennifer Stalley, Executive Secretary; Karen Cudmore, administrative staff; Erin Handke, Assistant Attorney General; Laura Ringling, Board Legal Counsel, Department of Social Services; and Marilyn Kinsman, Department of Social Services

Board members introduced themselves to Jay Trenhaile, the newest appointed board member.

Motion to approve the proposed agenda by Konz. Seconded by Hartman. The Board voted by roll call. Butler, Bartels, Konz, Hartman, Brown, Wangen and Trenhaile voted aye. Motion carried.

Butler asked for comments from the public. There were no comments offered.

Motion to approve the meeting minutes of April 17, 2020 by Wangen. Seconded by Konz. The Board voted by roll call. Butler, Bartels, Konz, Hartman, Brown, Wangen and Trenhaile voted aye. Motion carried.


Motion to go into executive session for consideration of contested cases and contractual matters at 10:16 am by Konz. Seconded by Wangen. The Board voted by roll call. Butler, Bartels, Konz, Hartman, Brown, Wangen and Trenhaile voted aye. Motion carried.

Butler declared the Board out of executive session at 10:41 am.


Stalley provided the Board with an update on COVID-19. Stalley noted Governor Noem’s executive order 2020-25 allows for the temporary suspension of the examination requirements for licensed professional counselors-mental health as a pre-requisite of licensure. Proof of examination is required by November 30, 2020 to the Board. The Board’s policy regarding the testing for professional counselor and marriage and family therapist plans of supervision remain in place.

Stalley provided an office update, including the list of new licensees since the last meeting, and the status of the database project. The licensee database will be available prior to the opening of license renewals in the fall.

Stalley provided an overview of the implementation of Senate Bills 18 and 19. The Board will begin accepting applications to reactivate a qualified expired license on July 1st. The changes to licensure by endorsement will also be implemented on July 1st. Applications to inactivate a license will be ready for license renewals in the fall. Other aspects of the bills will need to be implemented through administrative rule changes.

Motion for the administrative rules workgroup to prepare a revised version of the proposed changes to the professional counselor, professional counselor-mental health, and marriage and family therapists’ administrative rules to be submitted to the formal process for changes to administrative rules by Konz. Seconded by Wangen. The Board voted by roll call. Butler, Konz, Hartman, Brown, Wangen and Trenhaile voted aye. Motion carried.

The Board’s next meeting is scheduled for August 14th at 10:30 am (central).


The Board adjourned at 12:05 pm.

Respectfully Submitted,

Jennifer Stalley, Executive Secretary
### EMPLOYEE SALARIES

<table>
<thead>
<tr>
<th>Subobject</th>
<th>Operating</th>
<th>Expenditures</th>
<th>Encumbrances</th>
<th>Commitments</th>
<th>Remaining</th>
<th>PCT AVL</th>
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<tbody>
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<td>660</td>
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<td>2,481</td>
<td>79.0</td>
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<td><strong>3,141</strong></td>
<td><strong>660</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>2,481</strong></td>
<td><strong>79.0</strong></td>
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### EMPLOYEE BENEFITS

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<th>Commitments</th>
<th>Remaining</th>
<th>PCT AVL</th>
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<td><strong>271</strong></td>
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### 51 Personal Services

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### TRAVEL

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### CONTRACTUAL SERVICES

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# Remaining Authority by Object/Subobject

Expenditures current through 08/01/2020 02:20:35 PM

SOCIAL SERVICES -- Summary
FY 2021 Version - AS - Budgeted and Informational

FY Remaining: 91.5%

## Board of Counselor Examiners - Info

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<th>Subobject</th>
<th>Operating</th>
<th>Expenditures</th>
<th>Encumbrances</th>
<th>Commitments</th>
<th>Remaining AVL</th>
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**Subtotal** | 82,112 | 6,798 | 70,823 | 0 | 4,491 | 5.5 |

## SUPPLIES & MATERIALS

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<th>Subobject</th>
<th>Operating</th>
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<th>Encumbrances</th>
<th>Commitments</th>
<th>Remaining AVL</th>
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**Subtotal** | 3,900 | 430 | 0 | 0 | 3,470 | 89.0 |

## 52 Operating

**Subtotal** | 99,491 | 7,228 | 70,823 | 0 | 21,440 | 21.5 |

## Total

**Total** | 102,953 | 7,938 | 70,823 | 0 | 24,192 | 23.5 |
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<th>BALANCE</th>
<th>DR/CR</th>
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<td>MTD AMOUNT</td>
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$2,000.00 $2,000.00
## AVAILABLE FUNDS

**AS OF:** 07/31/2020

**FY YEAR REMAINING:** 91.8%

**PAY DAYS REMAINING:** 0

### BUDGET UNIT NAME

BOARD OF COUNSELOR EXAMINERS - INFO

### ORIGINAL

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<th>TRANSFERS</th>
<th>COMMITMENTS</th>
<th>ENCUMBRANCES</th>
<th>EXPENDITURES</th>
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<td>7,938.85</td>
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### BUDGETED TOT

| 102,953.00 | 0.00 | 0.00 | 70,822.80 | 7,938.85 | 24,191.35 | 104,664.64 |

### ALL COMP TOT

| 102,953.00 | 0.00 | 0.00 | 70,822.80 | 7,938.85 | 24,191.35 | 104,664.64 |

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<th>AMOUNT</th>
<th>COMMITMENTS</th>
<th>ENCUMBRANCES</th>
<th>EXPENDITURES</th>
<th>BUDGET AVAILABLE</th>
<th>PCT AVL</th>
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| TOTALS | 102,953.00 | 0.00 | 70,822.80 | 7,938.85 | 7,938.85 | 24,191.35 | 23.5 |

### BREAKOUT BY COMPANY:

#### COMPANY 6503-I  PROFESSIONAL & LICENSING BOARDS

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| OE SUBTOTALS | 99,491.00 | 0.00 | 70,822.80 | 7,228.36 | 7,228.36 | 21,439.84 | 21.5 |
| COMPANY 6503-I TOT | 102,953.00 | 0.00 | 70,822.80 | 7,938.85 | 7,938.85 | 24,191.35 | 23.5 |</p>
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**OBJECT: 5102 EMPLOYEE BENEFITS**

**GROUP: 51 PERSONAL SERVICES**

**COMP: 6503**

**CNTR: 0891000648**

**CNTR: 0891000648**

**CNTR: 0891000648**

**B. UNIT: 0891**
APPLICATION FOR PLAN OF SUPERVISION—PROFESSIONAL COUNSELOR

No supervision hours can accrue until a Plan of Supervision is approved for the applicant.

Please submit:
1) Completed application;
2) Attachment 1 completed and submitted directly to the Board by your Proposed Supervisor;
3) Proof of graduation (i.e. transcripts) from a CACREP program or a 48-hour master’s degree in counseling from an accredited Institution submitted directly to the Board;
4) Proof of a passing score on the National Counselor Examination (NCE) submitted directly to the Board;
5) Verification of other licenses;
6) Quality color photograph of applicant;
7) Verification of any name change (i.e. marriage/divorce); and
8) Non-refundable $100 application fee.

The application fee for a Plan of Supervision is non-refundable. If the applicant uses more than one approved supervisor to meet the supervision requirements for full licensure, no fee will be charged for additional supervisors. If adding a 2nd (or 3rd) Supervisor, complete and submit Page 1 and Attachment 1.

APPLICANT INFORMATION

Name: __________________________________________________________________________
Address: __________________________________________________________ City: ___________ State: ___________ Zip: _______________
Date of Birth: _________________________Social Security Number: __________________________
E-mail: ______________________________________ Phone: _______________________________
Name of Business:____________________________________________ Phone:_________________________
Address:__________________________________City:____________________ State:_______Zip:__________

PROPOSED SUPERVISOR NAME

Name: ____________________SD License Number: ________ Issue Date of License: __________
License type: _____LPC* _____LPC-MH _____LMFT _____CSW-PIP _____Psychologist _____Psychiatrist
* If Proposed Supervisor is an LPC, I acknowledge that my direct client contact hours and supervision hours acquired under the plan will not be allowed to be carried forward to an LPC-MH Plan of Supervision in the future.

Attachment 1 Completed: ___Yes ___No Attachment 1 must be completed and submitted directly to the Board by the Proposed Supervisor.
EDUCATION

Name of Post Graduate Institution: ______________________________________________________

City/State: ______________________________________________________________________

Date of Graduation: __________________________  Degree: ______________________________

Was your program of study CACREP approved?  _____ Yes   ______ No*  
*If No, complete Attachment 2 and document the content areas of your education.

Please request your school send an official copy of your transcripts directly to the South Dakota Board of 
Examiners for Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD 57501 or 
electronically to sdbce@midwestsolutionssd.com. Transcripts must be received directly from the school to 
be valid. Date requested:____________

NATIONAL EXAMINATION

A passing score on the National Counselor Examination (NCE) is required prior to beginning a Plan of 
Supervision for Professional Counselor (LPC). Date of Examination:____________

Please request your official national exam score be sent to the South Dakota Board of Examiners for 
Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD 57501 or released to the Board 
through the NBCC online results portal. Date requested:____________

MILITARY STATUS

____YES ____NO   Are you a member or the spouse of a member of the armed forces of the United 
States?  
If Yes, were you or your spouse the subject of a military transfer to South Dakota?  ______ Yes____No  
If Yes, did you leave employment to accompany your spouse to South Dakota?  ______ Yes____No

LEGAL QUESTIONS (If you answer yes to any question below, please provide a separate written 
explanation.)

____YES ____NO   Have you ever been convicted, pled no contest/nolo contender, pled guilty 
or been granted a deferred judgment or suspended imposition of sentence or had prosecution 
deferred with respect to a felony?

____YES ____NO   Have you ever been convicted, pled no contest/nolo contender, pled 
guilty to, or been granted a deferred judgement or suspended imposition of sentence, or had 
prosecution deferred with respect to a misdemeanor other than a class 2 traffic offense?

____YES ____NO   Have you been disciplined with a reprimand, censure, suspension, temporary 
suspension, probation, revocation, or refusal to renew a professional license in any state?

____YES ____NO   Are you $1,000 or more behind in child support payments?

____YES ____NO   Have you previously made application for licensure to this Board?
OTHER LICENSES

Do you currently hold a valid license to practice counseling in another state? _____ YES _____ NO
If yes, which state(s)? __________________________________________________________

If yes, please request the issuing state send a Letter of Verification to the South Dakota Board of Examiners
for Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD 57501 or electronically to
sdbce@midwestsolutionssd.com. Date requested:____________

STATISTICAL INFORMATION

These questions are asked for statistical purposes. Your answers are optional.

What is your gender? _____ Female _____ Male

What is your race? Please check all that apply.

☐ Asian          ☐ Hispanic or Latino
☐ American Indian or Alaska Native ☐ White or Caucasian
☐ Black or African American     ☐ Other
☐ Native Hawaiian or Pacific Islander ☐ Decline to Provide

APPLICATION FEE

Please include a personal check, cashier’s check, certified check or money order made payable to the State of South Dakota for the applicable amount.

☐ $100 non-refundable application fee

To be signed in the presence of a Notary Public

BY MY SIGNATURE BELOW, I VERIFY, UNDER PENALTY OF PERJURY, THAT I AM THE APPLICANT COMPLETING
THIS APPLICATION AND THAT ALL INFORMATION SUBMITTED IS TRUE AND CORRECT TO THE BEST OF MY
KNOWLEDGE. I FURTHER UNDERSTAND THAT FALSE OR INCORRECT INFORMATION, OMISSIONS,
INACCURACIES OR FAILURES TO MAKE FULL DISCLOSURE MAY RESULT IN THE CANCELLATION OR DENIAL OF A
PLAN OF SUPERVISION OR LICENSE ISSUED PURSUANT TO THIS APPLICATION AND MAY BE SUBJECT TO CIVIL
AND CRIMINAL PROCEEDINGS. I AGREE ALL INFORMATION IN THIS APPLICATION CAN BE VERIFIED AND
INVESTIGATED. I HAVE READ, AND AM FAMILIAR WITH THE SOUTH DAKOTA CODIFIED LAWS AND
ADMINISTRATIVE RULES REGULATING PROFESSIONAL COUNSELING AND HEREBY AGREE TO ABIDE BY SUCH
LAWS AND REGULATIONS.

___________________________________________ _________________________
Applicant Signature  Date

State of _______________ )      SS
County of _______________ )

On this ___ day of ______, 20___, the above applicant, ____________________________, personally
appeared, known to me or satisfactorily proven to be the same person whose name is subscribed to the
written instrument, and acknowledged that he/she executed the same for the purposes therein contained. In
witness where of, I have here unto set my hand and official seal.
Mail completed application and fee to:
SD Board of Examiners for Counselors & Marriage and Family Therapists
PO Box 340
Pierre, SD 57501

Attach Photo Here
For identification purposes, the applicant shall furnish one color headshot taken not more than six months before the date of application.
**ATTACHMENT 2 COURSEWORK REQUIREMENTS**  
**PROFESSIONAL COUNSELOR**

In the blanks provided, please write which course number(s) meet(s) these requirements from your transcript. If a course title is not clearly indicative of the content areas as outlined below, include the college catalog description or course syllabus and highlight the areas of the literature that best demonstrate coverage of the content area.

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<th>Content Area</th>
<th>Course Number(s)</th>
<th>Course Title(s)</th>
<th>College/University</th>
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<td><strong>Counseling theory:</strong> including a study of basic theories and principles of counseling and philosophic bases of the helping relationship;</td>
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<td><strong>Counseling techniques:</strong> including individual counseling practices, methods, facilitative skills, and the application of these skills;</td>
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<td><strong>Counseling Practicum</strong></td>
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<td><strong>Counseling Internship</strong></td>
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<td><strong>Human growth and development:</strong> including studies that provide a broad understanding of the nature and needs of individuals at all developmental levels with emphasis placed on psychological, sociological approaches and areas such as normal and abnormal human behavior, personality theory, and learning theory;</td>
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<td><strong>Social and Cultural Foundations:</strong> including studies of change, ethnic groups, subcultures, changing roles of women, sexism, urban and rural societies, population patterns, cultural mores, use of leisure time, and differing life patterns;</td>
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<td><strong>The helping relationship:</strong> individuals working together to resolve a conflict or difference and foster the personal growth and development of one of the two people. At least one of the parties has the intention of function and improved coping with the life of the other party;</td>
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<td><strong>Group counseling:</strong> including theory and types of groups, as well as descriptions of group practices, methods, dynamics, facilitative skills, and supervised practice;</td>
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<td><strong>Life-style and career development:</strong> including areas such as vocational-choice theory, relationship between career choice and life-style, sources of occupational and educational information, approaches to career decision-making processes and career development exploration techniques;</td>
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<td><strong>Individual appraisal:</strong> including the development of a framework for understanding the individual, including methods of data-gathering and interpretation, individuals and group testing, case study approaches, the study of individual differences, and consideration of ethnic, cultural, and sex factors;</td>
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<td><strong>Research and evaluation:</strong> including areas such as statistics, research design, the development of research and demonstration proposals, and the development and evaluation of program objectives;</td>
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<tr>
<td><strong>Professional orientation:</strong> professional, legal, and ethical responsibilities including: goals and objectives of professional counseling organizations, codes of ethics, legal considerations, standards of preparation, certification and licensing, and the role identity of counselor.</td>
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APPLICATION FOR PLAN OF SUPERVISION—PROFESSIONAL COUNSELOR – MENTAL HEALTH

No supervision hours can accrue until a Plan of Supervision is approved for the applicant.

Please submit:
1) Completed application;
2) Attachment 1 completed and submitted directly to the Board by your Proposed Supervisor;
3) Proof of graduation (i.e. transcripts) from a CACREP program or a 48-hour master’s degree in counseling from an accredited Institution submitted directly to the Board;
4) Verification of other licenses;
5) Quality color photograph of applicant; and
6) Verification of any name change (i.e. marriage/divorce).

There is no fee to apply for an LPC-MH Plan of Supervision. If adding a 2nd (or 3rd) Supervisor, complete and submit Page 1 and Attachment 1.

APPLICANT INFORMATION

Name: ___________________________________LPC License Number: ______________________________
Address: __________________________________ City: ___________ State: __________ Zip: _______
Date of Birth: ___________________________ Social Security Number: __________________________
E-mail: __________________________________ Phone: _______________________________
Name of Business: ____________________________ Phone: _______________________________
Address: __________________________________ City: ___________ State: __________ Zip: _______

PROPOSED SUPERVISOR NAME

Name: ___________________________________ SD License Number: ________ Issue Date of License: __________
License type:   ____LPC-MH   ____LMFT   ____CSW-PIP   ____Psychologist   ____Psychiatrist

Attachment 1 Completed: ___Yes ___No Attachment 1 must be completed and submitted directly to the Board by the Proposed Supervisor.
EDUCATION

Name of Post Graduate Institution: ______________________________________________________

City/State: ________________________________________________________________________

Date of Graduation: __________________________  Degree: ______________________________

Was your program of study CACREP approved? _____ Yes    ______ No*
*If No, complete Attachment 2 and document the content areas of your education.

Have your transcripts been previously submitted to the Board? _____ Yes   ______ No*
*If No, please request your school send an official copy of your transcripts directly to the South Dakota Board of Examiners for Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD 57501 or electronically to sdbce@midwestsolutionssd.com. Transcripts must be received directly from the school to be valid.  Date requested:___________

NATIONAL EXAMINATION

A passing score on the National Clinical Mental Health Counselor Examination (NCMHCE) is required prior to applying for licensure for a Licensed Professional Counselor-Mental Health (LPC-MH).

When completed, request your official NCMHCE score be sent to the South Dakota Board of Examiners for Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD 57501 or released to the Board through the NBCC online results portal.

MILITARY STATUS

_____YES _____NO  Are you a member or the spouse of a member of the armed forces of the United States?
   If Yes, were you or your spouse the subject of a military transfer to South Dakota?_____ Yes  _____No
   If Yes, did you leave employment to accompany your spouse to South Dakota?  _____Yes_____ No

LEGAL QUESTIONS (If you answer yes to any question below, please provide a separate written explanation.)

_____YES _____NO  Have you ever been convicted, pled no contest/nolo contender, pled guilty or been granted a deferred judgment or suspended imposition of sentence or had prosecution deferred with respect to a felony?

_____YES _____NO  Have you ever been convicted, pled no contest/nolo contender, pled guilty to, or been granted a deferred judgement or suspended imposition of sentence, or had prosecution deferred with respect to a misdemeanor other than a class 2 traffic offense?

_____YES _____NO  Have you been disciplined with a reprimand, censure, suspension, temporary suspension, probation, revocation, or refusal to renew a professional license in any state?

_____YES _____NO  Are you $1,000 or more behind in child support payments?

_____YES _____NO  Have you previously made application for licensure to this Board?
OTHER LICENSES

Do you currently hold a valid license to practice counseling in another state? _____ YES _____ NO

If yes, which state(s)? __________________________________________________________

If yes, please request the issuing state send a Letter of Verification to the South Dakota Board of Examiners for Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD 57501 or electronically to sdbce@midwestsolutionssd.com. Date requested:__________

To be signed in the presence of a Notary Public

BY MY SIGNATURE BELOW, I VERIFY, UNDER PENALTY OF PERJURY, THAT I AM THE APPLICANT COMPLETING THIS APPLICATION AND THAT ALL INFORMATION SUBMITTED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER UNDERSTAND THAT FALSE OR INCORRECT INFORMATION, OMISSIONS, INACCURACIES OR FAILURES TO MAKE FULL DISCLOSURE MAY RESULT IN THE CANCELLATION OR DENIAL OF A PLAN OF SUPERVISION OR LICENSE ISSUED PURSUANT TO THIS APPLICATION AND MAY BE SUBJECT TO CIVIL AND CRIMINAL PROCEEDINGS. I AGREE ALL INFORMATION IN THIS APPLICATION CAN BE VERIFIED AND INVESTIGATED. I HAVE READ, AND AM FAMILIAR WITH THE SOUTH DAKOTA CODIFIED LAWS AND ADMINISTRATIVE RULES REGULATING PROFESSIONAL COUNSELING AND HEREBY AGREE TO ABIDE BY SUCH LAWS AND REGULATIONS.

_________________________________________ _________________________
Applicant Signature Date

State of _______________)    SS
County of _____________)    SS

On this ___ day of ________, 20___, the above applicant, __________________________, personally appeared, known to me or satisfactorily proven to be the same person whose name is subscribed to the written instrument, and acknowledged that he/she executed the same for the purposes therein contained. In witness where of, I have here unto set my hand and official seal.

(SEAL) Notary Signature: _________________________

Notary Name: __________________________

My Commission Expires: _____________________
Mail completed application to:
SD Board of Examiners for Counselors & Marriage and Family Therapists
PO Box 340
Pierre, SD  57501

Attach Photo Here
For identification purposes, the applicant shall furnish one color headshot taken not more than six months before the date of application.

Board Use Only:
Attachment 1 Received:  Yes  No
Completed Application: Yes  No  If no, missing:  ____________________________________
In the blanks provided, please write which course number(s) meet(s) these requirements from your transcript. If a course title is not clearly indicative of the content areas as outlined below, include the college catalog description or course syllabus and highlight the areas of the literature that best demonstrate coverage of the content area.

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Course Number(s)</th>
<th>Course Title(s)</th>
<th>College/University</th>
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</thead>
<tbody>
<tr>
<td><strong>Counseling theory</strong>: including a study of basic theories and principles of counseling and philosophic bases of the helping relationship;</td>
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<tr>
<td><strong>Counseling techniques</strong>: including individual counseling practices, methods, facilitative skills, and the application of these skills;</td>
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<tr>
<td><strong>Counseling Practicum</strong></td>
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<td><strong>Counseling Internship</strong></td>
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<td><strong>Human growth and development</strong>: including studies that provide a broad understanding of the nature and needs of individuals at all developmental levels with emphasis placed on psychological, sociological approaches and areas such as normal and abnormal human behavior, personality theory, and learning theory;</td>
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<tr>
<td><strong>Social and Cultural Foundations</strong>: including studies of change, ethnic groups, subcultures, changing roles of women, sexism, urban and rural societies, population patterns, cultural mores, use of leisure time, and differing life patterns;</td>
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<tr>
<td><strong>The helping relationship</strong>: individuals working together to resolve a conflict or difference and foster the personal growth and development of one of the two people. At least one of the parties has the intention of function and improved coping with the life of the other party;</td>
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<td><strong>Group counseling</strong>: including theory and types of groups, as well as descriptions of group practices, methods, dynamics, facilitative skills, and supervised practice;</td>
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<tr>
<td><strong>Life-style and career development</strong>: including areas such as vocational-choice theory, relationship between career choice and life-style, sources of occupational and educational information, approaches to career decision-making processes and career development exploration techniques;</td>
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<tr>
<td><strong>Individual appraisal</strong>: including the development of a framework for understanding the individual, including methods of data-gathering and interpretation, individuals and group testing, case study approaches, the study of individual differences, and consideration of ethnic, cultural, and sex factors;</td>
<td></td>
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</tbody>
</table>
**Research and evaluation:** including areas such as statistics, research design, the development of research and demonstration proposals, and the development and evaluation of program objectives;

**Professional orientation:** professional, legal, and ethical responsibilities including: goals and objectives of professional counseling organizations, codes of ethics, legal considerations, standards of preparation, certification and licensing, and the role identity of counselor.

**Psychopathology:** including the general principles and practices of etiology, diagnosis, treatment, and prevention of mental and emotional disorders and dysfunctional behavior, and the general principles and practices for the promotion of optimal mental health;

**Clinical assessment:** including the specific models and methods for assessing mental status and the identification of mental illness or abnormal, deviant, or psychopathologic behavior by obtaining appropriate behavioral data using a variety of techniques, including non-projective personality assessments and achievements, aptitude, and intelligence testing, and translating findings in the diagnostic and statistical manual categories;

**Psychopharmacology:** including the basic classification, indications, and contraindications of the commonly prescribed psychopharmacological medications for the purpose of identifying the effects and side effects of prescribed psychotropic medications;

**Case management:** including the guidelines for conducting an intake interview and mental health history for planning and managing of client caseload manual categories;

**Foundation of mental health:** including the specific concepts and ideas related to mental health education, outreach, prevention, and mental health promotion.
APPLICATION FOR PLAN OF SUPERVISION—MARRIAGE AND FAMILY THERAPIST

No supervision hours can accrue until a Plan of Supervision is approved for the applicant.

Please submit:
1) Completed application;
2) **Attachment 1** completed and submitted directly to the Board by your Proposed Supervisor;
3) Proof of graduation (i.e. transcripts) from a CACREP program or a 48-hour master’s degree in counseling from an accredited Institution submitted directly to the Board;
4) Verification of other licenses;
5) Quality color photograph of applicant;
6) Verification of any name change (i.e. marriage/divorce); and
7) Non-refundable $100 application fee.

The application fee for a Plan of Supervision is non-refundable. If the applicant uses more than one approved supervisor to meet the supervision requirements for full licensure, no fee will be charged for additional supervisors. If adding a 2nd (or 3rd) Supervisor, complete and submit Page 1 and **Attachment 1**.

APPLICANT INFORMATION

Name: __________________________________________________________________________
Address: _____________________________________________ City: ___________ State:           Zip: __________
Date of Birth: _________________________Social Security Number: __________________________
E-mail: ______________________________________ Phone: _______________________________
Name of Business:______________________________________ Phone:_________________________
Address:__________________________________City:____________________ State:_______Zip:__________

PROPOSED SUPERVISOR NAME

Name: ________________________SD License Number: ________ Issue Date of License: _____________
License type: ____LPC-MH ____LMFT

**Attachment 1 Completed: ___Yes ___No** Attachment 1 must be completed and submitted directly to the Board by the Proposed Supervisor.
EDUCATION

Name of Post Graduate Institution: ______________________________________________________

City/State: __________________________________________________________________________

Date of Graduation: __________________________ Degree: ________________________________

Was your program of study COAMFTE or CACREP approved? _____ Yes ______ No*

*If No, complete Attachment 2 and document the content areas of your education.

Please request your school send an official copy of your transcripts directly to the South Dakota Board of Examiners for Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD 57501 or electronically to sdbce@midwestsolutionssd.com. Transcripts must be received directly from the school to be valid. Date requested:______________

NATIONAL EXAMINATION

A passing score on the MFT National Examination is required prior to applying for licensure for Licensed Marriage & Family Therapist (LMFT).

When completed, request your official MFT national exam score be sent to the South Dakota Board of Examiners for Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD 57501 or released to the Board through the AMFTRB online results portal.

MILITARY STATUS

_____YES _____NO Are you a member or the spouse of a member of the armed forces of the United States?

If Yes, were you or your spouse the subject of a military transfer to South Dakota? _____ Yes ___ No

If Yes, did you leave employment to accompany your spouse to South Dakota? _____Yes___No

LEGAL QUESTIONS (If you answer yes to any question below, please provide a separate written explanation.)

_____YES _____NO Have you ever been convicted, pled no contest/nolo contender, pled guilty or been granted a deferred judgment or suspended imposition of sentence or had prosecution deferred with respect to a felony?

_____YES _____NO Have you ever been convicted, pled no contest/nolo contender, pled guilty to, or been granted a deferred judgement or suspended imposition of sentence, or had prosecution deferred with respect to a misdemeanor other than a class 2 traffic offense?

_____YES _____NO Have you been disciplined with a reprimand, censure, suspension, temporary suspension, probation, revocation, or refusal to renew a professional license in any state?

_____YES _____NO Are you $1,000 or more behind in child support payments?

_____YES _____NO Have you previously made application for licensure to this Board?
OTHER LICENSES

Do you currently hold a valid license to practice counseling in another state?  ____ YES  ____ NO
If yes, which state(s)?  __________________________________________________________

If yes, please request the issuing state send a Letter of Verification to the South Dakota Board of Examiners for Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD  57501 or electronically to sdbce@midwestsolutionssd.com.  Date requested:______________

STATISTICAL INFORMATION

These questions are asked for statistical purposes.  Your answers are optional.

What is your gender?  ____ Female  ____ Male

What is your race?  Please check all that apply.

□ Asian  □ Hispanic or Latino
□ American Indian or Alaska Native  □ White or Caucasian
□ Black or African American  □ Other
□ Native Hawaiian or Pacific Islander  □ Decline to Provide

APPLICATION FEE  Please include a personal check, cashier’s check, certified check or money order made payable to the State of South Dakota for the applicable amount.

□ $100 non-refundable application fee

To be signed in the presence of a Notary Public

BY MY SIGNATURE BELOW, I VERIFY, UNDER PENALTY OF PERJURY, THAT I AM THE APPLICANT COMPLETING THIS APPLICATION AND THAT ALL INFORMATION SUBMITTED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.  I FURTHER UNDERSTAND THAT FALSE OR INCORRECT INFORMATION, OMISSIONS, INACCURACIES OR FAILURES TO MAKE FULL DISCLOSURE MAY RESULT IN THE CANCELLATION OR DENIAL OF A PLAN OF SUPERVISION OR LICENSE ISSUED PURSUANT TO THIS APPLICATION AND MAY BE SUBJECT TO CIVIL AND CRIMINAL PROCEEDINGS.  I AGREE ALL INFORMATION IN THIS APPLICATION CAN BE VERIFIED AND INVESTIGATED.  I HAVE READ, AND AM FAMILIAR WITH THE SOUTH DAKOTA CODIFIED LAWS AND ADMINISTRATIVE RULES REGULATING PROFESSIONAL COUNSELING AND HEREBY AGREE TO ABIDE BY SUCH LAWS AND REGULATIONS.

___________________________________________ _________________________
Applicant Signature Date

State of _______________ )    SS
County of _____________)

On this ___ day of ______, 20___, the above applicant, ________________________________, personally appeared, known to me or satisfactorily proven to be the same person whose name is subscribed to the written instrument, and acknowledged that he/she executed the same for the purposes therein contained.  In witness whereof, I have here unto set my hand and official seal.
(SEAL)

Notary Signature: _______________________

Notary Name: __________________________

My Commission Expires: __________________

Mail completed application and fee to:
SD Board of Examiners for Counselors & Marriage and Family Therapists
PO Box 340
Pierre, SD  57501

Board Use Only:

Application Fee  $__________  Check number __________  DSS Code______________  Date__________

Attachment 1 Received:  Yes   No

Completed Application:  Yes   No  If no, missing: ____________________________________________________
ATTACHMENT 2 – COURSEWORK REQUIREMENTS  
MARRIAGE AND FAMILY THERAPIST

In the blanks provided, please write which course number(s) meet(s) these requirements from your transcript. If a course title is not clearly indicative of the content areas as outlined below, include the college catalog description or course syllabus and highlight the areas of the literature that best demonstrate coverage of the content area.

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Course Number(s)</th>
<th>Course Title(s)</th>
<th>College/University</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARRIAGE AND FAMILY STUDIES (9 SEM CREDITS MINIMUM)</td>
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<tr>
<td>Introductory systems theory, family development, family systems (marital, sibling, individual subsystems), special family issues, gender and cultural issues, all with major focus from a systems theory orientation;</td>
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<tr>
<td>MARRIAGE AND FAMILY THERAPY (9 SEM CREDITS MINIMUM)</td>
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<tr>
<td>Advanced systems theory and interventions, major systemic marriage and family treatment approaches, (structural, strategic, neoanalytic (object relations), behavioral marriage and family therapy, communications, sex therapy, etc.</td>
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<tr>
<td>HUMAN DEVELOPMENT (9 SEM CREDITS MINIMUM)</td>
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<tr>
<td>At least one course in psychopathology-abnormal behavior is required and at least one course in assessment is required. The third course may be selected from human development (normal and abnormal), personality theory, or human sexuality;</td>
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<tr>
<td>PROFESSIONAL STUDIES (3 SEM CREDITS MINIMUM)</td>
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<tr>
<td>Professional ethics as a therapist including legal and ethical responsibilities and liabilities, family law, etc.</td>
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<tr>
<td>RESEARCH (3 SEM CREDITS MINIMUM)</td>
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<tr>
<td>Research course in marriage and family studies and therapy including research design, methodology, statistics;</td>
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<tr>
<td>PRACTICUM (SUPERVISED CLINICAL PRACTICE) 1 year minimum during graduate work</td>
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</table>
ATTACHMENT 1: Proposed Supervisor for Plan of Supervision Application

To be completed and submitted by the proposed Supervisor. No supervision hours can accrue until a completed Plan of Supervision application is approved for the Supervisee.

PROPOSED SUPERVISEE INFORMATION

Supervisee Name: ___________________________
Type of Plan of Supervision: ___LPC ___LPC-MH ___LMFT
Name of Business/Practice: ___________________________
Phone: ___________________________
Address: ___________________________
City: ___________________________
State: _______ Zip: ___________

PROPOSED SUPERVISOR INFORMATION

Name: __________________________________________________________________________________
Address: ___________________________
City: ___________________________
State: _______ Zip: ___________
E-mail: ___________________________
Phone: ___________________________
SD License Number: ___________________________
License Issue date: ___________________________
License type: ___LPC ___LPC-MH ___LMFT ___CSW-PIP ___Psychologist ___Psychiatrist

ACKNOWLEDGEMENT OF SUPERVISOR RESPONSIBILITIES

Acknowledge the following statements by marking the appropriate answer to each statement.

1) ____Yes ____No  I agree to serve as a Board Approved Supervisor for the proposed Supervisee.
2) ____Yes ____No  I am a current Board Approved Supervisor with the Board.
3) ____Yes ____No  I acknowledge the Supervisor duties and requirements that I must follow, including the required five methods of supervision as outlined by South Dakota administrative rules.
4) ____Yes ____No  I will follow the ACA/AAMFT Code of Ethics as a Supervisor.
5) ____Yes ____No  I ensure the practice setting/location is appropriate for the proposed Supervisee.
6) ____Yes ____No  I agree to notify the Board, in writing, of the completion or termination of an approved post graduate plan of supervision within 14 days of the completion or termination of the plan.

I attest to the fact the information I have provided above is true and accurate; that if approved, I am responsible for this applicant’s supervision as documented on this Attachment 1, and compliant with the South Dakota laws and administrative rules.

________________________________       ________________________________
Supervisor’s Signature                                                                  Date

Scan and send completed form to sdbce@midwestsolutionssd.com.
APPLICATION FOR BOARD APPROVED SUPERVISOR

Please submit:
1. Completed application;
2. Completion certificates or college transcripts and course description(s) verifying at least four hours of training in supervision in the five years immediately preceding the submission of this application;
3. Verification of liability insurance; and
4. Quality color photograph of applicant.

There is no fee for an Approved Supervisor Application. If approved, the Supervisor Status is valid from the date of approval through November 30 of the next even-numbered year and is subject to renewal. Proof of at least four hours of qualified continuing education, focused on supervision, acquired during the current continuing education cycle.

APPLICANT INFORMATION

Name: __________________________________________________________________________
Address: ____________________________ City: ___________________ State: _______ Zip: ______
Date of Birth: _________________________ Social Security Number: __________________________
E-mail: ______________________________ Phone: ______________________________
Name of Business: ___________________________ Phone: ______________________________
Address: ____________________________ City: ___________________ State: _______ Zip: ______

SUPERVISOR QUALIFICATIONS

Please select one:

□ Licensed by the Board and credentialed as an Approved Clinical Supervisor by the Center for Credentialing & Education, Inc. and recognized by the NBCC;

□ Licensed as a professional counselor, professional counselor-mental health, marriage and family therapist, certified social worker-private independent practice, psychologist or psychiatrist; actively licensed for at least two years; and 4 hours of qualified continuing education focused on supervision;

□ Licensed as a professional counselor, professional counselor-mental health, marriage and family therapist, certified social worker-private independent practice, psychologist or psychiatrist; actively licensed for at least one year; and 15 hours of qualified continuing education focused on supervision;
Licensed by the Board and an American Association for Marriage and Family Therapy approved clinical supervisor.

**LICENSE INFORMATION**

Please denote the current license(s) you hold and attach a copy of your current license(s):

<table>
<thead>
<tr>
<th>License Type</th>
<th>License Number</th>
<th>Date Issued</th>
<th>Good Through Date</th>
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<tbody>
<tr>
<td>LPC</td>
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<tr>
<td>LPC-MH</td>
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<td>LMFT</td>
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<tr>
<td>Psychologist</td>
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<tr>
<td>Psychiatrist</td>
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<tr>
<td>CSW-PIP</td>
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**TRAINING REQUIREMENTS**

At least four hours of training in supervision is required, please list the training you have completed within the past two years.

<table>
<thead>
<tr>
<th>Date</th>
<th>Type (Ethics)</th>
<th>Course Title</th>
<th>Course Sponsor</th>
<th>Course No.</th>
<th>Hours</th>
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</table>

**LEGAL QUESTIONS** (*If you answer yes to any question below, please provide a separate written explanation.*)

____YES ____NO Have you ever been convicted, pled no contest/nolo contender, pled guilty or been granted a deferred judgment or suspended imposition of sentence or had prosecution deferred with respect to a felony?

____YES ____NO Have you ever been convicted, pled no contest/nolo contender, pled guilty to, or been granted a deferred judgement or suspended imposition of sentence, or had prosecution deferred with respect to a misdemeanor other than a class 2 traffic offense?

____YES ____NO Have you been disciplined with a reprimand, censure, suspension, temporary suspension, probation, revocation, or refusal to renew a professional license in any state?

____YES ____NO Are you $1,000 or more behind in child support payments?

**ACKNOWLEDGEMENT OF SUPERVISOR RESPONSIBILITIES**

Acknowledge the following statements by marking the appropriate answer to each statement.

1) ____Yes ____No I agree to serve as a Board Approved Supervisor.
2) ____Yes ____No  I acknowledge the Supervisor duties and requirements that I must follow, including the required five methods of supervision as outlined by South Dakota administrative rules.

3) ____Yes ____No  I will follow the ACA/AAMFT Code of Ethics as a Supervisor.

4) ____Yes ____No  I ensure the practice setting/location is appropriate for Supervisees.

5) ____Yes ____No  I agree to notify the Board, in writing, of the completion or termination of an approved post graduate plan of supervision within 14 days of the completion or termination of the plan.

By signing, I attest that I understand and acknowledge the requirements needed to supervise candidates and agree to follow all South Dakota laws and administrative rules for an Approved Supervisor.

__________________________________________  __________________________
Applicant Signature                        Date

Attach Photo Here

Mail completed application to:
SD Board of Examiners for Counselors & Marriage and Family Therapists
PO Box 340
Pierre, SD  57501

Board Use Only:
Completed Application:  Yes   No
If no, missing: _______________________________________________
Date Received:          ____________
Date Approved:          ____________  Renewal due:  ____________
APPLICATION FOR LICENSURE

This is an application for licensure in South Dakota. Current Plan of Supervision number is required.

Please select one:

☐ Application for Professional Counselor License (LPC)
☐ Application for Professional Counselor License-Mental Health License (LPC-MH)
☐ Application for Marriage and Family Therapist License (LMFT)

Current Plan of Supervision number: __________________________

Please submit:

1) Completed application;
2) **Attachment A** completed and submitted directly to the Board by each Supervisor;
3) Proof of a passing score on the required national exam submitted directly to the Board;
4) Verification of any name change (i.e. marriage/divorce), if applicable;
5) Verification of a license in another state, if applicable;
6) Quality color photograph of applicant; and
7) Refundable $225 licensing fee.

Payment of the $225 licensing fee at the time of application helps expedite the processing of the license, if approved. If the application is denied, the $225 licensing fee is refundable.

APPLICANT INFORMATION

Name: __________________________________________________________________________
Address: __________________________________________________ City: ___________ State: ___________ Zip: ___________
Date of Birth: _________________________ Social Security Number: __________________________
E-mail: __________________________________________ Phone: _______________________________
Name of Business: __________________________________________ Phone: _______________________________
Address: __________________________________________ City: __________________________ State: ___________ Zip: ___________
SUPERVISED EXPERIENCE – PLAN OF SUPERVISION
Please provide the name of each Supervisor during your Plan of Supervision.

Name of Supervisor: ___________________ License Type: _______________ Dates of Supervision: _______________

Name of Supervisor: ___________________ License Type: _______________ Dates of Supervision: _______________

Additional Supervisors should be listed on a separate page.

Attachment A submitted to Board: ___Yes ___No  
Attachment A must be completed and submitted directly to the Board by each Supervisor.

NATIONAL EXAMINATION
Licensure in South Dakota requires passage of a national examination.

Please indicate which national examination(s) you passed:

____ National Counselor Examination (LPC) Date of Exam: _______
____ National Clinical Mental Health Counselor Examination (NCMHCE) Date of Exam: _______
____ National Examination in Marital and Family Therapy (AMFTRB) Date of Exam: _______

Request your official national exam score be sent to the South Dakota Board of Examiners for Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD 57501 or released to the Board through the NBCC or AMFTRB online results portal. Date requested: _______________

OTHER LICENSES
Do you currently hold a valid license to practice counseling in another state? _____ YES _____ NO
If yes, which state(s)? __________________________________________________________

If yes, please request the issuing state send a Letter of Verification to the South Dakota Board of Examiners for Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD 57501 or electronically to sdbce@midwestsolutionssd.com. Date requested: _______________

MILITARY STATUS

____ YES ____ NO  Are you a member or the spouse of a member of the armed forces of the United States?
If Yes, were you or your spouse the subject of a military transfer to South Dakota? _____Yes____No
If Yes, did you leave employment to accompany your spouse to South Dakota? _____Yes____No

LEGAL QUESTIONS (If you answer yes to any question below, please provide a separate written explanation.)

____ YES ____ NO  Have you ever been convicted, pled no contest/nolo contender, pled guilty or been granted a deferred judgment or suspended imposition of sentence or had prosecution deferred with respect to a felony?

____ YES ____ NO  Have you ever been convicted, pled no contest/nolo contender, pled guilty to, or been granted a deferred judgement or suspended imposition of sentence, or had prosecution deferred with respect to a misdemeanor other than a class 2 traffic offense?
____YES ____NO  Have you been disciplined with a reprimand, censure, suspension, temporary suspension, probation, revocation, or refusal to renew a professional license in any state?

____YES ____NO  Are you $1,000 or more behind in child support payments?

____YES ____NO  Have you previously made application for licensure to this Board?

**LICENSE FEE**  Please include a personal check, cashier’s check, certified check or money order made payable to the State of South Dakota for the applicable amount.

☐ $225 license fee

**To be signed in the presence of a Notary Public**

**BY MY SIGNATURE BELOW, I VERIFY, UNDER PENALTY OF PERJURY, THAT I AM THE APPLICANT COMPLETING THIS APPLICATION AND THAT ALL INFORMATION SUBMITTED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER UNDERSTAND THAT FALSE OR INCOMPLETE INFORMATION, OMISSIONS, INACCURACIES OR FAILURES TO MAKE FULL DISCLOSURE MAY RESULT IN THE CANCELLATION OR DENIAL OF A PLAN OF SUPERVISION OR LICENSE ISSUED PURSUANT TO THIS APPLICATION AND MAY BE SUBJECT TO CIVIL AND CRIMINAL PROCEEDINGS.**  
**I AGREE ALL INFORMATION IN THIS APPLICATION CAN BE VERIFIED AND INVESTIGATED.**  **I HAVE READ, AND AM FAMILIAR WITH THE SOUTH DAKOTA CODED LAWS AND ADMINISTRATIVE RULES REGULATING THE LICENSE APPLIED FOR AND HEREBY AGREE TO ABIDE BY SUCH LAWS AND REGULATIONS.**

____________________________________  _________________________
Applicant Signature  Date

State of _______________)  ) SS
County of _______________)

On this ___ day of _______, 20___, the above applicant, ___________________________, personally appeared, known to me or satisfactorily proven to be the same person whose name is subscribed to the written instrument, and acknowledged that he/she executed the same for the purposes therein contained. In witness where of, I have here unto set my hand and official seal.

(SEAL)  
Notary Signature: ________________________
Notary Name: __________________________
My Commission Expires: ________________
Attach Photo Here

For identification purposes, the applicant shall furnish one color headshot taken not more than six months before the date of application.

Mail completed application and fee to:
SD Board of Examiners for Counselors & Marriage and Family Therapists
PO Box 340
Pierre, SD 57501

Board Use Only:
License Fee $__________ Check number __________ DSS Code_____________ Date________

Completed Application Yes No If no, missing: ____________________________________________

Issue date __________ Valid through date __________ CEU________
Attachment A – Supervised Experience with Board Approved Supervisor

To be completed and submitted directly to the Board by each Supervisor
sdbce@midwestsolutionssd.com

The supervisee named below is applying for a license to practice counseling in the State of South Dakota. The South Dakota Board of Examiners for Counselors and Marriage and Family Therapists requires submission of information by the approved supervisor, to verify the candidate’s supervised experience.

SUPERVISEE INFORMATION
Supervisee Name:________________________________ Practice Location:_______________________
Type of Plan of Supervision: ____LPC  ____LPC-MH  ____LMFT

SUPERVISOR INFORMATION
Name of Approved Supervisor:_______________________ License #_______________________
License type: _____LPC _____LPC-MH _____LMFT _____CSW-PIP _____Psychologist _____Psychiatrist

As required by South Dakota Law and Administrative Rules, I attest to the following statements:

I attest to the fact the above Supervisee completed the minimum hours of direct client contact. Supervisor’s Initials __________

I attest to the fact the above Supervisee completed the minimum 100 hours of supervision. Supervisor’s Initials __________

I attest that one hour of supervision took place for every 20 hours of direct client contact by the Supervisee. Supervisor’s Initials __________

I attest to the fact at least five hours of each of the required supervision methods took place during supervision. Supervisor’s Initials __________

1. The presentation and staffing of cases; Hours:______
2. The critiquing of audio or video counseling; Hours:______
3. The direct observations of the supervisee; Hours:______
4. Co-counseling with the supervisee; and Hours:______
5. Review of supervisee recordkeeping. Hours:______

I attest I held an active license during the entirety of this supervision period. Supervisor’s Initials ______
**Tracking Form Summary**

| **Dates of Supervision by this supervisor** | Start (mm/dd/yy)__________ |
| | End (mm/dd/yy)__________ |

| **Direct Client Contact*** |  |
| Number of Direct Client Contact hours acquired by electronic means: | ____________ |
| Number of Direct Client Contact hours acquired in person: | ____________ |
| **Total** number of Direct Client Contact hours supervised during this period: | ____________ |

| **Supervision Hours**** |  |
| Total number of supervision hours acquired in individual setting: | ____________ |
| Total number of supervision hours acquired in a group setting: | ____________ |
| **Total** number of supervision hours: | ____________ |

“I attest to the fact these hours are true and accurate.” **Supervisor’s Initials** ____________

---

*If supervisee is pursuing a professional counselor license (LPC) no more than 400 hours of direct client contact may be acquired by electronic means. If supervisee is pursuing a marriage and family therapist license (LMFT) nor more than 1,000 hours of direct client contact may be acquired by electronic means. If supervisee is pursuing a professional counselor-mental health license (LPC-MH) all direct client contact hours may be acquired by electronic means.

**No more than 50 hours of supervision may be acquired in a group setting.

I attest to the fact the information I have provided above is true and accurate; that I was responsible for this applicant’s supervision as documented on this Attachment A, supervision took place within the requirements of South Dakota laws and administrative rules and that we were compliant with the South Dakota laws and administrative rules.

______________________________       ______________________________
Supervisor’s Signature                                                              Date

Scan and send completed form to sdbce@midwestsolutionssd.com
APPLICATION BY ENDORSEMENT

This is an application for out-of-state applicants who are currently licensed to practice counseling in another state or territory of the United States and meet the requirements set forth by SDCL 36-32-67 and 36-33-45.

Please select one:

□ Application for Professional Counselor License (LPC)
□ Application for Professional Counselor License-Mental Health License (LPC-MH)
□ Application for Marriage and Family Therapist License (LMFT)

Please submit:
1) Completed application;
2) Non-refundable $100 application fee;
3) Verification of a license, at the highest level of independent practice, in another state(s) for at least 3 years;
4) Proof of a passing score on the required national exam submitted directly to the Board;
5) Proof of active practice in the previous 3 years;
6) Quality color photograph of applicant;
7) Verification of any name change (i.e. marriage/divorce); and
8) Refundable $100 license fee.

The $100 application fee is non-refundable and required at the time of application, along with the $100 licensing fee. If the application is denied, the $100 licensing fee is refundable.

APPLICANT INFORMATION

Name: __________________________________________________________________________

Address: ___________________________ City: ___________ State: ______ Zip: ______

Date of Birth: _________________________ Social Security Number: __________________________

E-mail: ___________________________ Phone: ___________________________

Name of Business: ___________________________ Phone: ___________________________

Address: ___________________________ City: ___________ State: ______ Zip: ______
OTHER LICENSES

Do you currently hold a valid license to practice in another state? _____ YES _____ NO

List of state(s) that you currently hold a valid license:_______________________________________

How many years have you held the license(s)? _______________ License number(s)_____________

Is the level of license the highest level of licensure for a professional counselor in that state? __Y __N

Request the issuing state send a Letter of Verification to the South Dakota Board of Examiners for Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD 57501 or electronically to sdbce@midwestsolutionssd.com. Date requested:_________________

NATIONAL EXAMINATION

Licensure by Endorsement in South Dakota requires passage of a national examination.

Please indicate which national examination(s) you passed:

_____ National Counselor Examination (NCE) Date of Exam: _______

_____ National Clinical Mental Health Counselor Examination (NCMHCE) Date of Exam: _______

_____ National Examination in Marital and Family Therapy (AMFTRB) Date of Exam: _______

If you have not passed a national exam, you are not eligible for a license by endorsement.

Request your official national exam score be sent to the South Dakota Board of Examiners for Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD 57501 or released to the Board through the NBCC or AMFTRB online results portal. Date requested:_________________

PROOF OF ACTIVE PRACTICE

In the past 36 months, have you actively practiced* counseling at the highest level of licensure in the state(s) where you currently hold an active license? __________ YES __________ NO

*For purposes of answering this question, “actively practiced” means at least 1,500 hours of clinical experience in the three years immediately preceding this application. Documentation of an active practice may be requested by the Board. Such documentation may include an affidavit, calendars, or other proof of an active practice by the applicant.

MILITARY STATUS

Are you a member or the spouse of a member of the armed forces of the United States? __Yes __ No

If Yes, were you or your spouse the subject of a military transfer to South Dakota? __ Yes __ No

If Yes, did you leave employment to accompany your spouse to South Dakota? __ Yes __ No
LEGAL QUESTIONS (If you answer yes to any question below, please provide a separate written explanation.)

____YES ____NO  Have you ever been convicted, pled no contest/nolo contender, pled guilty or been granted a deferred judgment or suspended imposition of sentence or had prosecution deferred with respect to a felony?

____YES ____NO  Have you ever been convicted, pled no contest/nolo contender, pled guilty to, or been granted a deferred judgement or suspended imposition of sentence, or had prosecution deferred with respect to a misdemeanor other than a class 2 traffic offense?

____YES ____NO  Have you been disciplined with a reprimand, censure, suspension, temporary suspension, probation, revocation, or refusal to renew a professional license in any state?

____YES ____NO  Are you $1,000 or more behind in child support payments?

____YES ____NO  Have you previously made application for licensure to this Board?

STATISTICAL INFORMATION

These questions are asked for statistical purposes. Your answers are optional.

What is your gender?                Female                     Male

What is your race?  Please check all that apply.

☐ Asian                              ☐ Hispanic or Latino
☐ American Indian or Alaska Native   ☐ White or Caucasian
☐ Black or African American          ☐ Other
☐ Native Hawaiian or Pacific Islander ☐ Decline to Provide

APPLICATION AND LICENSE FEES  Please include a personal check, cashier’s check, certified check or money order made payable to the State of South Dakota for the applicable amount.

☐ $100 non-refundable application fee

☐ $100 license fee

To be signed in the presence of a Notary Public

BY MY SIGNATURE BELOW, I VERIFY, UNDER PENALTY OF PERJURY, THAT I AM THE APPLICANT COMPLETING THIS APPLICATION AND THAT ALL INFORMATION SUBMITTED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER UNDERSTAND THAT FALSE OR INCORRECT INFORMATION, OMISSIONS, INACCURACIES OR FAILURES TO MAKE FULL DISCLOSURE MAY RESULT IN THE CANCELLATION OR DENIAL OF A PLAN OF SUPERVISION OR LICENSE ISSUED PURSUANT TO THIS APPLICATION AND MAY BE SUBJECT TO CIVIL AND CRIMINAL PROCEEDINGS. I AGREE ALL INFORMATION IN THIS APPLICATION CAN BE VERIFIED AND INVESTIGATED. I HAVE READ, AND AM FAMILIAR WITH THE SOUTH DAKOTA CODIFIED LAWS AND ADMINISTRATIVE RULES REGULATING THE LICENSE APPLIED FOR AND HEREBY AGREE TO ABIDE BY SUCH LAWS AND REGULATIONS.

___________________________________________ _________________________
Applicant Signature Date
State of ______________)

County of _____________

On this ___ day of _______, 20___, the above applicant, ___________________________, personally appeared, known to me or satisfactorily proven to be the same person whose name s subscribed to the written instrument, and acknowledged that he/she executed the same for the purposes therein contained. In witness where of, I have here unto set my hand and official seal.

(SEAL)

Notary Signature: _______________________

Notary Name: __________________________

My Commission Expires: ________________

Attach Photo Here

For identification purposes, the applicant shall furnish one color headshot taken not more than six months before the date of application.

Mail completed application and fees to:
SD Board of Examiners for Counselors & Marriage and Family Therapists
PO Box 340
Pierre, SD 57501

Board Use Only:
Application Fee $ __________ Check number __________ DSS Code __________ Date __________
License Fee $ __________ Check number __________ DSS Code __________ Date __________
Completed Application Yes No If no, missing: _________________________________
APPLICATION FOR TEMPORARY LICENSE BY ENDORSEMENT

This is an application for a 90-day, temporary license for applicants who are licensed out-of-state but have not yet taken the national examination required for licensure in South Dakota. SDCL 36-32-68 and SDCL 36-33-46

Please select one:

□ Application for Temporary Professional Counselor License (LPC)
□ Application for Temporary Professional Counselor License-Mental Health (LPC-MH)
□ Application for Temporary Marriage and Family Therapist (LMFT)

Please submit:
1. Completed application;
2. Non-refundable $100 temporary application fee;
3. Verification of a license, at the highest level of independent practice, in another state(s) for at least 3 years;
4. Proof of active practice in the previous 3 years;
5. Quality color photograph of applicant;
6. Verification of any name change (i.e. marriage/divorce); and
7. Refundable $50 temporary license fee.

The $100 application fee is non-refundable and required at the time of application, along with the $50 temporary license fee. If the application is denied, the $50 licensing fee is refundable.

APPLICANT INFORMATION

Name: __________________________________________________________________________
Address: ___________________________________________ City: ___________ State: ___ Zip: ______
Date of Birth: _________________________ Social Security Number: ________________________________
E-mail: ___________________________________________ Phone: ________________________________
Name of Business: ___________________________ Phone: ________________________________
Address: ___________________________ City: ___________ State: ___ Zip: ______

SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES
SOUTH DAKOTA BOARD OF EXAMINERS FOR COUNSELORS & MARRIAGE AND FAMILY THERAPISTS
1351 N. Harrison Ave., Pierre, SD 57501
Tel: 605.224.1721 Email: sdbce@midwestsolutionssd.com

dss.sd.gov/licensingboards/counselors/counselors.aspx
OTHER LICENSES

Do you currently hold a valid license to practice in another state? _____ YES _____ NO

List of state(s) that you currently hold a valid license:__________________________________________

How many years have you held the license(s)? _______________ License number(s) ____________

Is the level of license the highest level of licensure for a professional counselor in that state? __Y __N

Please request the issuing state send a Letter of Verification to the South Dakota Board of Examiners for Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD 57501 or electronically to sdbce@midwestsolutionssd.com. Date requested:______________

PROOF OF ACTIVE PRACTICE

In the past 36 months, have you actively practiced* counseling at the highest level of licensure in the state(s) where you currently hold an active license? ___________ YES __________ NO

*For purposes of answering this question, “actively practiced” means at least 1,500 hours of clinical experience in the three years immediately preceding this application. Documentation of an active practice may be requested by the Board. Such documentation may include an affidavit, calendars, or other proof of an active practice by the applicant.

MILITARY STATUS

Are you a member or the spouse of a member of the armed forces of the United States? __Yes __No

If Yes, were you or your spouse the subject of a military transfer to South Dakota? __ Yes __No

If Yes, did you leave employment to accompany your spouse to South Dakota? __ Yes __No

LEGAL QUESTIONS (If you answer yes to any question, please provide a separate written explanation.)

_____YES _____NO Have you ever been convicted, pled no contest/nolo contender, pled guilty or been granted a deferred judgment or suspended imposition of sentence or had prosecution deferred with respect to a felony?

_____YES _____NO Have you ever been convicted, pled no contest/nolo contender, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence, or had prosecution deferred with respect to a misdemeanor other than a class 2 traffic offense?

_____YES _____NO Have you been disciplined with a reprimand, censure, suspension, temporary suspension, probation, revocation, or refusal to renew a professional license in any state?

_____YES _____NO Are you $1,000 or more behind in child support payments?

_____YES _____NO Have you previously made application for licensure to this Board?
STATISTICAL INFORMATION

These questions are asked for statistical purposes. Your answers are optional.

What is your gender? _____ Female _____ Male

What is your race? Please check all that apply.

☐ Asian ☐ Hispanic or Latino
☐ American Indian or Alaska Native ☐ White or Caucasian
☐ Black or African American ☐ Other
☐ Native Hawaiian or Pacific Islander ☐ Decline to Provide

APPLICATION AND LICENSE FEES

Please include a personal check, cashier’s check, certified check or money order made payable to the State of South Dakota for the applicable amount.

☐ $100 nonrefundable temporary application fee
☐ $50 temporary license fee

To be signed in the presence of a Notary Public

BY MY SIGNATURE BELOW, I VERIFY, UNDER PENALTY OF PERJURY, THAT I AM THE APPLICANT COMPLETING THIS APPLICATION AND THAT ALL INFORMATION SUBMITTED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER UNDERSTAND THAT FALSE OR INCORRECT INFORMATION, OMissions, inaccuracies or failures to make full disclosure may result in the cancellation or denial of a plan of supervision or license issued pursuant to this application and may be subject to civil and criminal proceedings. I agree all information in this application can be verified and investigated. I have read, and am familiar with the South Dakota codified laws and administrative rules regulating the license applied for and hereby agree to abide by such laws and regulations.

___________________________________________ _________________________
Applicant Signature Date

State of ___________________)
) SS
County of ___________________)

On this ___ day of ______, 20___, the above applicant, ________________________________, personally appeared, known to me or satisfactorily proven to be the same person whose name s subscribed to the written instrument, and acknowledged that he/she executed the same for the purposes therein contained. In witness where of, I have here unto set my hand and official seal.

(SEAL)

Notary Signature: ________________________________
Notary Name: ________________________________
My Commission Expires: ________________________________
Mail completed application and fees to:
SD Board of Examiners for Counselors & Marriage and Family Therapists
PO Box 340
Pierre, SD  57501

Board Use Only:
Temporary Application Fee  $____________   Check number  ____________  DSS Code_______________  Date_________

Temporary License Fee  $ ____________ Check number  ____________  DSS Code_______________  Date_________

Completed Application  Yes   No   If no, missing:   ____________________________________________________

If approved:  Issue date:_________  Expired date: __________
APPLICATION FOR INACTIVE LICENSE

This is an application to inactivate your counseling license.

Check all that apply:

☐ Inactivate Professional Counselor License (LPC)
☐ Inactivate Professional Counselor License-Mental Health (LPC-MH)
☐ Inactivate Marriage and Family Therapist (LMFT)

Please submit:

1. Completed application; and
2. Non-refundable $25 inactive license fee.

Name:_______________________________________ License Number(s):_____________________________

Address:__________________________________City:____________________ State:_______Zip:__________

E-mail:_____________________________________________________ Phone:_________________________

An inactive license is not a license to practice professional counseling. An inactive license will expire four years after date of issuance. An inactive license can be reactivated within the four year period by payment of the license renewal fee and proof of having completed the required continuing education during the preceding two-year period.

BY MY SIGNATURE BELOW, I VERIFY, UNDER PENALTY OF PERJURY, THAT I AM THE APPLICANT COMPLETING THIS APPLICATION AND THAT ALL INFORMATION SUBMITTED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER UNDERSTAND THAT FALSE OR INCORRECT INFORMATION, OMISSIONS, INACCURACIES OR FAILURES TO MAKE FULL DISCLOSURE MAY RESULT IN THE CANCELLATION OR DENIAL OF A PLAN OF SUPERVISION OR LICENSE ISSUED PURSUANT TO THIS APPLICATION AND MAY BE SUBJECT TO CIVIL AND CRIMINAL PROCEEDINGS. I AGREE ALL INFORMATION IN THIS APPLICATION CAN BE VERIFIED AND INVESTIGATED. I HAVE READ, AND AM FAMILIAR WITH THE SOUTH DAKOTA CODIFIED LAWS AND ADMINISTRATIVE RULES REGULATING THE LICENSE APPLIED FOR AND HEREBY AGREE TO ABIDE BY SUCH LAWS AND REGULATIONS.

_________________________________________  __________________________
Signature of Applicant                Date

Board Use Only:

Inactive License Fee $_______  Check number ___________  DSS Code______________ Date__________
APPLICATION TO REACTIVATE LICENSE

This is an application to reactivate an inactive or expired license.

Please submit:
1. Completed application;
2. Proof of the required continuing education during the preceding two-year period;
3. Proof of a passing score on the national exam submitted directly to the Board, if applicable;
4. Quality color photograph; and
5. Non-refundable license renewal fee.

Reactivate an Inactive or Expired license:  □ Inactive  □ Expired*

*If Expired, complete the national exam section, page 2.

Check license type:     □ LPC    □ LPC-MH    □ LMFT

Name: _________________________________Previous License Number: ________________________

Address: ______________________________ City: ___________ State:          Zip: ___________

Date of Birth: _______________________ Social Security Number: _________________________

E-mail: ____________________________________ Phone: _______________________________

Name of Business:____________________________ Phone:_____________________________

Address:__________________________________City:____________________ State:_______Zip:__________

LEGAL QUESTIONS (If you answer yes to any question, please provide a separate written explanation.)

____YES  ____NO    Have you ever been convicted, pled no contest/nolo contender, pled guilty or been
granted a deferred judgment or suspended imposition of sentence or had prosecution deferred with
respect to a felony?

____YES  ____NO    Have you ever been convicted, pled no contest/nolo contender, pled guilty to, or
been granted a deferred judgement or suspended imposition of sentence, or had prosecution deferred
with respect to a misdemeanor other than a class 2 traffic offense?

____YES  ____NO    Have you been disciplined with a reprimand, censure, suspension, temporary suspension,
probation, revocation, or refusal to renew a professional license in any state?

____YES  ____NO    Are you $1,000 or more behind in child support payments?

____YES  ____NO    Have you previously made application for licensure to this Board?
CONTINUING EDUCATION VERIFICATION
Please list each continuing education program you are claiming in the spaces provide below. Include a copy of the certificate of completion for the course(s) you are submitting to meet the continuing education requirements of 40 hours of continuing education during the two-year period immediately preceding the reactivation request.

<table>
<thead>
<tr>
<th>Date</th>
<th>Type (Ethics or General)</th>
<th>Title of Course</th>
<th>Course Sponsor</th>
<th>Course Number</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example 1/1/20</td>
<td>Ethics</td>
<td>Ethics for Counselors</td>
<td>SD Counseling Association</td>
<td>BCE-2020-001</td>
<td>4</td>
</tr>
</tbody>
</table>

NATIONAL EXAMINATION (For Expired license only)
Reactivating an Expired license requires passage of a national examination after the date the license expired.

___Yes ___No   Have you completed passage of a national exam after the date your license expired? If yes, please indicate which exam:

  ___National Counselor Examination (NCE)   Date of Exam: _______
  ___National Clinical Mental Health Counselor Examination (NCMHCE)   Date of Exam: _______
  ___National Examination in Marital and Family Therapy (AMFTRB)   Date of Exam: _______

Please request your official national exam score be sent to the South Dakota Board of Examiners for Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD  57501 or released to the Board through the NBCC or AMFTRB online results portal. Date requested:_______

LICENSE RENEWAL FEE Please include a personal check, cashier’s check, certified check or money order made payable to the State of South Dakota for the applicable amount:

- ☐ $225 non-refundable license renewal fee for reactivating Inactive license
- ☐ $450 non-refundable license renewal fee for reactivating Expired license
To be signed in the presence of a Notary Public

BY MY SIGNATURE BELOW, I VERIFY, UNDER PENALTY OF PERJURY, THAT I AM THE APPLICANT COMPLETING THIS APPLICATION AND THAT ALL INFORMATION SUBMITTED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER UNDERSTAND THAT FALSE OR INCORRECT INFORMATION, OMISSIONS, INACCURACIES OR FAILURES TO MAKE FULL DISCLOSURE MAY RESULT IN THE CANCELLATION OR DENIAL OF A PLAN OF SUPERVISION OR LICENSE ISSUED PURSUANT TO THIS APPLICATION AND MAY BE SUBJECT TO CIVIL AND CRIMINAL PROCEEDINGS. I AGREE ALL INFORMATION IN THIS APPLICATION CAN BE VERIFIED AND INVESTIGATED. I HAVE READ, AND AM FAMILIAR WITH THE SOUTH DAKOTA CODIFIED LAWS AND ADMINISTRATIVE RULES REGULATING THE LICENSE APPLIED FOR AND HEREBY AGREE TO ABIDE BY SUCH LAWS AND REGULATIONS.

___________________________________________ _________________________
Applicant Signature Date

State of _______________) ) SS
County of _____________) )

On this ___ day of ______, 20___, the above applicant, ___________________________, personally appeared, known to me or satisfactorily proven to be the same person whose name is subscribed to the written instrument, and acknowledged that he/she executed the same for the purposes therein contained. In witness where of, I have here unto set my hand and official seal.

(SEAL) Notary Signature: _______________________
Notary Name: __________________________
My Commission Expires: ________________

Attach Photo Here

For identification purposes, the applicant shall furnish one color headshot taken not more than six months before the date of application.

Mail completed application and renewal fee to:
SD Board of Examiners for Counselors & Marriage and Family Therapists
PO Box 340
Pierre, SD 57501

Board Use Only:
Inactive Renewal Fee $_______ Check number __________ DSS Code __________ Date _________
Date of Reactivation: _________ Reactivation letter sent to licensee: __________