



South Dakota Board of Examiners for Counselors &
Marriage and Family Therapists

P.O. Box 340, 1351 N. Harrison Ave., Pierre, SD 57501-0340

Ph: 605-224-1721

Fax: 1-888-425-3032

E-mail: SDBCE@midwestsolutionssd.com dss.sd.gov/licensingboards/examiners.aspx

**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 Reinstate 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

P.O. Box 340, 1351 N. Harrison Ave., Pierre, SD 57501-0340

Ph: 605-224-1721

Fax: 1-888-425-3032

E-mail: SDBCE@midwestsolutionssd.com dss.sd.gov/licensingBoards/examiners.aspx

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, and Wangen voted aye. Trenhaile abstained. Motion carried.

Motion to accept the financial report as of May 31, 2020 by Brown. Seconded by Hartman. 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.

Motion to dismiss complaint 2020-01 by Konz. Seconded by Hartman. The Board voted by roll call. Brown, Konz, Hartman, Wangen and Trenhaile voted aye. Butler was recused. Bartels abstained. Motion carried.

Motion to adopt the order in the Matter of the Licensed Professional Counselor Plan of Supervision application of Wendy Lohan by Wangen. Seconded by Brown. The Board voted by roll call. Butler, Bartels, Konz, Hartman, Brown, Wangen and Trenhaile voted aye. Motion carried.

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).

Motion to adjourn by Wangen. Seconded by Konz. The Board voted by roll call. Butler, Konz, Hartman, Brown, Wangen and Trenhaile voted aye. Motion carried.

The Board adjourned at 12:05 pm.

Respectfully Submitted,

Jennifer Stalley, Executive Secretary

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%

0891 Subobject	Board of Counselor Examiners - Info Operating	Expenditures	Encumbrances	Commitments	Remaining	PCT AVL
EMPLOYEE SALARIES						
5101030 Board & Comm Mbrs Fees	3,141	660	0	0	2,481	79.0
Subtotal	3,141	660	0	0	2,481	79.0
EMPLOYEE BENEFITS						
5102010 Oasi-employer's Share	321	50	0	0	271	84.4
Subtotal	321	50	0	0	271	84.4
51 Personal Services						
Subtotal	3,462	710	0	0	2,752	79.5
TRAVEL						
5203030 Auto-priv (in-st.) H/rte	4,331	0	0	0	4,331	100.0
5203100 Lodging/in-state	1,507	0	0	0	1,507	100.0
5203130 Non-employ. Travel-in St.	1,100	0	0	0	1,100	100.0
5203140 Meals/taxable/in-state	112	0	0	0	112	100.0
5203150 Non-taxable Meals/in-st	450	0	0	0	450	100.0
5203260 Air-comm-out-of-state	2,000	0	0	0	2,000	100.0
5203280 Other-public-out-of-state	180	0	0	0	180	100.0
5203300 Lodging/out-state	2,024	0	0	0	2,024	100.0
5203320 Incidentals-out-of-state	75	0	0	0	75	100.0
5203330 Non-employ Travel-out-st.	1,000	0	0	0	1,000	100.0
5203350 Non-taxable Meals/out-st	700	0	0	0	700	100.0
Subtotal	13,479	0	0	0	13,479	100.0
CONTRACTUAL SERVICES						
5204020 Dues & Membership Fees	1,550	900	0	0	650	41.9
5204050 Computer Consultant	0	0	7,500	0	-7,500	0.0
5204080 Legal Consultant	7,000	0	0	0	7,000	100.0
5204090 Management Consultant	54,605	5,377	63,323	0	-14,095	0.0
5204131 Other Consulting	7,500	0	0	0	7,500	100.0
5204160 Workshop Registration Fee	1,550	0	0	0	1,550	100.0
5204200 Central Services	82	0	0	0	82	100.0
5204201 Central Services	1,584	446	0	0	1,138	71.8
5204204 Central Services	0	54	0	0	-54	0.0
5204207 Central Services	521	18	0	0	503	96.5
5204360 Advertising-newspaper	300	0	0	0	300	100.0
5204460 Equipment Rental	750	0	0	0	750	100.0
5204510 Rents-other	3,300	0	0	0	3,300	100.0

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%

0891	Board of Counselor Examiners - Info						PCT
Subobject		Operating	Expenditures	Encumbrances	Commitments	Remaining	AVL
5204530	Telecommunications Srvc	1,100	0	0	0	1,100	100.0
5204590	Ins Premiums & Surety Bds	2,270	0	0	0	2,270	100.0
5204960	Other Contractual Service	0	3	0	0	-3	0.0
Subtotal		82,112	6,798	70,823	0	4,491	5.5
SUPPLIES & MATERIALS							
5205020	Office Supplies	0	346	0	0	-346	0.0
5205028	Office Supplies	400	0	0	0	400	100.0
5205328	Printing-commercial	1,350	0	0	0	1,350	100.0
5205350	Postage	2,000	84	0	0	1,916	95.8
5205390	Food Stuffs	150	0	0	0	150	100.0
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		102,953	7,938	70,823	0	24,192	23.5

STATE OF SOUTH DAKOTA
CASH CENTER BALANCES
AS OF: 07/31/2020

AGENCY: 08 SOCIAL SERVICES
BUDGET UNIT: 0891 BOARD OF COUNSELOR EXAMINERS - INFO

COMPANY	CENTER	ACCOUNT	BALANCE	DR/CR	CENTER DESCRIPTION
6503	0891000648	1140000	104,664.64	DR	BOARD OF COUNSELOR EXAMINERS
COMPANY/SOURCE TOTAL 6503 648			104,664.64	DR *	
COMP/BUDG UNIT TOTAL 6503 0891			104,664.64	DR **	
BUDGET UNIT TOTAL 0891			104,664.64	DR ***	

**BOARD OF COUNSELOR EXAMINERS
REVENUE SUMMARY
FOR MONTH ENDING 07-31-20**

COMP	ACCOUNT	BDGT YEAR	GRANT YEAR	CENTER	FUND SRC	SUB FUND	FISCAL YEAR	FISCAL MONTH	YTD AMOUNT	MTD AMOUNT
6503	4293945	0	0	0891000	648		2021	01	\$ 500.00	\$ 500.00
6503	4293947	0	0	0891000	648		2021	01	\$ 400.00	\$ 400.00
6503	4293948	0	0	0891000	648		2021	01	\$ 100.00	\$ 100.00
6503	4293949	0	0	0891000	648		2021	01	\$ 50.00	\$ 50.00
6503	4293950	0	0	0891000	648		2021	01	\$ 200.00	\$ 200.00
6503	4293952	0	0	0891000	648		2021	01	\$ 175.00	\$ 175.00
6503	4293980	0	0	0891000	648		2021	01	\$ 100.00	\$ 100.00
6503	4293981	0	0	0891000	648		2021	01	\$ 100.00	\$ 100.00
6503	4293982	0	0	0891000	648		2021	01	\$ 225.00	\$ 225.00
6503	4896000	0	0	0891000	648		2021	01	\$ 150.00	\$ 150.00
									\$ 2,000.00	\$ 2,000.00

BA20JB60

AVAILABLE FUNDS
AS OF: 07/31/2020
FY YEAR REMAINING: 91.8%
PAY DAYS REMAINING: 0

MONTHLY

PAGE 1,362

BUDGET UNIT 0891

DATE 08/01/2020

BUDGET UNIT NAME BOARD OF COUNSELOR EXAMINERS - INFO

COMP	ORIGINAL APPROPRIATION	APPROPRIATION TRANSFERS	YEAR-TO-DATE COMMITMENTS	YEAR-TO-DATE ENCUMBRANCES	YEAR-TO-DATE EXPENDITURES	AVAILABLE APPROPRIATIONS	CASH BALANCE
6503-I	102,953.00	0.00	0.00	70,822.80	7,938.85	24,191.35	104,664.64
BUDGETED TOT	102,953.00	0.00	0.00	70,822.80	7,938.85	24,191.35	
ALL COMP TOT	102,953.00	0.00	0.00	70,822.80	7,938.85	24,191.35	

TOTAL BUDGETED:

	OBJECT OF EXPENDITURE	AMOUNT BUDGETED	COMMITMENTS YEAR-TO-DATE	ENCUMBRANCES YEAR-TO-DATE	EXPENDITURES		BUDGET AVAILABLE	PCT AVL
					MONTHLY	YEAR-TO-DATE		
5101	EMPLOYEE SALARIES	3,141.00	0.00	0.00	660.00	660.00	2,481.00	79.0
5102	EMPLOYEE BENEFITS	321.00	0.00	0.00	50.49	50.49	270.51	84.3
5203	TRAVEL	13,479.00	0.00	0.00	0.00	0.00	13,479.00	100.0
5204	CONTRACTUAL SVCS	82,112.00	0.00	70,822.80	6,798.61	6,798.61	4,490.59	5.5
5205	SUPPLIES & MATRLS	3,900.00	0.00	0.00	429.75	429.75	3,470.25	89.0
	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

5101000	EMPLOYEE SALARIES	3,141.00	0.00	0.00	660.00	660.00	2,481.00	79.0
5102000	EMPLOYEE BENEFITS	321.00	0.00	0.00	50.49	50.49	270.51	84.3
5203000	TRAVEL	13,479.00	0.00	0.00	0.00	0.00	13,479.00	100.0
5204000	CONTRACTUAL SVCS	82,112.00	0.00	70,822.80	6,798.61	6,798.61	4,490.59	5.5
5205000	SUPPLIES & MATRLS	3,900.00	0.00	0.00	429.75	429.75	3,470.25	89.0
	PS SUBTOTALS	3,462.00	0.00	0.00	710.49	710.49	2,751.51	79.5
	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

STATE OF SOUTH DAKOTA
 MONTHLY OBJECT/SUB-OBJECT REPORT BY BUDGET UNIT
 FOR PERIOD ENDING: 07/31/2020

AGENCY 08 SOCIAL SERVICES
 BUDGET UNIT 0891 BOARD OF COUNSELOR EXAMINERS - INFO

CENTER	COMP	ACCOUNT	DESCRIPTION	CURRENT MONTH	YEAR-TO-DATE	
COMPANY NO		6503				
COMPANY NAME		PROFESSIONAL & LICENSING BOARDS				
0891000648	6503	510103000	BOARD & COMM MBRS FEES	660.00	660.00	
ACCT: 5101		EMPLOYEE SALARIES		660.00	660.00	*
0891000648	6503	510201000	OASI-EMPLOYER'S SHARE	50.49	50.49	
ACCT: 5102		EMPLOYEE BENEFITS		50.49	50.49	*
ACCT: 51		PERSONAL SERVICES		710.49	710.49	**
0891000648	6503	520402000	DUES & MEMBERSHIP FEES	900.00	900.00	
0891000648	6503	520409000	MANAGEMENT CONSULTANT	5,377.20	5,377.20	
0891000648	6503	520420100	BFM CENTRAL SERVICES	446.02	446.02	
0891000648	6503	520420400	RECORDS MGMT SERVICES	54.40	54.40	
0891000648	6503	520420700	HUMAN RESOURCES SERVICES	18.05	18.05	
0891000648	6503	520496000	OTHER CONTRACTUAL SERVICE	2.94	2.94	
ACCT: 5204		CONTRACTUAL SERVICES		6,798.61	6,798.61	*
0891000648	6503	520502000	OFFICE SUPPLIES	345.95	345.95	
0891000648	6503	520535000	POSTAGE	83.80	83.80	
ACCT: 5205		SUPPLIES & MATERIALS		429.75	429.75	*
ACCT: 52		OPERATING EXPENSES		7,228.36	7,228.36	**
COMP: 6503				7,938.85	7,938.85	***
CNTR: 0891000648				7,938.85	7,938.85	****
CNTR: 089100064				7,938.85	7,938.85	*****
CNTR: 0891000				7,938.85	7,938.85	*****
B UNIT: 0891				7,938.85	7,938.85	*****

STATE OF SOUTH DAKOTA
 MONTHLY EXPENDITURE REPORT
 FOR PERIOD ENDING: 07/31/2020

AGENCY 08 SOCIAL SERVICES
 BUDGET UNIT 0891 BOARD OF COUNSELOR EXAMINERS - INFO

COMP	CENTER	ACCOUNT	DOCUMENT NUMBER	POSTING DATE	JV APPVL #, OR PAYMENT #	SHORT NAME	VENDOR NUMBER	VENDOR GROUP	AMOUNT	DR/ CR
COMPANY NO		6503								
COMPANY NAME		PROFESSIONAL & LICENSING BOARDS								
6503	0891000648	510103000	CGEX200626	07/02/2020					420.00	DR
6503	0891000648	510103000	CGEX200713	07/17/2020					180.00	DR
6503	0891000648	510103000	CGEX200728	07/31/2020					60.00	DR
	OBJSUB:	5101030							660.00	DR **
	OBJECT:	5101 EMPLOYEE SALARIES							660.00	DR ***
6503	0891000648	510201000	CGEX200626	07/02/2020					32.13	DR
6503	0891000648	510201000	CGEX200713	07/17/2020					13.77	DR
6503	0891000648	510201000	CGEX200728	07/31/2020					4.59	DR
	OBJSUB:	5102010							50.49	DR **
	OBJECT:	5102 EMPLOYEE BENEFITS							50.49	DR ***
	GROUP:	51 PERSONAL SERVICES							710.49	DR ****
6503	0891000648	520402000	2357	07/10/2020	00030303	AMERICANAS	12115387	01	900.00	DR
	OBJSUB:	5204020							900.00	DR **
6503	0891000648	520409000	21SC081003-JUNE	07/22/2020	00663146	MIDWESTSOL	12199902		5,377.20	DR
	OBJSUB:	5204090							5,377.20	DR **
6503	0891000648	520420100	FM006049	07/28/2020					446.02	DR **
	OBJSUB:	5204201							446.02	DR **
6503	0891000648	520420400	RM006029	07/15/2020					54.40	DR
	OBJSUB:	5204204							54.40	DR **
6503	0891000648	520420700	PL006040	07/22/2020					18.05	DR
	OBJSUB:	5204207							18.05	DR **
6503	0891000648	520496000	47349	07/10/2020	00660966	BADGERSTAT	12208910		2.94	DR
	OBJSUB:	5204960							2.94	DR **
	OBJECT:	5204 CONTRACTUAL SERVICES							6,798.61	DR ***
6503	0891000648	520502000	28850	07/10/2020	00660949	JCPRINTING	12124414		345.95	DR
	OBJSUB:	5205020							345.95	DR **
6503	0891000648	520535000	MS006034	07/17/2020					83.80	DR
	OBJSUB:	5205350							83.80	DR **
	OBJECT:	5205 SUPPLIES & MATERIALS							429.75	DR ***
	GROUP:	52 OPERATING EXPENSES							7,228.36	DR ****
	COMP:	6503							7,938.85	DR *
	CNTR:	0891000648							7,938.85	DR *****
	CNTR:	089100064							7,938.85	DR *****
	CNTR:	0891000							7,938.85	DR *****
	B. UNIT:	0891							7,938.85	DR *****

SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES
**SOUTH DAKOTA BOARD OF EXAMINERS FOR COUNSELORS &
MARRIAGE AND FAMILY THERAPISTS**

PO BOX 340, 1351 N. Harrison Ave., Pierre, SD 57501
Tel: 605.224.1721 Email: sdbce@midwestsolutionsd.com
Website: dss.sd.gov/licensingboards/counselors/counselors.aspx

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@midwestsolutionsd.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 contendere, 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 contendere, 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?

(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:

Application Fee \$_____ Check number _____ DSS Code _____ Date _____

Attachment 1 Received: Yes No

Completed Application: Yes No If no, missing: _____

**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.

Content Area	Course Number(s)	Course Title(s)	College/ University
Counseling theory: including a study of basic theories and principles of counseling and philosophic bases of the helping relationship;			
Counseling techniques: including individual counseling practices, methods, facilitative skills, and the application of these skills;			
Counseling Practicum			
Counseling Internship			
Human growth and development: 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;			
Social and Cultural Foundations: 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;			
The helping relationship: 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;			
Group counseling: including theory and types of groups, as well as descriptions of group practices, methods, dynamics, facilitative skills, and supervised practice;			
Life-style and career development: 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;			
Individual appraisal: 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;			
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.			

SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES
**SOUTH DAKOTA BOARD OF EXAMINERS FOR COUNSELORS &
MARRIAGE AND FAMILY THERAPISTS**

PO BOX 340, 1351 N. Harrison Ave., Pierre, SD 57501
Tel: 605.224.1721 Email: sdbce@midwestsolutionsd.com
Website: dss.sd.gov/licensingboards/counselors/counselors.aspx

**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 contendere, 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 contendere, 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 _____)

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.

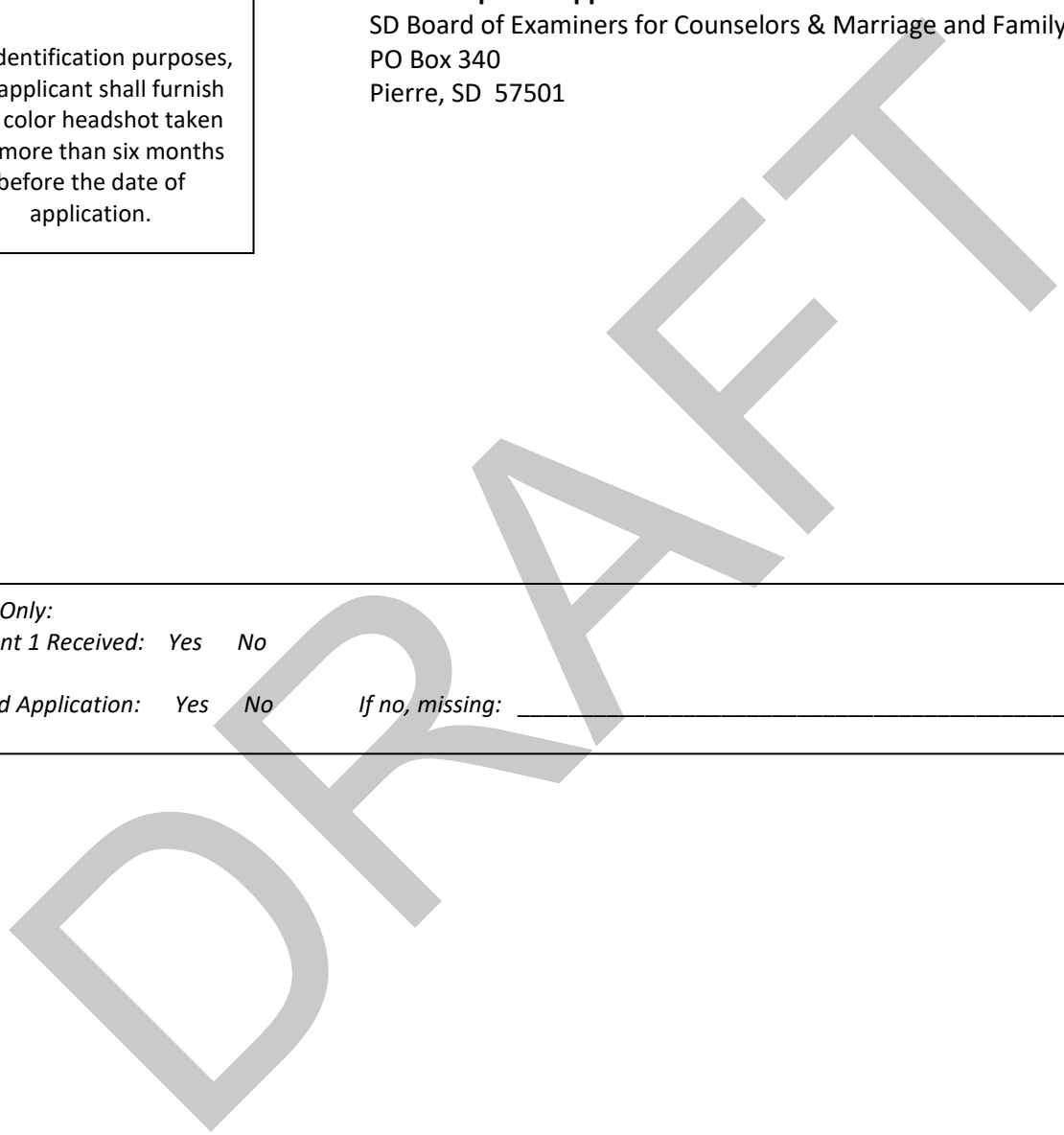
Mail completed application to:

SD Board of Examiners for Counselors & Marriage and Family Therapists
PO Box 340
Pierre, SD 57501

Board Use Only:

Attachment 1 Received: Yes No

Completed Application: Yes No If no, missing: _____



ATTACHMENT 2 COURSEWORK REQUIREMENTS PROFESSIONAL COUNSELOR – MENTAL HEALTH

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.

Content Area	Course Number(s)	Course Title(s)	College/ University
Counseling theory: including a study of basic theories and principles of counseling and philosophic bases of the helping relationship;			
Counseling techniques: including individual counseling practices, methods, facilitative skills, and the application of these skills;			
Counseling Practicum			
Counseling Internship			
Human growth and development: 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;			
Social and Cultural Foundations: 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;			
The helping relationship: 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;			
Group counseling: including theory and types of groups, as well as descriptions of group practices, methods, dynamics, facilitative skills, and supervised practice;			
Life-style and career development: 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;			
Individual appraisal: 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;			

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.			

SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES
**SOUTH DAKOTA BOARD OF EXAMINERS FOR COUNSELORS &
MARRIAGE AND FAMILY THERAPISTS**

PO BOX 340, 1351 N. Harrison Ave., Pierre, SD 57501
Tel: 605.224.1721 Email: sdbce@midwestsolutionsd.com
Website: dss.sd.gov/licensingboards/counselors/counselors.aspx

**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 contendere, 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 contendere, 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.

- | | |
|--|---|
| <input type="checkbox"/> Asian | <input type="checkbox"/> Hispanic or Latino |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> White or Caucasian |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other |
| <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> 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 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 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.

Content Area	Course Number(s)	Course Title(s)	College/ University
MARRIAGE AND FAMILY STUDIES (9 SEM CREDITS MINIMUM) 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;			
MARRIAGE AND FAMILY THERAPY (9 SEM CREDITS MINIMUM) 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.			
HUMAN DEVELOPMENT (9 SEM CREDITS MINIMUM) 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;			
PROFESSIONAL STUDIES (3 SEM CREDITS MINIMUM) Professional ethics as a therapist including legal and ethical responsibilities and liabilities, family law, etc.			
RESEARCH (3 SEM CREDITS MINIMUM) Research course in marriage and family studies and therapy including research design, methodology, statistics;			
PRACTICUM (SUPERVISED CLINICAL PRACTICE) 1 year minimum during graduate work			

SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES
**SOUTH DAKOTA BOARD OF EXAMINERS FOR COUNSELORS &
MARRIAGE AND FAMILY THERAPISTS**

PO Box 340, 1351 N. Harrison Ave., Pierre, SD 57501
Tel: 605.224.1721 Email: sdbce@midwestsolutionsd.com
Website: dss.sd.gov/licensingboards/counselors/counselors.aspx

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@midwestsolutionsd.com.

SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES
**SOUTH DAKOTA BOARD OF EXAMINERS FOR COUNSELORS & MARRIAGE
 AND FAMILY THERAPISTS**

PO BOX 340, 1351 N. Harrison Ave., Pierre, SD 57501
 Tel: 605.224.1721 Email: sdbce@midwestsolutionsd.com
 Website: dss.sd.gov/licensingboards/counselors/counselors.aspx

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):

License Type	License Number	Date Issued	Good Through Date
LPC			
LPC-MH			
LMFT			
Psychologist			
Psychiatrist			
CSW-PIP			

TRAINING REQUIREMENTS

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

Date	Type (Ethics)	Course Title	Course Sponsor	Course No.	Hours

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 contendere, 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 contendere, 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

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

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: _____

SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES
**SOUTH DAKOTA BOARD OF EXAMINERS FOR COUNSELORS &
MARRIAGE AND FAMILY THERAPISTS**

PO BOX 340, 1351 N. Harrison Ave., Pierre, SD 57501
Tel: 605.224.1721 Email: sdbce@midwestsolutionsd.com
Website: dss.sd.gov/licensingboards/counselors/counselors.aspx

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 contendere, 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 contendere, 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 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: _____

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

DRAFT

Board Use Only:

License Fee \$ _____ Check number _____ DSS Code _____ Date _____

Completed Application Yes No If no, missing: _____

Issue date _____ Valid through date _____ CEU _____

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

Attachment A – Supervised Experience with Board Approved Supervisor

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@midwestsolutionsd.com

SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES
**SOUTH DAKOTA BOARD OF EXAMINERS FOR COUNSELORS &
 MARRIAGE AND FAMILY THERAPISTS**

PO BOX 340, 1351 N. Harrison Ave., Pierre, SD 57501
 Tel: 605.224.1721 Email: sdbce@midwestsolutionsd.com
 Website: dss.sd.gov/licensingboards/counselors/counselors.aspx

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 contendere, 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 contendere, 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.

- | | |
|--|---|
| <input type="checkbox"/> Asian | <input type="checkbox"/> Hispanic or Latino |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> White or Caucasian |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other |
| <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> 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 _____)
) 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: _____

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: _____

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

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: _____

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 contendere, 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 contendere, 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
- American Indian or Alaska Native
- Black or African American
- Native Hawaiian or Pacific Islander
- Hispanic or Latino
- White or Caucasian
- Other
- 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: _____

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

DRAFT

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: _____

SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES
**SOUTH DAKOTA BOARD OF EXAMINERS FOR COUNSELORS &
MARRIAGE AND FAMILY THERAPISTS**

PO BOX 340, 1351 N. Harrison Ave., Pierre, SD 57501
Tel: 605.224.1721 Email: sdbce@midwestsolutionsd.com
Website: dss.sd.gov/licensingboards/counselors/counselors.aspx

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 _____

SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES
**SOUTH DAKOTA BOARD OF EXAMINERS FOR COUNSELORS &
 MARRIAGE AND FAMILY THERAPISTS**

PO BOX 340, 1351 N. Harrison Ave., Pierre, SD 57501
 Tel: 605.224.1721 Email: sdbce@midwestsolutionsd.com
 Website: dss.sd.gov/licensingboards/counselors/counselors.aspx

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 contendere, 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 contendere, 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.

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

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

