State of New Hampshire

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
DIVISION OF LICENSING AND BOARD ADMINISTRATION
Board of Mental Health Practice
7 Eagle Square, Concord, NH 03301-2412
Phone: 603-271-2152

INSTRUCTIONS AND CHECKLIST

APPLICATION INFORMATION FOR LICENSURE AS A SOCIAL WORK ASSOCIATE

Prior to completing the application, it is strongly recommended that all applicants review administrative rules Mhp 100-500 online at www.oplc.nh.gov/board-mental-health-practice and verify that all educational, exam, and supervision requirements are met. It is also recommended that applicants maintain a copy of their application for their records.

All applicants must pass the ASWB Clinical Level Exam prior to submitting an application for licensure.

There is a non-refundable application fee which must be in the form of a check or money order payable to the State of New Hampshire. All fees must accompany the completed application.

Please make sure all of the following information is included when submitting your application packet to the Board office:

1. A completed application booklet and resume.
2. A completed Summary of Supervised Clinical Experience form.
3. A completed Supervisor's Confirmation of Clinical Experience form(s) in an envelope that has been signed and sealed by the supervisor. At least one supervisor must also complete a professional reference form.
4. A Licensure Verification from another jurisdiction (if applicable).
5. Three Professional Reference forms that have been signed and sealed by each reference. At least one (1) professional reference form shall be from a supervisor.
6. An official undergraduate **and** master's/or doctoral transcript in an envelope that has been sealed by the school.
7. Proof of passing the ASWB Clinical or Bachelor's Exam. If you took the exam in NH, not more than two years ago, it is likely we have it on file. If you took it out of state or more than two years ago contact ASWB to request a copy of your exam score.
8. New Hampshire Criminal Offender Record Report with fingerprints as outlined in RSA 330-A:15-a.
9. A check or money order payable to the State of New Hampshire - Treasurer. Refer to our fees page for amount.

All application materials should be submitted to:

NH Board of Mental Health Practice
7 Eagle Square
Concord, NH 03301

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
STATE OF NEW HAMPSHIRE
7 Eagle Square - Concord, N.H. 03301-4980
Telephone 603-271-2152

UNIVERSAL APPLICATION FOR INITIAL LICENSE

Profession for which application is being filed:_____

APPLICANT INFORMATION BASED ON TYPE OF PERSON

Applicant is (check one): ☐ An Individual ☐ An entity

For individuals:

Full Legal Name:_____
Suffix, such as "Jr." or "III", if any

Other name(s) in which applicant holds or has held a professional license:_____

_____

Date of birth (MM/DD/YYYY):_____

Social Security Number*:_____

*The OPLC is required by 42 U.S.C. 666(a)(13) and RSA 161-B:11, VI-a to ask for your social security number. The number will be held confidential by the OPLC and used only for enforcement of the laws governing child support.

Home Physical Address:_____
Street name & number, Apt. # if any Municipality County State Zip Code Country if not US

Home Mailing Address: ☐ Check if same as physical address

IF DIFFERENT:_____
Street name & number or PO Box number Town/City State Zip Code Country if not US

Home/Personal Telephone Number: (_____) _____-_____

Designated email address*:_____
* Email address to which notices, license will be sent

If known, anticipated place of business name:_____

Address:_____
Street name & number Municipality State Zip Code Country if not US

Telephone number: (_____) _____-_____

Applicant's primary language: ☐ English ☐ Other (specify):_____ Other Languages:_____

Applicant is (check if applicable): ☐ Applying for facilitated licensure
☐ Currently on active military duty*
☐ Legally married to an individual who is currently on active military duty*
* "On active military duty" means on active duty in the U.S. armed forces.

Information needed for workforce analysis, all individuals (ref. Plc 304.03(a)(10):

a. Applicant's sex at birth: [drop-down list; select one: ☐ Female ☐ Male ☐ Prefer not to answer]

b. 1. Applicant's race or ethnicity: [drop-down list; select all that apply: ☐ American Indian or Alaska Native; ☐ Asian; ☐ Black or African American; ☐ Native Hawaiian or Pacific Islander; ☐ White; ☐ Some other race; ☐ Prefer not to answer]

2. Applicant is of Hispanic, Latino/a, or Spanish origin? [drop-down list; select one: ☐ Yes ☐ No ☐ Prefer not to answer]

c. Highest level of education, whether or not related to the profession in which licensure is being sought [drop-down list, select one: ☐ High school diploma or equivalency; ☐ Some college, no degree; ☐ Technical/Vocational Certificate; ☐ Associate's Degree; ☐ Bachelor's Degree; ☐ Master's Degree; ☐ Post-graduate training; ☐ Professional/Doctorate Degree; ☐ Postdoctoral training; ☐ Prefer not to answer]

d. Where the applicant completed the education program or degree, as applicable, that first qualified the applicant for the license being applied for, provided that if the program or degree was completed on-line, identify where the on-line program was housed [drop-down list, select one: ☐ [drop-down list of U.S. states and territories] ☐ Another Country (not U.S.) ☐ Prefer not to answer]

e. Relative to the applicant's employment status, whether the applicant is: [drop-down list, select one: ☐ Actively working in a position that requires this license ☐ Actively working in a position in the same profession that does not require this license ☐ Actively working in a different profession ☐ Not currently working ☐ Retired ☐ Prefer not to answer]

f. Relative to the applicant's employment plans for the next 2 years, whether the applicant intends to: [drop-down list, select one: ☐ Increase hours in a field related to this license ☐ Decrease hours in a field related to this license ☐ Seek employment in a field unrelated to this license..☐ Retire ☐ Continue as is ☐ Not sure or plans unknown ☐ Prefer not to answer

g. Identification of the specialty, field, or area of practice in which the applicant spends the most professional time [drop-down list based on profession, including ☐ Prefer not to answer]

h. Does the applicant use or expect to use telehealth to deliver services to patients? [drop-down list, select one: ☐ Yes ☐ No ☐ Prefer not to answer]

i. The state in which the applicant's primary practice is located, if applicable [drop-down list of U.S. states and territories plus ☐ Not applicable and ☐ Prefer not to answer]

j. The 5-digit zip code of the applicant's primary practice location, if applicable:____[open text field] ☐ Prefer not to answer

k. Relative to the applicant's current employment arrangement at their principal practice location, whether the applicant is [drop-down list, select all that apply: ☐ Self-employed or a consultant ☐ Salaried employee ☐ Hourly employee ☐ In temporary employment or Locum Tenens ☐ Other arrangement ☐ Not employed ☐ Prefer not to answer]

l. In the applicant's primary employment or practice, whether the applicant's primary role is that of: [drop-down list, select all that apply: ☐ Administrator ☐ Clinical practitioner ☐ Faculty or other educator ☐ Researcher ☐ Other ☐ Not applicable ☐ Prefer not to answer]

Information needed for workforce analysis, applicants in any health care field (ref. Plc 304.02(a)(11):

a. Identification of the practice setting at the applicant's primary practice location [drop-down list based on profession ☐ Prefer not to answer]

b. What population groups does or will the applicant provide(s) services to? [drop-down list, select all that apply: ☐ Newborns to 2 years ☐ Children ages 2-10 ☐ Adolescents ages 11-19 ☐ Adults ☐ Geriatrics ages 65+ ☐ Pregnant women ☐ Veterans ☐ Incarcerated individuals ☐ Individuals with disabilities ☐ Individuals who speak a language other than English ☐ Medicaid ☐ Medicare ☐ Sliding Fee Scale ☐ None of the above ☐ Prefer not to answer]

c. An estimate of the number of hours per week the applicant spends or expects to spend at their primary practice location [drop-down list, select one: ☐ 0 hours per week/Not applicable ☐ 1-4 hours per week ☐ 5-8 hours per week ☐ 9-12 hours per week ☐ 13-16 hours per week ☐ 17-20 hours per week ☐ 21-24 hours per week ☐ 25-28 hours per week ☐ 29-32 hours per week ☐ 33-36 hours per week ☐ 37-40 hours per week ☐ 41 or more hours per week ☐ Prefer not to answer]

d. An estimate of the number of hours per week the applicant spends or expects to spend in direct patient care [drop-down list, select one: ☐ 0 hours per week/Not applicable ☐ 1-4 hours per week ☐ 5-8 hours per week ☐ 9-12 hours per week ☐ 13-16 hours per week ☐ 17-20 hours per week ☐ 21-24 hours per week ☐ 25-28 hours per week ☐ 29-32 hours per week ☐ 33-36 hours per week ☐ 37-40 hours per week ☐ 41 or more hours per week ☐ Prefer not to answer]

For applicants in any health care field, does applicant intend to practice in New Hampshire more than 50% of the time, whether in-person or by telehealth? ☐ Yes ☐ No

If specific training or a specific degree is required for your profession by applicable law, provide the name of the educational institution that provided the training or degree required and the date the training was completed or degree was received:

Name of educational institution:_____ Date completed/degree received:_____

For entities:

Full Legal Name*:_____

*Name shown on document(s) that created the entity

Office of Professional Licensing and Certification
7 Eagle Square - Concord, New Hampshire 03301-4980
(603) 271-2152

Each other name used when doing business in New Hampshire:_____

_____

Legal form (check one): ☐ Corporation ☐ LLC ☐ Professional Association ☐ Partnership

☐ Other:_____

Jurisdiction in which formed:_____ Date of Formation (MM/DD/YYYY):_____

Employer ID number or other federal tax ID number assigned by the IRS:_____

Primary physical address in NH:_____

Street name & number, Suite # if any Municipality County Zip Code

NH mailing address:: ☐ Check if same as physical address

IF DIFFERENT:_____

Street name & number or PO Box number Town/City Zip Code

Main telephone number:_(_____)_____-_____

Designated email address*:_____

* Email address to which notices, license will be sent

Name of Authorized Signer* (AS):_____

* Individual who is legally authorized to sign the application

AS Telephone Number:_(_____)_____-_____ AS email:_____

Other contact individuals (authorized to interact with OPLC regarding the application, issued license) (if any):

Name	Telephone Number	Email Address

ALL APPLICANTS:

Information on Current or Past Licensure* in Other Jurisdictions:

Jurisdiction	License Number	Date initially licensed	Date most recently licensed	Status (in good standing, expired, suspended, revoked, denied renewal)

* Includes licenses, certificates, registrations, or other form of approval required to practice

If applying based on endorsement, identify which of the above jurisdictions you believe has requirements for licensure that are substantially similar to or greater than those in New Hampshire:_____

Background/Character Questions ("you" means the applicant):

Questions:	Yes	No
Are you now or do you have any reason to believe that you will soon be the subject of a disciplinary proceeding, settlement agreement, or consent decree undertaken or issued by a professional licensing board of any jurisdiction?		
Has any malpractice claim been made against you within the past 10 years?		
Have you, for disciplinary reasons, been put on administrative leave, been fired for cause other than staff reductions from a position at your place of employment, or had any privileges limited, suspended, or revoked in any professional setting within the past 10 years?		
Have you been denied the privilege of taking an examination required for any professional licensure within the past 10 years?		
Have you committed any act(s) within the past 10 years that would violate the laws or rules that govern the profession for which the application is being filed?		
Have you ever been found guilty or entered a plea of no contest to any felony that is related to professional practice?		
Have you been found guilty of or entered a plea of no contest to, within the past 10 years, any felony that is **not** related to professional practice, or any misdemeanor?		

Have you ever been the subject of any disciplinary action by any professional licensing authority within the past 10 years?		
Have you, within the past 10 years, been denied a license or other authorization to practice in any jurisdiction?		
Have you, within the past 10 years, surrendered a license or other authorization to practice issued by any jurisdiction for any reason?		

Does applicant have a DEA number? ☐ No ☐ Yes (provide number):_____

Does applicant store, administer, or dispense controlled drugs in a setting that is not regulated under RSA 318 relative to pharmacies and pharmacists? ☐ No ☐ Yes (provide location):_____

For applicants in any health care profession (information required by RSA 125:25-c):

Do you have an ownership interest in any diagnostic or therapeutic service(s) or company(ies)? ☐ No ☐ Yes

If yes, provide the following for each service or company:

Name	Address	Specific Diagnostic/Therapeutic Services Offered

Disclosure of Contact Information*:

For individuals: Do you consent to the disclosure of any of your personal contact information? Check applicable column for each item:

Information	Yes, I consent to disclosure	No, do not disclose
Home or other personal telephone number		
Designated email address		
Home address		
Home mailing address (if different from home address)		

For entities: Do you consent to the disclosure of your designated email address? ☐ No ☐ Yes

***** *OPLC will not disclose this information unless authorized by you, unless ordered to do so by a court of competent jurisdiction.*

Required Documentation

Each applicant must provide the following with this application:

A clear explanation, including all relevant facts, the date(s) of the action, and the sanction(s) imposed, of the relevant circumstances of:

(1) Any license sanctions, including fines or penalties, imposed administratively or via a court proceeding in a jurisdiction listed above; and

(2) Any "yes" answer provided to a background and character question that is not covered by (1)

Each applicant required to take one or more examinations (including the English proficiency score if required by applicable law) must arrange to have the applicant's examination scores sent directly to the OPLC Licensing Bureau by the third party testing organization.

Each applicant required to be registered or certified by a regional or national credentialing organization must provide proof that the requisite credential has been obtained, or if applicable law allows an application for initial licensure to be filed prior to obtaining the credential, proof that the applicant has met the requirements for obtaining the credential.

Each applicant for licensure by endorsement based on a license issued by a foreign jurisdiction, as defined in Plc 313.10(b), must provide the evaluation of foreign credentials required by Plc 313.12.

Office of Professional Licensing and Certification
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Each applicant for licensure by endorsement must provide primary source verification of licensure in the jurisdiction in which applicant is currently licensed that the applicant believes has requirements that are substantially similar to New Hampshire's requirements, that:

(1) Identifies the applicant by name; and

(2) Clearly shows that the applicant is authorized to practice the occupation or profession in that jurisdiction and is in good standing.

Even if not applying for licensure by endorsement, each applicant who is licensed in any other jurisdiction(s) must provide:

Either: (1) An official letter of verification sent directly to the licensing bureau at customersupport@oplc.nh.gov, or if the information cannot be sent electronically, at the mailing address for the OPLC specified in Plc 102.03, from each state that has issued the applicant a license or other authorization to practice the profession for which application is being made, that states:

a. Whether the license or other authorization is or was, during its period of validity, in good standing; and

b. Whether any disciplinary action is pending or was taken against the license or other authorization to practice, whether administratively or via a court proceeding;

OR: If the information required by (1), above, is available on a website and is considered by the issuing jurisdiction to be a primary source verification, the URL of each such website.

Each applicant on active military duty must provide proof of service status in the form of verification from the Defense Finance and Accounting Service at https://www.dfas.mil/garnishment/verifyservice/.

Each applicant for facilitated licensure as a military spouse must provide:

(1) Proof of the spouse's service status as stated above, and

(2) Proof of marriage in the form of either:

a. A copy of the front and back of the applicant's current military spouse identification card; or

b. A copy of the applicant's official marriage certificate, and, if the certificate is not in English, an English translation of the certificate that is certified by the translator as being an accurate translation;

Each applicant that is an entity must provide:

(1) A copy of the legal document that confers authority on the Authorized Signer identified above to sign the application on the applicant's behalf; and

(2) Confirmation from the New Hampshire Secretary of State's Office that the entity applying for licensure is in good standing and authorized to do business in New Hampshire.

Fee

Application-Related Fee* - as stated in Plc 1002, except that for facilitated licensure, only the inspection fee, if any, and examination fee, if any, shall be paid

* For initial licensure, the application processing and licensing fee specified in Plc 1002, any examination fee specified in Plc 1002, and any inspection fee specified in Plc 1002 for the license being applied for

If fee is paid by check or money order, the check or money order should be made payable to "Treasurer, State of New Hampshire." If your application is denied, the Application-Related Fee(s) will not be refunded.

Signature and Attestation

By signing below, the applicant attests that:

- The applicant is not under investigation by any professional licensing board and the applicant's credentials have not been suspended or revoked by any professional licensing board, unless a written explanation of each such occurrence is being submitted with this application;
- The information and documentation provided are true, complete, and not misleading to the best of the applicant's knowledge and belief;

- The applicant understands that providing false or misleading information constitutes grounds for denial, suspension, or revocation of a license; and
- The applicant understands that knowingly providing false material information constitutes a misdemeanor under RSA 641:3 relative to falsification in official matters.

Applicant's Signature:_____

Date Signed:_____

State of New Hampshire

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DIVISION OF LICENSING AND BOARD ADMINISTRATION
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BOARD OF MENTAL HEALTH PRACTICE

SUMMARY OF SUPERVISED CLINICAL EXPERIENCE FORM – CLINICAL MENTAL HEALTH COUNSELORS, INDEPENDENT CLINICAL SOCIAL WORKERS, PASTORAL PSYCHOTHERAPIST, OR SCHOOL SOCIAL WORKERS

All applicants are required to complete the "Summary of Supervised Clinical Experience" form and submit it with the application. The hours on this form must match the hours verified on the supervisor's confirmation of clinical experience form. This includes both present and if applicable past supervisors.

APPLICANT'S NAME: _____

Start & end date of post-grad supervision	Name of Facility	Name of Supervisor	Total Hours of Individual Supervision	Total Hours of Clinical Experience
Total Hours of Supervised Clinical Experience				

BY SIGNING BELOW, I CERTIFY THAT THE FOREGOING IS CORRECT TO THE BEST OF MY KNOWLEDGE.

APPLICANT'S SIGNATURE _____ DATE _____

State of New Hampshire

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BOARD OF MENTAL HEALTH PRACTICE

SUPERVISOR'S CONFIRMATION OF CLINICAL EXPERIENCE FORM - CLINICAL MENTAL HEALTH COUNSELORS, INDEPENDENT CLINICAL SOCIAL WORKERS, PASTORAL PSYCHOTHERAPIST, OR SCHOOL SOCIAL WORKERS

This **request to the Supervisor for release of information to the Board** is to be completed by the applicant and forwarded to the supervisor of clinical experience.

Send one form to each supervisor and have them **return it to you** in a signed sealed envelope.

I am applying for licensure as a **CLINICAL MENTAL HEALTH COUNSELOR, INDEPENDENT CLINICAL SOCIAL WORKER, PASTORAL PSYCHOTHERAPIST, OR SCHOOL SOCIAL WORKER** in the State of New Hampshire. The Board of Mental Health Practice requires confirmation of supervised clinical experience. This is your authority to release all information you have in your files.

Applicant's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

SUMMARY OF POST-MASTERS SUPERVISED CLINICAL EXPERIENCE

Name of Facility: _____

Address of Facility: _____

Applicant's Title at the time of supervision: _____

Dates of Supervised Clinical Experience: From (Mo/Yr) _____ to (Mo/Yr) _____

FACE-TO-FACE Individual Supervision: Hrs per Wk: _____ Total supervised face-to-face hours: _____

Total Hours of Paid Post-Master's Supervised Clinical Work Experience*: _____
(* Number of hours worked per week X Number of weeks worked)

If the supervision took place in New Hampshire was an approved "Candidate Licensure Supervisor Agreement" on file in the Board's Office prior to the Commencement of supervision? [ ] Yes [ ] NO

SUPERVISOR'S CONFIRMATION

Supervisor: Provide on a separate sheet attached to this form:

1) A description of the supervisory methods and the types of issues dealt with during supervision;
2) A description of the type of work performed by the applicant; and
3) A description of the quality of work performed by the applicant.

Printed Supervisors Name: _____

Title at the time of Supervision: _____

Address: _____

Highest degree earned: _____

Licensed as: _____ State: _____ License#: _____ Date Issued: _____

Phone Number: _____

Signature: _____ Date: _____

Licensure Verification Form

New Hampshire Board of Mental Health Practice

RELEASE OF INFORMATION FROM OTHER LICENSING AUTHORITIES

I am applying for licensed clinical mental health counselor in the State of New Hampshire. The NH Board of Mental Health Practice requires that the following form be completed by each jurisdiction in which I am now or was previously licensed. This constitutes your authority to release any and all information in your files, favorable or otherwise to the NH Board of Mental Health Practice. Please complete the form, put it in a sealed envelope, sign the back of the envelope and **RETURN IT TO THE APPLICANT.**

Biographic Information:

Last Name First Name Middle Name Gen. Suffix

Mailing Address City State Zip Code

Date of Birth:

License Number (if known) Signature

The following should be completed by the licensing authority and returned directly to the applicant in a sealed envelope signed across the back.

1. Name of Licensing Authority: _____
2. Full Name of Licensee: _____
3. License Number: _____
4. Is License Current? Yes No Expiration Date: _____
5. Is License Restricted? Yes No
6. Previous Disciplinary Action? Yes No
7. Pending Investigations? Yes No

If the answer is yes to questions 5, 6 or 7, please attach supporting information.

Please affix official Board seal here

_____

Signature/Title

April 23, 2015

State of New Hampshire

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Board of Mental Health Practice
7 Eagle Square, Concord, NH 03301-2412
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Professional Reference Form

TO BE COMPLETED BY APPLICANT AND FORWARDED TO THE REFERENCE:

I am applying for (check one that applies) [ ] Licensed Independent Clinical Social Worker; [ ] Licensed Clinical Mental Health Counselor; [ ] Licensed Marriage and Family Therapist; [ ] Licensed Pastoral Psychotherapist. The New Hampshire Board of Mental Health Practice requires professional references. THIS IS YOUR AUTHORITY TO RELEASE ANY INFORMATION YOU HAVE IN YOUR FILE FAVORABLE OR OTHERWISE. **RETURN THIS FORM TO THE APPLICANT IN A SIGNED SEALED ENVELOPE.**

(Please print legibly)
Name_____ Address_____

Signature_____ Date _____

TO BE COMPLETED BY REFERENCE:

Professional relation to applicant_____

Length of time you've known applicant: From (Mo/Yr)_____to (Mo/Yr) _____

Please provide a brief description of your knowledge of the applicant's professional and ethical behavior. _____

_____

_____

_____

Title of applicant's position and name of organization he/she was employed at when you worked with them_____

Brief description of applicant's duties & responsibilities: _____

_____

_____

Area of applicant's specialties: _____

Do you attest and certify that the applicant is an individual of good moral character?

[ ] Yes [ ] No

If No, please explain_____

_____

If you are aware that the applicant has been or is the subject of any malpractice or civil suit involving the practice of their profession, or if they have been charged or convicted of a crime in any state or country; the disposition of which was other than acquittal or dismissal; or if there have been or are any complaints or charges of violation of the ethical codes, professional misconduct, unprofessional conduct, incompetence or negligence made or pending against them; or that they have ever been required to surrender their license/certification or have been found guilty of, or have entered into a consent decree regarding a violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country by any licensing board or professional ethics body; please clarify those circumstances and the current status of the applicant below.

_____

_____

_____

Quality and extent of your endorsement:

[ ] Without Reservation [ ] With Reservation [ ] No Recommendation

If you checked "With Reservation," please elaborate_____

_____

_____

THIS FORM IS TO BE RETURNED TO THE APPLICANT IN A SIGNED SEALED ENVELOPE.

Signature of Reference _____ Date _____

(Please Print)
Name_____

Address_____

Phone Number_____ Title_____ Degree_____

Licensed/Certified (Specialty)_____ State_____

License Number _____

State of New Hampshire

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(Please print legibly)
Name_____ Address_____

Signature_____ Date _____

TO BE COMPLETED BY REFERENCE:

Professional relation to applicant_____

Length of time you've known applicant: From (Mo/Yr)_____to (Mo/Yr) _____

Please provide a brief description of your knowledge of the applicant's professional and ethical behavior. _____

_____

_____

_____

Title of applicant's position and name of organization he/she was employed at when you worked with them_____

Brief description of applicant's duties & responsibilities: _____

_____

_____

Area of applicant's specialties: _____

Do you attest and certify that the applicant is an individual of good moral character?

[ ] Yes [ ] No

If No, please explain_____

_____

If you are aware that the applicant has been or is the subject of any malpractice or civil suit involving the practice of their profession, or if they have been charged or convicted of a crime in any state or country; the disposition of which was other than acquittal or dismissal; or if there have been or are any complaints or charges of violation of the ethical codes, professional misconduct, unprofessional conduct, incompetence or negligence made or pending against them; or that they have ever been required to surrender their license/certification or have been found guilty of, or have entered into a consent decree regarding a violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country by any licensing board or professional ethics body; please clarify those circumstances and the current status of the applicant below.

_____

_____

_____

Quality and extent of your endorsement:

[ ] Without Reservation [ ] With Reservation [ ] No Recommendation

If you checked "With Reservation," please elaborate_____

_____

_____

THIS FORM IS TO BE RETURNED TO THE APPLICANT IN A SIGNED SEALED ENVELOPE.

Signature of Reference _____ Date _____

(Please Print)
Name_____

Address_____

Phone Number_____ Title_____ Degree_____

Licensed/Certified (Specialty)_____ State_____

License Number _____

State of New Hampshire

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(Please print legibly)
Name_____ Address_____

Signature_____ Date _____

TO BE COMPLETED BY REFERENCE:

Professional relation to applicant_____

Length of time you've known applicant: From (Mo/Yr)_____to (Mo/Yr) _____

Please provide a brief description of your knowledge of the applicant's professional and ethical behavior. _____

_____

_____

_____

Title of applicant's position and name of organization he/she was employed at when you worked with them_____

Brief description of applicant's duties & responsibilities: _____

_____

_____

Area of applicant's specialties: _____

Do you attest and certify that the applicant is an individual of good moral character?

[ ] Yes [ ] No

If No, please explain_____

_____

If you are aware that the applicant has been or is the subject of any malpractice or civil suit involving the practice of their profession, or if they have been charged or convicted of a crime in any state or country; the disposition of which was other than acquittal or dismissal; or if there have been or are any complaints or charges of violation of the ethical codes, professional misconduct, unprofessional conduct, incompetence or negligence made or pending against them; or that they have ever been required to surrender their license/certification or have been found guilty of, or have entered into a consent decree regarding a violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country by any licensing board or professional ethics body; please clarify those circumstances and the current status of the applicant below.

_____

_____

_____

Quality and extent of your endorsement:

[ ] Without Reservation [ ] With Reservation [ ] No Recommendation

If you checked "With Reservation," please elaborate_____

_____

_____

THIS FORM IS TO BE RETURNED TO THE APPLICANT IN A SIGNED SEALED ENVELOPE.

Signature of Reference _____ Date _____

(Please Print)
Name_____

Address_____

Phone Number_____ Title_____ Degree_____

Licensed/Certified (Specialty)_____ State_____

License Number _____