

State of Oregon
BOARD OF LICENSED PROFESSIONAL COUNSELORS & THERAPISTS
2016 LICENSE RENEWAL APPLICATION

TOTAL FEE – \$127.00 (includes \$2 Oregon Health Authority survey fee)

OFFICIAL MAILING ADDRESS:

Name: _____

Mailing Address: _____

OFFICIAL EMAIL ADDRESS: Confidential – Check here if you want this to be confidential.

License No: _____ **License Type (LPC or LMFT):** _____ **Birth Date:** _____

- Check the official mailing, primary and additional place(s) of practice, residence and email addresses and correct as necessary.
- If you use a P.O. Box, a physical location address is also needed.
- If you list more than one practice address, the primary place of practice will be used for the directory of licensees and interns.

PRIMARY PLACE OF PRACTICE:

Business Name _____

Street _____

City _____ State _____ Zip _____

Phone _____ Fax _____

ADDITIONAL PRACTICE ADDRESSES: (include additional page(s) if necessary)

Business Name/Address	City/State/Zip	Country	Phone
-----------------------	----------------	---------	-------

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

RESIDENCE ADDRESS: Confidential – Check here if you want your home address to be confidential.

Street _____

City _____ State _____ Zip _____

Phone _____

HEALTH CARE WORKFORCE QUESTIONNAIRE:

Pursuant to ORS 676.410, all licensees must complete the Health Care Workforce Questionnaire at each renewal. You must attest below that you completed the online Questionnaire. The Board will audit for compliance with this requirement. The Questionnaire can be found here:

<https://oregondas.allegiantech.com/cgi-bin/qwebcorporate.dll?idx=A2HG6N>

A link to this survey is provided on the OBLPCT website under “Forms.”

Attestation (Required for Renewal of License):

For this renewal, I have completed the Health Care Workforce Questionnaire. _____ (initial)

Enter the code provided to you upon survey completion: _____

PLEASE ANSWER ALL THE QUESTIONS AND SIGN

Certification: Read and answer the following questions carefully. Attach an explanation for any questions checked “YES”.

Since your most recent application or renewal:

- | | YES | NO |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Have you been the subject of a complaint to a self-regulated professional organization, licensing board or agency? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you received a disciplinary sanction under any professional license or certification? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you voluntarily surrendered a license to practice? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has any professional licensing authority refused to issue, refused to renew, or denied you a license to practice a health care profession? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you been named as a defendant in a lawsuit or other legal action? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you aware of any current, proposed, pending or threatened professional complaints or civil or criminal action against you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any condition that in any way impairs or may impair your capacity to perform the duties of a counselor or marriage and family therapist with reasonable skill and safety? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you been found in any civil, administrative, or criminal proceeding to have possessed, used, or distributed controlled substances or prescription drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you been cited, arrested for, charged with or convicted of the commission of any crime, offense or violation of the law in any state or by the federal government even if those charges were dismissed? | <input type="checkbox"/> | <input type="checkbox"/> |

Race, Ethnicity, and Language Skills (Please check one – this is voluntary, not required)

- American Indian/Alaska Native
- Asian
- Black/African American (not of Hispanic origin)
- Hispanic/Latino
- Native Hawaiian/Other Pacific Islander
- White/Caucasian (not of Hispanic origin)
- Other: _____

Ethnicity: _____
Languages: _____

CUSTODIAN OF RECORD – Please submit the custodian of record form if not previously provided. The Form may be found on the Board’s website at: <http://www.oregon.gov/oblpc>

SWORN STATEMENT:

I swear/affirm that all information on the application for renewal is correct. I am in compliance with the licensing law and rules; and there is no reason for denial of the license renewal. If practicing in Oregon, I affirm that I distribute a PDS (unless I have an exemption) and that all content on the PDS is accurate.

Signature (required)

Date (required)