



# BOARD OF LICENSED PROFESSIONAL COUNSELORS & THERAPISTS

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Oregon.gov/OBLPCT

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## REACTIVATION REQUEST FORM

For inactive licensees requesting to change to active status. Please allow up to 2 weeks to process your request.

Name: \_\_\_\_\_ License #: \_\_\_\_\_

Date you wish to be reactivated: \_\_\_\_\_ -or-  As soon as possible

### **(1) PROFESSIONAL ACTIVITIES:**

Please briefly describe the professional activities you have engaged in (if any) during the time your license has been on inactive status:

### **(2) EXAM REQUIREMENT (if applicable):**

If your date of requested reactivation is more than 5 years from the date your license became inactive, then you will need to complete and submit with this application the Oregon Law and Rules exam.

### **(3) CONTINUING EDUCATION (CE) REPORT:**

Summarize the CE that you have completed within the last 24 months of the date of requested reactivation. Indicate ethics (min. 6), cultural competency (min. 4), and supervision (min. 3 for supervisors) in the training description field. Attach an additional sheet if necessary. Complete CE rules and guidelines can be found at Oregon.gov/OBLPCT. If you are selected for random audit, you will need to provide documentation for CE claimed on this form, and CE completed through the remainder of your period.

Date	Program Title	Training Description	Training Sponsor	Clock Hours

I hereby request reactivation of my license. I understand that: (1) *I am not authorized to provide professional counseling or marriage and family therapy services in Oregon until I receive Board approval of my reactivation;* (2) My CE must comply with the requirements of OAR Chapter 833 Division 80; (3) I must maintain evidence of completion for each program claimed above for at least two years after my next CE reporting period ends; (4) I will be required to complete a prorated amount of CE through the remainder of my CE period; and (5) the Board may request further information or documentation to clarify my request. I swear and affirm by my signature that all information provided in this form is true and correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mail this request, along with your check or money order for \$125 payable to OBLPCT, to the address above.