MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Maryland Board of Professional Counselors and Therapists
4201 Patterson Avenue, Suite 316 * Baltimore, Maryland 21215
410-764-4732 * Fax: 410-358-1610 * www.health.maryland.gov/bopc

LICENSURE/CERTIFICATION REINSTATEMENT FORM

REINSTATMENT FEE:
Certification: $350.00 License: $501.00

FOR BOARD USE ONLY
Date application received _____
Fee enclosed: Yes ☐ No ☐
Check/Money Order # _____

MAKE CHECK OR MONEY ORDER PAYABLE TO: The Board of Professional Counselors and Therapists.

***ATTACH COPIES OF REQUIRED CEUs:**

See COMAR 10.58.05.10 for CEU requirements

***LICENSED BEHAVIOR ANALYSTS ONLY: ATTACH COPY OF VALID BCBA OR BCBA-D CREDENTIAL (NO CEU'S REQUIRED).**

TYPE OR PRINT INFORMATION * MAIL FORM AND FEE TO THE BOARD * INCOMPLETE FORMS WILL BE RETURNED

License/Cert #	Social Security No.			Date of Birth:	
Last Name:		First:		MI:	Maiden:
Home Address:	Street:	City:	County:	State:	Zip Code:
Mailing Address (If different than above	Street:	City:	County:	State:	Zip Code:
Business Address:	Street:	City:	County:	State:	Zip Code:
Home Phone:	Work:	Cell:	Email:		

Race: ☐ Caucasian ☐ African-American ☐ American Indian ☐ Pacific Islander /Asian ☐ Hispanic ☐ Other _____

Sex: ☐ Male ☐ Female | Maryland In State Graduate ☐ Yes ☐ No | Year of Graduation _____

Are you currently licensed/certified in another profession? Yes ☐ No ☐ If yes, indicate profession

Employment Status: ☐ Full-time (35 Hrs. or More) ☐ Part-time ☐ Inactive

Primary Employer:	☐ Private or group practice ☐ State or local government ☐ Federal military ☐ Federal non military ☐ Educational setting ☐ Business/industry ☐ Other (specify) _____
Places of Employment:	☐ Hospital ☐ Nursing Home ☐ Clinic ☐ Practitioner Office ☐ Physician's Office ☐ Rehab Agency ☐ Visiting Nurse ☐ College/University ☐ Federal military ☐ Federal nonmilitary ☐ Other (specify)_____
If inactive, describe reason:	☐ Retired ☐ Student ☐ Unemployed ☐ Career change ☐ Other (specify)_____

List other states or jurisdiction licensed:			
Previous residence since last renewal	Maryland ☐	Out of State ☐	

If seeking employment no. of weeks seeking employment _____

THIS SECTION MUST BE COMPLETED TO REINSTATE LICENSE/CERTIFICATION.

I hereby certify that I have earned the required Continuing Education Units.

Total hours of CEU's earned: _____

LICENSED BEHAVIOR ANALYST ONLY:

BCBA / BCBA-D EXPIRATION DATE: ___/___/____

Today's Date:_____/_____/_____

Signature: _____

ATTACH COPIES OF REQUIRED CONTINUING EDUCATION UNITS (CEU'S) WITH THIS FORM.

COMPLETE THIS SECTION ONLY IF NAME HAS CHANGED. PLEASE PRINT

LAST NAME AND GENERATIONAL INDICATOR (JR., III, ETC)

FIRST NAME AND MIDDLE NAME/INITIAL

COMPLETE THIS SECTION ONLY IF ADDRESS HAS CHANGED. PLEASE PRINT

ADDRESS

CITY STATE ZIP CODE

FOREIGN COUNTRY

THIS SECTION MUST BE COMPLETED TO REACTIVATE LICENSE/CERTIFICATION

Since your last registration: Write Y for YES or N for NO next to each question. PROVIDE A DETAILED EXPLANATION FOR EACH QUESTION YOU ANSWER YES TO.

_____ 1. Have you been addicted to the use of drugs or alcohol with the result that your ability to practice your profession has been impaired?

_____ 2. Has any State Licensing or Disciplinary Board or a comparable body in the Armed Service denied your application for licensure/certification reinstatement or renewal, or taken any action against your license/certification including but not limited to reprimand, suspension, or revocation?

_____ 3. Have you surrendered or failed to renew a license in any State?

_____ 4. Are there any outstanding complaints, investigations, or charges pending against you in any State by any Licensing or Disciplinary Board or a comparable body in the Armed Services?

_____ 5. Have you had a physical or mental illness that currently impairs your ability to practice your profession?

_____ 6. Have you pled guilty, nolo contendere, or been convicted of, or received probation before judgment or any criminal act (excluding traffic violations)?

_____ 7. Have you pled guilty nolo contendere, or been convicted of, or received probation before judgment of driving while intoxicated or of a controlled dangerous substance offence?

_____ 8. Has any hospital or related health care institution or employer denied you privileges or employment, denied any application for privileges or employment, failed to renew your privileges or contract or limited, restricted, suspended, revoked, or terminated your privileges or contract for any reason related to your practice?

_____ 9. Has the conditions of your employment been affected by any termination of employment, suspension, or probation for any reason related to your practice?

_____ 10. Has a malpractice suit been filed against you or has a claim for damages been settled or awarded against you?

I attest that the information I have given on this application are true and correct to the best of my knowledge and belief.

Signature _____ **Date:** _____