MEDICAL LICENSURE GROUP

MENTAL HEALTH PROVIDER ACQUISITION FORM

Please complete this form and return to Admin@MedicalLicensureGroup.com

Contact Information

Name (First Middle Last Suffix) _____ LMHC/LCSW/LMFT _____

Maiden or Previous Names(s) _____

Date of Change _____ Reason for Change _____

Home Address _____ City, State Zip _____

Work Address _____ City, State Zip _____

Home Email _____ Cell Phone _____

Work Email _____ Work Phone _____

Other Contact _____ Home Phone _____

Preferred Contact Method ◯ Work ◯ Cell/Home ◯ Work Email ◯ Home Email

Preferred Mailing Address ◯ Work ◯ Home

Identifying Information

Date of Birth _____ Place of Birth _____

Citizenship Status _____ Eye Color _____

Hair Color _____ Height Ft _____ In _____ Weight _____

Race _____ Social Security Number _____

Gender ◯ Male ◯ Female Naturalization Date (if applicable) _____

U.S Military Service

◯ Yes ◯ No

Branch _____ Rank _____

Dates of Service From _____ To _____

Discharge Status _____ Discharge Date _____

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Education Information

Starting with high school, list in chronological order all schools, colleges, universities attended, whether completed or not.

Name	City/State	Month/Year From-To	Major/Degree

International Graduates

Foreign education programs may require evaluation for CACREP equivalency prior to license issuance.

Supervised Experience

Please list all supervised experience in chronological order, including practicum and internships.

Facility Name	City/State	Month/Year From-To	Hours Completed

Supervising Counselors

Please list the qualified Supervising Counselor(s) who assisted with your Supervised Experience.

Facility Name	Supervisor Name	State License Number	Email/Phone

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Examination History

Indicate which licensing examination you took. (NCMHCE, NCE, ASWB, AMFTRB, etc.)

Examination	Date of Exam	Number of Attempts

Licenses

List ALL states where you hold or have held a license to practice, regardless of the current status.

State	Type	License Number	Issue Date	Expiration Date	Status

Practice History

List in chronological order all professional practice experience including private or group practice, hospital appointments, etc. Explain any unaccounted for periods of time exceeding 30 days.

Facility Name	City/State	Month/Year From-To	Position

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Certifications

Certifying Board	Specialty	Date Certified

Adverse Actions

Attach details for any affirmative answers.

Has a claim for malpractice ever been made against you, regardless of the outcome? ○ Yes ○ No

If yes, how many? _____

Any adverse actions taken against you by a school/university, hospital, licensing board, etc.? ○ Yes ○ No

Been arrested, charged or convicted of a violation of any local, state, or federal statute? ○ Yes ○ No

Note: Failure to report such events could result in processing delays, fines by the board, or denial of license!

Useful Information

Please use the space below to provide any information that will be useful to us during the application process (e.g. - closed facilities, timeline gaps, relocation dates, etc.)

MEDICAL LICENSURE GROUP

MENTAL HEALTH PROVIDER SERVICE AGREEMENT

OFFICE USE ONLY _____

I, _____ (the undersigned), am hiring you (Medical Licensure Group, LLC) to assist me in applying for state medical licensure, registrations, and credentials as specified below (the "Services") or as requested from time to time either verbally or in writing by myself, my employer or representatives. I agree to provide you all information and documents required for you to perform the Services, whether directly or via my employer or representatives. I affirm such information is and will be accurate and complete and such documents will be true, correct, and complete copies. I am aware of, and remain responsible for, the deadlines and eligibility requirements for each license, registration, or credential for which I am applying with your assistance. I agree to pay any fees or other charges required or imposed by the licensing boards to file or process my applications for licensure, registration, or credentials that are the subject of the Services. I acknowledge you have no authority to grant or cause to be granted any licensure, registration, or credential and, therefore, you will not be liable to me or any other person regarding the final outcome of my applications for licensure, registration, or credentials. I further acknowledge that you make no guarantee of any timelines in which any license, registration or credential will be granted. I acknowledge I have read and agree to the additional terms and conditions specified at www.MedicalLicensureGroup.com/terms-and-conditions/.

State Licensure Services

☐ **Initial License or Reinstatement ($700/ea)**
State(s)_____

☐ **Express Processing ($200/ea)**
Accelerated application preparation
State(s): _____
Note: State Medical Boards review applications in date order

☐ **Completion ($550/ea)**
For already-submitted applications
State(s)_____

Other Helpful Services

☐ **License Maintenance & Renewal ($225/ea)**
Renewal of currently-active license
State(s)_____

☐ **Curriculum Vitae Preparation ($95)**

☐ **Portfolio Management ($550)**
Collection and storage of entire professional history

☐ **Portfolio Maintenance ($225/yr)**
Documents reviewed/updated annually

By signing below, I have read and agree to the above statement and terms and conditions.

Signature_____ Date:_____