

STATE OF KANSAS  
BEHAVIORAL SCIENCES REGULATORY BOARD

712 S Kansas Avenue, Topeka, KS 66603-3817  
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[lvawter@ink.org](mailto:lvawter@ink.org)

TRANSITION FROM LICENSED MASTERS LEVEL PSYCHOLOGIST  
TO LICENSED CLINICAL PSYCHOTHERAPIST

(Only printed or typewritten form will be accepted. Fax copies will not be accepted.)

**Information and Instructions:** Thank you for your interest in transitioning from a Licensed Masters Level Psychologist to a Licensed Clinical Psychotherapist. Please complete:

- Section 1: Identifying Information
- Section 2: Clinical Practice Within Last Five Years, and
- The appropriate appendices of Section 3:Licensure Options.

At the time of application, make sure you have all of the needed transcripts or forms returned to you and submit them in their sealed envelopes that have been signed across the seal.

**Note:** If you send in your transition application prior to July 1, 2000 do not send in your transition application fee, you will be asked to send it in at a later time. If you send in your transition application after July 1, 2000 please send in a transition application fee of \$75.00 along with your transition application. Your transition application will be processed and you will be notified of the decision after July 28, 2000 (that is the projected date for rules and regulations to be approved).

**SECTION 1. IDENTIFYING INFORMATION**

NAME TO APPEAR ON LICENSE \_\_\_\_\_ Date \_\_\_\_\_

LIST OTHER NAME(S) USED \_\_\_\_\_ Title: \_\_\_\_\_ Gender \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ LMLP License # \_\_\_\_\_

See below for information \_\_\_\_\_

Mo.	Day	Year
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Expiration Date \_\_\_\_\_

Preferred Mailing Address: Business \_\_\_\_\_ Home \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_  
Street Apt # City State Zip+4

E-MAIL ADDRESS \_\_\_\_\_

BUSINESS PHONE \_\_\_\_\_ EXT. \_\_\_\_\_ FAX \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_  
Street City State Zip+4

SOCIAL SECURITY NUMBER: K.S.A. 74-139 and amendments thereto requires the board to request that applicants provide their social security number. Upon request of the Director of Taxation, the board shall provide to the Director of Taxation a listing of all applicants and licensees, along with such persons' social security number and address. The board may disclose a licensee's social security number and address on expired license lists and may distribute such lists to other agencies such as SPS, Blue Cross/Blue Shield, etc.

**SECTION 2. CLINICAL PRACTICE WITHIN LAST FIVE YEARS**

To be eligible for consideration an applicant must be able to demonstrate that he/she has been actively engaged in the practice of master's level psychology within five years prior to July 1, 2000.

Applicant Name \_\_\_\_\_ Date \_\_\_\_\_

LMLP License # \_\_\_\_\_ Expiration Date \_\_\_\_\_

**Instructions for Applicant:** Please complete the following information and have your supervisor/employer attest that the information is accurate. **Return this form in the signed, sealed envelope at the time of making application.**

<p>Employer: _____</p> <p>Address: _____</p> <p>Employment/Work Dates: From: _____ To: _____</p> <p>Hours Per Week: _____</p> <p>Position Title: _____</p> <p>LMLP Supervisor's Name/Position Title: _____</p>	<p>Work Description:</p>          
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I attest that the foregoing information supplied by the applicant is true to the best of my knowledge and I further attest that I have been personally acquainted with the applicant for \_\_\_\_ years. I believe the applicant to be of good professional character and worthy of confidence. I attest that the applicant [\_\_\_\_did] [\_\_\_\_did not] engage in the practice of masters level psychology while employed or working at the above referenced site.

Name (Print) \_\_\_\_\_

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

Title: \_\_\_\_\_

**Return this completed form as soon as possible to the applicant after first signing along the seal on the back of the sealed envelope.**

**SECTION 3. LICENSURE OPTIONS**

In order for a licensee to transition to the LCP license, there must be provided a demonstration of competence to diagnose and treat mental disorders through **at least two** of the following areas acceptable to the board. Please indicate the areas applicable for your transition and complete the corresponding appendices.

- \_\_\_\_\_ (a) Graduate coursework **or** passing the EPPP exam with a 70 % score (Complete Appendix A);
- \_\_\_\_\_ (b) Three years of clinical practice in a community mental health center, its contracted affiliate or a state mental hospital **or** three years of clinical practice in other settings with demonstrated experience in diagnosing and treating mental disorders (Complete Appendix B); **or**
- \_\_\_\_\_ (c) Attestation from one professional licensed to diagnose and treat mental disorders in independent practice **or** licensed to practice medicine and surgery that the applicant is competent to diagnose and treat mental disorders (Complete Appendix C).

**APPENDIX A.**

REQUIREMENT: Graduate coursework **or** passing a national, clinical examination.

**GRADUATE COURSEWORK**

Applicants must have a minimum of nine transcribed graduate credit hours of coursework addressing clinical theory, assessment, and treatment issues including three credit hours addressing psychopathology. Please request that an **original transcript** be sent to you upon completion of coursework. **The signed, sealed envelope must be submitted to BSRB along with your application.**

Course Number	Course Title	Semester and Year Completed	Credit Hours	University

Total \_\_\_\_\_

**NATIONAL CLINICAL EXAMINATION**

The board is currently using the EPPP exam administered by the Professional Examination Service. If you have previously taken the exam, please arrange for the board's receipt of the official test scores by requesting that the testing company (or the out-of-state credentialing board) send the scores directly to you in an envelope that is signed (or officially stamped) across the sealed envelope. **At the time of making application, submit the test scores in the sealed, signed envelope.**

Have you previously taken the EPPP Examination? \_\_\_\_\_

Location and date exam was taken: \_\_\_\_\_ Score \_\_\_\_\_

**APPLICANT'S ATTESTATION:** I certify the foregoing answers and information furnished above are given in good faith with the understanding that it will be utilized for purposes of determining my eligibility for licensure in the State of Kansas. Any response or information I have provided is true and correct to the best of my knowledge and belief.

\_\_\_\_\_  
Date of Application

\_\_\_\_\_  
Signature of Applicant



APPENDIX C. ATTESTATION OF CLINICAL COMPETENCE TO DIAGNOSE AND TREAT MENTAL DISORDERS

REQUIREMENT: Attestation from one professional licensed to diagnose and treat mental disorders in independent practice or licensed to practice medicine and surgery, that the applicant is competent to diagnose and treat mental disorders. Qualifying professionals include licensed psychologists, licensed specialist clinical social workers, and licensed physicians.

Instructions to Applicant: Please have a qualified individual complete form and return to you. At the time of application, submit this attestation to BSRB in the signed, sealed envelope.

Name of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Referencing Individual (please print)\_\_\_\_\_

Profession of referencing Individual and License Number \_\_\_\_\_

Agency Name and Address \_\_\_\_\_

The above named individual has applied for transition from Licensed Masters Level Psychologist to Licensed Clinical Psychotherapist. The Behavioral Sciences Regulatory Board is asking that you provide a written response attesting to this individual's competency to diagnose and treat mental disorders. Please complete all information requested and return to the applicant in a sealed envelope that has been signed across the seal.

- a) Are you related by blood or marriage to the applicant? If yes, state relationship: \_\_\_\_\_
b) How long have you known the applicant? (please include dates) \_\_\_\_\_
c) In what work setting have you known the applicant (Name of Agency) \_\_\_\_\_
d) What relationship (such as supervisor, co-worker) have you had with the applicant which has aided you in forming any opinion of his/her competence? \_\_\_\_\_
e) Are you aware of any significant facts concerning the applicant's background which would reflect unfavorably on the applicant's character and fitness to practice as a Licensed Clinical Psychotherapist? \_\_\_\_\_ If yes, please state these facts as fully as possible on a separate sheet of paper.
f) In your opinion is the applicant competent to diagnose and treat mental disorders? \_\_\_\_\_
g) What evidence can you provide related to the applicant's competence to diagnose and treat mental disorders? Include amount and length of experience. (Feel free to expand on a separate sheet of paper if needed).

Reference's Attestation: I certify the foregoing answers and information furnished above are given in good faith with the understanding that it will be utilized for purposes of determining the applicant's competence to diagnose and treat mental disorders in the State of Kansas. Any response or information I have provided is true and correct to the best of my knowledge and belief. Where I have relied upon other sources of information, they are only those which I believe to be accurate and reliable.

(Date)

Signature

Return this completed form as soon as possible to the applicant after first signing along the seal on the back of the sealed envelope.