

## Examination Information

Mental Health Practitioner, Marriage and Family Therapy, Professional Counseling and Social Work

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The following provides information relating to the examination process. If you have further questions, please contact Cindy Kelley 402-471-4905 or [cindy.L.kelley@nebraska.gov](mailto:cindy.L.kelley@nebraska.gov)

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### **Application:**

**If you DO NOT currently hold a Nebraska provisional license, please contact our office for additional information.**

The "Examination Registration Application" provides information relating to 3 different examination types:

1. Social Work Examination (MSW Degree)
2. Marriage and Family Therapy Examination (MFT Degree)
3. Counselor Examination (Counseling or Related Degree)

**Step 1:** Complete and submit the attached [Examination Registration Application](#), which can be printed from the mental health Home page under [applications](#): <http://dhhs.ne.gov/Licensure/Pages/Mental-Health-and-Social-Work-Practice.aspx>

This completed application can be FAXED to: 402-742-1106 or e-mailed to [cindy.L.kelley@nebraska.gov](mailto:cindy.L.kelley@nebraska.gov)

**Step 2:** Once your completed registration is received in our office, we will process your examination authorization letter, which you should receive (via email, if provided to us) in about two weeks.

The authorization letter will provide you with instructions on the second part of the registration process, which you'll complete directly with the testing service.

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### **Testing Accommodations:**

Attachment G is required if you're requesting testing accommodations relating to a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing. If requesting accommodations for an [ASWB](#) Examination, you must complete the ASWB accommodation application. You may access their form by conducting an Internet search for: [aswb.org](http://aswb.org) or call them at: (800) 225-6880

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### **Scores:**

After testing, scores will be available to you at the test site. Individuals who successfully pass the examination, will not receive additional confirmation of their passing score from our office. Individuals who do not pass the examination, may re-register by following the same registration process again. Most testing services require a 90-day wait, before retesting. There is no limit on the number of times an individual may test.

**APPLICATION TO TAKE THE EXAMINATION  
 Marriage and Family Therapy, Professional  
 Counselor, or Social Work**

Licensure Unit  
 P.O. Box 94986 - Lincoln, Nebraska 68509-4986  
 Telephone #: 402-471-4905 cindy.L.kelley@nebraska.gov FAX: 402-742-1106

(Print or Type)

<b>SECTION A: PERSONAL INFORMATION</b> (All applicants must complete this section)				
1	Name:	First:	Middle:	Last:
2	Public Address:	PO/Street/Route:		
		City:	State:	Zip:
3	Date of Birth:	Place of Birth:		
4	Telephone #: (Optional)	E-Mail Address: For purpose of examination correspondence		
5	Check the Appropriate Box(s):	Social Security Number (SSN)		
		Alien Registration Number ("A#")		
Neb. Rev. Stat. 38-123 mandates the disclosure of your social security number to DHHS. Although your number is not public information, DHHS may disclose it for child support enforcement purposes and to the Department of Revenue, the Department of Labor and for other Administrative purposes.				
<b>If requesting accommodations, complete, (Attachment 1).</b> This form must be submitted to our office <u>prior</u> to receiving authorization to test. If for <u>ASWB</u> exam, you must complete their form. Search internet for: aswb.org				

<b>SECTION B: EXAMINATION CATEGORY</b>	
Check the appropriate examination you wish to take. An individual whose degree makes him/her eligible for certification as a certified master social worker, a certified professional counselor, or a certified marriage and family therapist, <b>must</b> take and pass the examination their degree qualifies them for. An applicant who does <u>not</u> meet the educational background for one of the certifications previously listed, <u>must</u> take the NBCC/NCE or the NBCC/NCMHCE.	
<p><b>Social Work Examination (MSW Degree):</b> Association of Social Work Boards (ASWB)</p> <p><b><u>The clinical category must be taken if applying for LMHP/LIMHP</u></b></p> <p><input type="checkbox"/> <b>Clinical</b> Category</p> <p><b><u>If applying only for CMSW and NOT LMHP/LIMHP</u></b></p> <p><input type="checkbox"/> <b>Advanced</b> Category</p> <p><input type="checkbox"/> <b>Master's</b> Category</p> <p style="color: red; font-size: small;">For purposes of registering for the Social Work examination, you must print your name on the line below <b>exactly</b> as it appears on your <b>current</b> government-issued photo I.D.</p> <p>Name: _____</p> <p style="font-size: small;">If the above name <b>DOES NOT</b> match the name on any Nebraska credential issued to you by this office, you must contact Cindy Kelley (cindy.L.kelley@nebraska.gov) for further instructions.</p>	<p>All examinations are administered via computerized testing at a specified testing center.</p> <p>Please submit this completed application to our office.</p> <p>In <b>approximately 10 working days</b> you will receive the appropriate 'approval to test letter' from our office. You will then follow the instructions provided to complete your examination registration process.</p> <p><b>DO NOT SUBMIT EXAMINATION FEES TO THIS OFFICE.</b></p>
<input type="checkbox"/> <b>Marriage and Family Therapy Examination (MFT Degree):</b> Association of Marital and Family Therapy Regulatory Boards (AMFTRB)	
<input type="checkbox"/> <b>Counselor Examination (Counseling or Related Degree):</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> National Counselor Examination (NCE)</li> <li><input type="checkbox"/> National Clinical Mental Health Counselor Examination (NCMHCE)</li> </ul>	

**SECTION C: ATTESTATION** All applicants must complete both part of this section

**Attestation:** For the purpose of complying with Neb. Rev. Stat. §§4-108 through 4-114 and 38-129 (check **ONE** of the boxes below):

**I attest that:**

I am a citizen of the United States.

**OR**

I am a qualified alien under the Federal Immigration and Nationality Act.

I am a nonimmigrant lawfully present in the United States.

Check this box if you are **NOT** a citizen of the United States, a nonimmigrant, nor a qualified alien under the Federal Immigration and Nationality Act.

**Application Attestation: I attest that:**

- 1. I have read the application or have had the application read to me; and
- 2. All statements on this application are true and complete.

Print Name: \_\_\_\_\_

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

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

**CONFIDENTIAL INFORMATION**

Department of Health and Human Services  
 Division of Public Health – Licensure Unit  
 P.O. Box 94986 - Lincoln, Nebraska 68509-4986  
 (402)471-4905 [cindy.l.kelley@nebraska.gov](mailto:cindy.l.kelley@nebraska.gov)

**ACCOMMODATION REQUEST FORM  
 MENTAL HEALTH PRACTITIONER EXAMINATION**

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered a confidential record and will not be shared with any outside source without your express written permission, unless release is ordered by a court of competent jurisdiction, or otherwise authorized by law.

Applicant Name	First:	MI:	Last:
ADDRESS	Street/PO/Route:		
	City:	State:	Zip:
Name of Examination			
Telephone No		Date of Examination	
Specify Disability			

**(Check all that apply)**

- Accessible Testing Site
- Braille
- Large print
- Tape
- Reader as accommodation for visual impairment
- Scribe/amanuensis as accommodation for visual or motor impairment
- Reader as accommodation for learning disability
- Scribe/amanuensis as accommodation for learning disability
- Sign Language Interpreter
- Extended Time
  - Time-and-a-half
  - Double time
  - More than double time (specify): \_\_\_\_\_
- Separate testing area
- Use of computer or other adaptive equipment (specify): \_\_\_\_\_
- Other (specify): \_\_\_\_\_

Comments: \_\_\_\_\_

Signed: \_\_\_\_\_

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

**DOCUMENTATION OF DISABILITY RELATED NEEDS**

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

IF YOU HAVE EXISTING DOCUMENTATION OF HAVING THE SAME OR SIMILAR ACCOMMODATION PROVIDED TO YOU IN ANOTHER TEST SITUATION, YOU MAY SUBMIT SUCH DOCUMENTATION INSTEAD OF HAVING THIS PORTION OF THE FORM COMPLETED.

I have known \_\_\_\_\_ since \_\_\_\_\_  
(test applicant) (date)

in my capacity as a \_\_\_\_\_  
(professional title)

The applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, he/she should be accommodated by providing the following: (check all that apply)

- Accessible Testing Site
- Braille
- Large print
- Tape
- Reader as accommodation for visual impairment
- Scribe/amanuensis as accommodation for visual or motor impairment
- Reader as accommodation for learning disability
- Scribe/amanuensis as accommodation for learning disability
- Sign Language Interpreter
- Extended Time
  - Time-and-a-half
  - Double time
  - More than double time (specify): \_\_\_\_\_
- Separate testing area
- Use of computer or other adaptive equipment (specify): \_\_\_\_\_
- Other (specify): \_\_\_\_\_

Comments: \_\_\_\_\_

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

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

Printed Name: \_\_\_\_\_

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

License # (if applicable): \_\_\_\_\_