Regular Mailing Address	Courier Delivery Address
STATE BOARD OF MEDICINE **P.O. BOX 2649** **HARRISBURG, PA 17105-2649** **Email:** st-medicine@pa.gov	**STATE BOARD OF MEDICINE** **2601 NORTH THIRD STREET** **HARRISBURG, PA 17110** **717-783-1400/717-787-2381**

APPLICATION FOR A BEHAVIOR SPECIALIST LICENSE

An application SHOULD NOT be submitted until you have obtained a master's or post master's degree in an approved field or a related field AND have the required Functional Behavior Assessment and clinical experience.

The following 8 items should be submitted by the applicant to the Board at the same time:

1.	Complete pages 1 and 2 of the application and submit to the Board with the appropriate fee.
2.	Submit the $75 fee via check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** Note: A processing fee of $20 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt.
3.	If documents will be submitted to the Board under a name different from your present name, submit a copy of the legal document evidencing the name change (i.e., marriage license, divorce decree, naturalization, etc.).
4.	**ALL APPLICANTS** must provide an official notification of information (Self Query) from the National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank. Please refer to the NPDB-HIPDB website for additional information. **When you receive the "Response to your Self Query," forward the entire report directly to the Board Office.** You should make a copy for your records.
5.	**CURRICULUM VITAE/RESUME** – Attach a current Curriculum Vitae listing **all** periods of employment or unemployment (i.e., child rearing, etc.) from graduation from college/university (undergraduate) to present. The list must be in chronological order, include the month and year, and indicate the state/territory in which the employment occurred.
	IMPORTANT INFORMATION REGARDING BACKGROUND CHECKS –To expedite the application process, all three clearance/criminal background checks should be submitted with the application for licensure. If any of the background checks are more than 90 days old and your all of the supporting documentation for your application has not been received, you will be required to obtain current/new clearance/criminal background documentation before your license can be issued. For more information, please refer to Numbers 6, 7 and 8 below.
6.	A Criminal History Record Information Report (CHRI) from the state where the applicant currently resides and/or any state where the applicant has resided within the last 10 years must be completed by the State Police for all states where you have resided in the last 10 years and submitted to the Board. The report(s) should be submitted with the initial application for licensure. **If the report(s) become more than 90 days old and the application is not complete, you will be required to provide a current/updated Criminal History Record Information Report(s)**. • The CHRI must contain the applicant's **date of birth and/or social security number**. • The CHRI must either state "No Record" or "Record Exists." Background checks that reflect "Pending", "Under Review", or "Under Request" cannot be submitted. • Questions regarding the status of a CHRI must be directed to the State Police. • If "Records Exist", submit **originals** of the following for **EACH** conviction: a) The conviction summary information provided by the State Police; b) Certified copies of court documents; c) Letter from Probation Officer, dated within 90 days, indicating current probationary status/completion date; d) Police reports; e) Detailed description (in applicant's words) of the circumstances surrounding the conviction, the basis for the conviction and the disposition of the conviction. • Pennsylvania background checks may be obtained from the Pennsylvania State Police Central Repository, 1800 Elmerton Avenue, Harrisburg, PA 17110-9785.
7.	Contact the Pennsylvania Department of Public Welfare, Child Line and request a Child Abuse History Clearance be completed. The report(s) should be submitted with the initial application for licensure. **If the report(s) become more than 90 days old and the application is not complete, you will be required to provide a current/updated Child Abuse History Clearance report(s)**. **PLEASE NOTE: VOID/UNACCEPTABLE IF COPIED-Originals will NOT be returned.** • The Pennsylvania Child Abuse History Clearance Form (CY 113) is available on the Department of Public Welfare website. • Questions regarding the status of a request for Child Abuse Clearance must be directed to the Department of Public Welfare.

8.	Contact the Federal Bureau of Investigation (FBI) through their website at http://www.fbi.gov/about-us/cjis/background-checks/submitting-an-identification-record-request-to-the-fbi to obtain an FBI Criminal Background Check. You should follow the steps outlined on this website to obtain the report(s). The report(s) should be submitted with the initial application for licensure. **If the report(s) become more than 90 days old and the application is not complete, you will be required to provide a current/updated FBI Report(s)**. **PLEASE NOTE: VOID/UNACCEPTABLE IF COPIED- Originals will NOT be returned.** • The processing time for obtaining a request from the FBI could be as long as 8 weeks. • Questions regarding the FBI Criminal Background Check process must be directed to the FBI. • If COGENT is used to obtain a set of your fingerprints, visit http://www.pa.cogentid.com/index.htm and register through the **Department of Public Welfare only.**
The following items may come from multiple sources and can be submitted separately as they become available:	
9.	**VERIFICATION OF MASTER'S (or Higher) DEGREE OR POST MASTER'S CERTIFICATE – Form 2** – Complete Section 1 of the Verification of Education form and forward to your college/university for completion of Section 2 (Forms 5 and 6 may also be needed). • The verification form and an official school transcript must be sent to the Board. • The transcript and verification form must verify the completion of a master's degree or higher from an accredited college/university and include a major course of study in school, clinical, developmental or counseling psychology, special education, social work, speech therapy, occupational therapy, professional counseling, behavioral analysis, nursing or another related field. • **The verification form(s) must be completed and returned, along with an official school transcript, directly to the Board by the college/university in an official school envelope.**
10.	**VERIFICATION OF FUNCTIONAL BEHAVIOR ASSESSMENT EXPERIENCE** – **Form 3** – Complete Section 1 of the Verification of Behavior Assessment Experience form and forward it to your previous/current employer or clinical supervisor for completion of Section 2. • The form must verify the completion of at least 1 (one) year of experience involving functional behavior assessments of individuals under 21 years of age, including the development and implementation of behavioral supports or treatment plans. • **The verification form must be completed by the applicant's employer or clinical supervisor and returned directly to the Board from the employer or supervisor in a sealed envelope.** • If more than one employer or supervisor, please make copies of the form and distribute, as necessary.
11.	**VERIFICATION OF CLINICAL/IN-PERSON EXPERIENCE** – **Form 4** – Complete Section 1 of the Verification of Clinical Experience form and forward to your previous/current employer or clinical supervisor for completion of Section 2. • The employer or supervisor must verify completion of at least 1,000 hours of in-person experience with individuals under 21 years of age with behavioral challenges or autism spectrum disorders. • **The verification form must be completed and returned directly to the Board from the employer or clinical supervisor in a sealed envelope.** • If more than one employer or supervisor, please make copies of the form and distribute, as necessary.
12.	**VERIFICATION OF 90 HOURS OF EVIDENCE-BASED COURSEWORK** – **Form 5** – **(IF APPLICABLE: See Form 2 for details)** – Complete Section 1 of the Verification of Evidence-Based Coursework form. • For university coursework, forward to the school for completion of Section 2A. **The verification form must be returned directly to the Board in a sealed envelope.** • For BACB continuing education or BAS-approved trainings, the applicant should complete section 2B. **The verification form and supplemental documentation verifying completion of approved trainings can be returned to the Board by the applicant.**
13.	**VERIFICATION THAT MASTER'S DEGREE/POST MASTER'S CERTIFICATE AWARDED IS A RELATED FIELD** – **Form 6** – **(IF APPLICABLE: See Form 2 for details)** – Complete Section 1 of Form 6 and submit it to your school, university or program to verify that you obtained a master's degree/post master's certificate in a related field. **The verification form must be completed and returned directly to the Board in an official school envelope.** **DO NOT** submit an application until you have obtained, or a university is able to verify, that you have completed a master's or post master's degree in one of the approved fields or a related field.
14.	**VERIFICATION OF LICENSURE** – Contact the state board office(s) where you hold or ever held licensure/certification to practice as a health care professional and request letters of good standing. The verification letter must include the following: license issue and expiration date, license status (current or expired) and disciplinary standing. The letter(s) of good standing must be sent directly to the Pennsylvania Board from each state board office in an official board envelope.

PLEASE NOTE – If this application is not completed within six months, updates of certain sections and/or supporting documents will be required. If the application has not been completed within one year from the date it was received, applicants will be required to submit a new application (with another application processing fee) and supporting documents, as necessary. This six month period does not include the criminal background checks. These documents are only valid for 90 days from the date of issue. For more information, please refer to Numbers 6, 7 and 8 above. Training documentation does not expire and will not need to be resubmitted.

(March 1, 2013)

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APPLICATION FOR A BEHAVIOR SPECIALIST LICENSE

Form 1

Submit the $75 fee via check or money order, made payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE.** Note: A processing fee of $20 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt.

APPLICANT INFORMATION
(Please Print or Type)

NAME:	Last		First		Middle						
ADDRESS*:	Street										
City			State		ZIP						
DATE OF BIRTH:	Month	Day	Year	**SOCIAL SECURITY NUMBER:**							
TELEPHONE NUMBER:											
EMAIL ADDRESS:											

If your supporting documents are listed under another name or names, please list below:

Last First Middle

NAME OF MASTER'S DEGREE, POST MASTER'S CERTIFICATE OR OTHER PROGRAM:													
NAME OF SCHOOL:													
ADDRESS OF SCHOOL:	Street												
City			State					ZIP					
DATES OF ATTENDANCE:	**FROM**	**Month**	**Day**	**Year**	**TO**	**Month**	**Day**	**Year**	**DATE OF GRADUATION:**	Month	Day	Year	

* All correspondence and the license/registration will be mailed to this address unless the Board is officially notified of an address change.

LEGAL QUESTIONS

YOU MUST ANSWER THE FOLLOWING QUESTIONS.

If you answer "YES" to #2 through #7, provide complete details on a separate sheet of paper as well as certified copies of relevant documents. **Sign and date below**.

		Yes	No
1.	Do you hold or have you ever held a license, certification or registration (active or inactive, current or expired) to practice in ANY health-care profession in any jurisdiction, state, territory or country? **If yes, list the jurisdiction(s) and type of license, certification or registration here:**		
2.	Have you ever withdrawn an application for a license, certificate or registration, had an application for a license denied or refused, or for any disciplinary reason agreed not to reapply for a license, certificate or registration in ANY profession in any jurisdiction, state, territory or country?		
3.	Have you ever had disciplinary action taken against your license, certificate or registration issued to you in ANY profession in any jurisdiction, state, territory or country?		
4.	Have you ever been convicted, found guilty or entered a plea of nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in ANY jurisdiction, state, territory or country? **You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.**		
5.	Have you ever had practice privileges denied, revoked or restricted in a hospital or other health care facility? Have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
6.	Have you ever had your provider privileges terminated by any medical assistance agency for cause?		
7.	Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? **Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of any Pennsylvania Department of State Professional Health Monitoring Program.**		

SIGNED STATEMENT

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

_____ _____

Signature of Applicant Date

_____

Printed Name of Applicant

(March 1, 2013)

VERIFICATION OF EDUCATION – Form 2

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle
NAME OF COLLEGE/UNIVERSITY:			
ADDRESS:	City	State	ZIP

Request that the college/university submit an official transcript and that the transcript be sent directly to the board in an official school envelope from the college/university or their authorized agent.

SECTION 2 – TO BE COMPLETED BY THE UNIVERSITY'S AUTHORIZED AGENT

NAME OF DEGREE PROGRAM:			
MAJOR COURSE OF STUDY:	☐ **Behavioral Analysis**	☐ **Special Education**	☐ **Speech Therapy**
☐ **Psychology**: (School; Clinical; Counseling or Developmental)	☐ **Professional Counseling**	☐ **Social Work**	☐ **Occupational Therapy**
☐ **Nursing Specialty**_____	☐ Another Related Field (List Specific Field): _____ ***If this box is checked, the university agent must sign below and complete and submit Form 6.***		

NAME OF STUDENT:	Last		First	Middle			
DATE STUDENT BEGAN TO ATTEND THIS PROGRAM:	Month	Day	Year	**DATE OF GRADUATION:**	Month	Day	Year

CHOOSE ONLY ONE OPTION BELOW

Option 1 ☐ **I CERTIFY THAT THE APPLICANT COMPLTED A MASTER'S DEGREE OR POST MASTER'S CERTIFICATE PROGRAM IN THE AREA INDICATED ABOVE WHICH INCLUDED ALL 90 HOURS OF EVIDENCE-BASED COURSEWORK LISTED BELOW:**

- **3 HOURS OF PROFESSIONAL ETHICS**
- **16 HOURS OF ASSESSMENT COURSEWORK OR TRAINING**
- **8 HOURS OF CRISIS INTERVENTION**
- **5 HOURS OF FAMILY COLLABORATION**
- **18 HOURS OF AUTISM-SPECIFIC COURSEWORK/TRAINING**
- **16 HOURS OF INSTRUCTIONAL STRATEGIES & BEST PRACTICES**
- **8 HOURS OF CO-MORBIDITY & MEDICATIONS**
- **16 HOURS OF ADDRESSING SPECIFIC SKILL DEFICITS TRAINING**

This coursework may be in-person instruction-led or online distance education and does not need to be autism-specific—unless noted.

Option 2 ☐ **I CERTIFY THAT THE APPLICANT COMPLETED A MASTER'S DEGREE OR POST MASTER'S CERTIFCATE PROGRAM IN THE AREA INDICATED ABOVE.** ***The program included some, but not all, of the 90 hours of evidence-based coursework in the content areas listed above.***

IF THIS BOX IS CHECKED, A UNIVERSITY AGENT SHOULD ALSO COMPLETE AND SUBMIT FORM 5 (VERIFICATION OF EVIDENCE-BASED COURSEWORK) TO DOCUMENT THOSE COURSES/HOURS THAT WERE FULFILLED THROUGH THE GRADUATE PROGRAM.

Option 3 ☐ **I CERTIFY THAT THE APPLICANT COMPLETED A MASTER'S DEGREE OR POST MASTER'S DEGREE CERTIFICATE PROGRAM IN THE AREA INDICATED ABOVE.** ***However, the program did not include any of the 90 hours of evidence-based coursework in the content areas listed above.***

SIGNATURE OF UNIVERSITY AGENT:				
DATE:	Month	Day	Year	Upon completion, the school must return the form(s) and transcripts directly to the Pennsylvania State Board of Medicine in an official school envelope.
Seal of college/university) *(If the college/university does not have a seal, please submit a letter signed by the university agent attesting to that.)*				***DO NOT RETURN THIS FORM TO THE APPLICANT***

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(March 1, 2013)

PENNSYLVANIA STATE BOARD OF MEDICINE

VERIFICATION OF ONE YEAR OF FUNCTIONAL BEHAVIOR ASSESSMENT EXPERIENCE – Form 3

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME OF APPLICANT:	Last	First	Middle

Submit the verification of functional behavior assessment experience form to your employer or clinical supervisor to verify that the above-named applicant has completed one year of experience involving functional behavior assessments of individuals under 21 years of age, including the development and implementation of behavioral supports or treatment plans. The employer/supervisor must complete the form indicating the number of months they can attest to being performed under their direction/supervision. The supervisor MUST return the completed form directly to the Board. If more than one employer/supervisor, make a copy of the verification of functional behavior assessment experience form and have each employer/supervisor complete and submit a verification form.

SECTION 2 – TO BE COMPLETED BY A PREVIOUS OR CURRENT SUPERVISOR(S) QUALIFIED TO VERIFY COMPLETION OF ONE FULL YEAR OF EXPERIENCE INVOLVING FUNCTIONAL BEHAVIOR ASSESSMENT EXPERIENCE

NAME OF EMPLOYER or SUPERVISOR:	Last	First	Middle

ADDRESS:	Street		
City		State	ZIP

CERTIFICATION/LICENSE #		PROFESSION:		STATE:	

NUMBER OF MONTHS OF FUNCTIONAL BEHAVIOR ASSESSMENT EXPERIENCE THE ABOVE-NAMED INDIVIDUAL COMPLETED UNDER MY SUPERVISION/DIRECTION:	# Months	From (MM/DD/YYYY)	To (MM/DD/YYYY)

I CERTIFY THAT THE INDIVIDUAL REQUESTING LICENSURE AS A BEHAVIOR SPECIALIST AND LISTED IN SECTION 1 ABOVE HAS COMPLETED THE NUMBER OF MONTHS OF EXPERIENCE AS LISTED ABOVE INVOLVING FUNCTIONAL BEHAVIOR ASSESSMENTS OF INDIVIDUALS UNDER 21 YEARS OF AGE, INCLUDING THE DEVELOPMENT AND IMPLEMENTATION OF BEHAVIORAL SUPPORTS OR TREATMENT PLANS.

SIGNATURE OF EMPLOYER or SUPERVISOR:				
DATE:	Month	Day	Year	Upon completion, please return this completed form directly to the Pennsylvania State Board of Medicine.
				DO NOT RETURN THIS FORM TO THE APPLICANT

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(March 1, 2013)

PENNSYLVANIA STATE BOARD OF MEDICINE

VERIFICATION OF CLINICAL/IN-PERSON EXPERIENCE – Form 4

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME OF APPLICANT:	Last	First	Middle

Submit the verification of clinical experience form to your previous or current employer/supervisor(s) and request they return the completed form directly to the board. If more than one supervisor, make a copy of the verification of clinical/in-person experience form and have each supervisor complete and submit a verification form.

SECTION 2 – TO BE COMPLETED BY THE PREVIOUS OR CURRENT EMPLOYER/SUPERVISOR(S) OF 1,000 HOURS OF CLINICAL/IN-PERSON EXPERIENCE

NAME OF EMPLOYER or SUPERVISOR:	Last	First	Middle

ADDRESS:	Street

City	State	ZIP

CERTIFICATION or LICENSE #		PROFESSION:		STATE:	

NUMBER OF HOURS OF CLINICAL/IN-PERSON EXPERIENCE COMPLETED UNDER MY SUPERVISION:	

I CERTIFY THAT THE INDIVIDUAL REQUESTING LICENSURE AS A BEHAVIOR SPECIALIST AND LISTED IN SECTION 1 ABOVE HAS COMPLETED THE NUMBER OF HOURS OF CLINICAL/IN-PERSON EXPERIENCE AS LISTED ABOVE WITH INDIVIDUALS UNDER 21 YEARS OF AGE WITH BEHAVIORAL CHALLENGES OR AUTISM SPECTRUM DISORDERS.

SIGNATURE OF EMPLOYER or SUPERVISOR:				
DATE:	Month	Day	Year	Upon completion, please return this completed form directly to the Pennsylvania State Board of Medicine.

DO NOT RETURN THIS FORM TO THE APPLICANT

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(March 1, 2013)

VERIFICATION OF 90 HOURS OF EVIDENCE-BASED COURSEWORK

Form 5

USE THIS FORM ONLY IF YOUR UNIVERSITY CANNOT VERIFY THAT YOUR DEGREE PROGRAM INCLUDED ALL 90 HOURS OF THE COURSEWORK LISTED IN SECTION 2 OF FORM 2.

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle

NAME OF COLLEGE/UNIVERSITY or TRAINING PROGRAM: (check all that apply)	☐ College/University:_____ ☐ BACB Continuing Education ☐ BAS-Approved Training
ADDRESS OF COLLEGE/UNIVERSITY: (if applicable)	Street

City	State	ZIP

Every application must include verification that ALL 90 hours of evidence-based coursework have been completed. These hours can be completed through an accredited college or university; training approved by the BACB or the Bureau of Autism Services; or a combination of these options. The 90 hours must be fulfilled in the following areas:

- **3 hours of professional ethics**
- **8 hours of autism-specific coursework or training**
- **16 hours of assessments coursework or training**
- **16 hours of instructional strategies and best practices**
- **8 hours of crisis intervention**
- **8 hours of co-morbidity and medications**
- **5 hours of family collaboration**
- **16 hours of addressing specific skill deficits training**

You must submit verifications to comply with all of coursework required. The verification of evidence-based coursework requirement for licensure WILL NOT be considered complete until all 90 hours of the required coursework have been verified. If you completed one or more of these requirements through different schools/continuing education programs, you will need to make a copy of Form 5 for each program and submit the forms following the instructions provided below.

PLEASE NOTE: THE BOARD OF MEDICINE DOES NOT EVALUATE COURSEWORK OR TRAININGS. ONLY SUBMIT SUPPORTING DOCUMENTATION THAT COMPLIES WITH THE PROCEDURES BELOW.

SECTION 2A: PROCEDURES FOR DOCUMENTING UNIVERSITY/COLLEGE COURSEWORK (if applicable)

Applicants should submit this form to the college/university where the coursework was completed. The education provider should return this completed form, along with the completed Form 2 and an official transcript, directly to the Board of Medicine in an official school/program envelope.

This coursework may be in-person instruction-led or online distance education. The university/college should verify ONLY the specific hours/coursework completed through their program.

SECTION 2B: PROCEDURES FOR DOCUMENTING BACB CONTINUING EDUCATION OR BAS-APPROVED TRAININGS (if applicable)

If submitting proof of coursework completed through BACB continuing education or BAS approved trainings, the applicant should complete and sign this form and return it directly to the Board of Medicine with all supporting documentation. The documentation of attendance/training completion MUST list the content area(s) and hours completed and include a trainer's signature. For BAS-approved trainings, submitted documentation should also include the BAS approval statement and course number.

(March 1, 2013)

Name of Applicant:	Last	First	Middle

SECTION 2A – TO BE COMPLETED BY A UNIVERSITY AGENT TO DOCUMENT THAT THE DEGREE OR CERTIFICATE PROGRMA INCLUDED AT LEAST THE NUMBER OF HOURS LISTED IN EACH CONTENT AREA

Indicate the number of hours for each content area that were completed through the college/university coursework.

☐	**Professional Ethics (3 hours required)**	☐	**Autism-Specific (18 hours required)**	☐	**Assessments (16 hours required)**	☐	**Crisis Intervention (8 hours required)**
☐	**Family Collaboration (5 hours required)**	☐	**Instructional Strategies & Best Practices (16 hours required)**	☐	**Co-Morbidity & Medications (8 hours required)**	☐	**Addressing Specific Skill Deficits (16 hours required)**

I CERTIFY THAT THE INDIVIDUAL LISTED ABOVE AND IN SECTION 1 OF THIS VERIFICATION OF EVIDENCE-BASED COURSEWORK FORM HAS COMPLETED THE REQUIRED HOURS IN THE CATEGORIES CHECKED ABOVE.

NAME OF UNIVERSITY AGENT (Print)	
SIGNATURE OF UNIVERSITY AGENT	
DATE: Month / Day / Year	Upon completion, the school must return the form(s) and transcripts directly to the Pennsylvania State Board of Medicine in an official school envelope.
Seal of college or university *(If the college/university does not have a seal, please submit a letter signed by the university agent attesting to that.)*	***DO NOT RETURN THIS FORM TO THE APPLICANT***

SECTION 2B – TO BE COMPLETED BY THE APPLICANT TO DOCUMENT SUPPLEMENTAL TRAININGS

Indicate the number of hours in each content area for which supplemental documentation is attached. If you are not submitting any hours toward a content area, leave that box blank.

APPLICANT TIP: Staple all documentation for a single content area together. You can also submit a summary cover sheet if you are submitting multiple trainings within multiple content areas for BACB or BAS coursework.

☐	**Professional Ethics (3 hours required) Total # of hours:** _____	☐	**Autism-Specific (18 hours required) Total # of hours:** _____	☐	**Assessments (16 hours required) Total # of hours:** _____	☐	**Crisis Intervention (8 hours required) Total # of hours:** _____
☐	**Family Collaboration (5 hours required) Total # of hours:** _____	☐	**Instructional Strategies & Best Practices (16 hours required) Total # of hours:** _____	☐	**Co-Morbidity & Medications (8 hours required) Total # of hours:** _____	☐	**Addressing Specific Skill Deficits (16 hours required) Total # of hours:** _____

I VERIFY THAT I HAVE COMPLETED IN FULL THE SUPPLEMENTAL TRAININGS INDICATED ABOVE, AND THAT THE COURSEWORK HAS BEEN APPROVED BY THE BACB OR BAS.

SIGNATURE OF APPLICANT (Print)	
DATE: Month / Day / Year	☐ **Additional information will be submitted by a college/university**

Return this form to the Board of Medicine with any required documentation.

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(March 1, 2013)

VERIFICATION THAT MASTER'S DEGEE/POST MASTER'S CERTIFICATE AWARDED IS A RELATED FIELD – Form 6

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME OF APPLICANT:	Last	First	Middle

Submit this form to your school, university or program to verify that you completed master's degree or post master's certificate in a field related to school, clinical, developmental or counseling psychology; special education; social work; speech therapy; occupational therapy; professional counseling; behavioral analysis or nursing. The school, university or program must complete the form indicating substantial relationship of your major to the practice of a behavior specialist. The school, university or program MUST return the completed form directly to the Board.

SECTION 2 – TO BE COMPLETED BY THE SCHOOL, UNIVERSITY OR PROGRAM WHERE YOU COMPLETED YOUR MAJOR

Check Box

☐ **I CERTIFY THAT THE INDIVIDUAL REQUESTING LICENSURE AS A BEHAVIOR SPECIALIST AND LISTED IN SECTION 1 ABOVE HAS COMPLETED a master's or doctoral degree program, or post-master's certificate program. The degree or certificate was not awarded in one of the following fields: school, clinical, developmental or counseling psychology; special education; social work; speech therapy; occupational therapy; professional counseling; behavioral analysis or nursing. However, the degree or certificate was awarded in a related field.**

_____

Name of Degree/Certificate Awarded

IN ADDITION TO FORM 6 , APPLICANTS WITH A MAJOR COURSE OF STUDY NOT LISTED IN FORM 2, (VERIFICATION OF EDUCATION) ARE REQURIED TO SUBMIT VERIFICATION OF 90 HOURS OF EVIDENCED-BASED COURSEWORK EITHER THROUGH A COMPLETED SECTION 2 OF FORM 2 OR THROUGH FORM 5

NAME OF COLLEGE/UNIVERSITY:			
ADDRESS:	Street		
City		State	ZIP
NAME OF UNIVERSITY AGENT: (Print)	Last	First	Middle

SIGNATURE OF UNIVERSITY AGENT:			
DATE:	Month	Day	Year

Seal of college or university
(If the college/university does not have a seal, please submit a letter signed by the university agent attesting to that.)

Upon completion, the school must return the form(s) and transcripts directly to the Pennsylvania State Board of Medicine in an official school envelope.

DO NOT RETURN THIS FORM TO THE APPLICANT

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