

Complete application for Certification or Licensure

After completing the parts of this application that pertain to the certification or license for which you are applying, mail complete application to:

***Florida Association of Christian Counselors and Therapists
Dr. Bryan “Buddy” Morrow, Jr.
Licensure Board Chairman
2603 SW Brim St.
Lake City, FL 32024***

***Telephone: 386-963-4495
Email: BBMorrow@FACCCA.com***

FLORIDA ASSOCIATION OF CHRISTIAN COUNSELORS AND THERAPISTS

APPLICATION FOR LICENSURE OR CERTIFICATION

AS A CHRISTIAN COUNSELOR AND THERAPIST
(Please type or print)

Where the space provided is not sufficient, attach additional sheets. A resume is not an acceptable substitution for the completion of any question on this application. Submit this application and the appropriate application fee from the fee schedule (non-refundable) for each license. Applications not correctly completed will be returned for corrections.

License Applied for: Please select 1st and 2nd choices and mark them accordingly

- Certified Christian Counselor** (CCC)
A lay person who is working in a counseling or mental health field.
- Clinical Temperament Therapist** (CTT)
A person who is in the process of Temperament training.
- Licensed Clinical Temperament Therapist** (LCTT)
A person who has completed temperament training, internship, and supervision.
- Certified Pastoral Counselor** (CPC)
A Minister who practices in the area of counseling.
- Licensed Pastoral Counselor** (LCP)
A Minister who holds a Bachelor degree and has completed an internship under recognized supervision in Pastoral counseling.
- Certified Clinical Christian Therapist** (CCCT)
A person who is seeking a Masters degree in the mental health field under the supervision of a FACCT approved supervisor.
- Licensed Clinical Christian Therapist** (LCCT)
A person who holds a Masters degree having completed practicum, internship, and supervision.
- Certified Christian Social Worker** (CCSW)
A person working towards a M.S.W. degree from an accredited college or university.

- Licensed Clinical Christian Social Worker (LCCSW)**
A person who holds a M.S.W. degree from a CSWE accredited college or university.
- Certified Christian Marriage and Family Therapist (CCMFT)**
A person who is seeking a Masters degree in the mental health field under the supervision of a FACCT approved supervisor.
- Licensed Christian Marriage and Family Therapist (LCMFT)**
A person who holds a Masters degree having completed practicum, internship, and supervision.
- Licensed Clinical Christian Psychologist (LCCP) or (CPY) for Ph.D.'s**
A person who holds a Ph.D. in Psychology (or related discipline) with completed internship and supervision.
- Board Certified Supervisor (BCS)**
A person who holds a FACCT license or the equivalent.
- Board Certified Instructor (BCI)**
A FACCT member qualified in specific areas.

PLEASE READ. THIS IS IMPORTANT TO MEET QUALIFICATIONS!

- Masters level and above applicants currently licensed by the state of Florida in Mental Health Disciplines may transfer license after meeting the theological criteria.
- All Certification and Licensure applicants must be licensed or ordained by a recognized ecclesiastical body or under the direct supervision of said Ministries.
- All Licensure requires a minimum of thirty (30) credit hours of Biblical Studies or equivalent approved by FACCT.

Manner of Licensure: Check one

- By Examination
- By Reciprocity
- By Grandfather Clause (To June 30, 2015)

I. Personal Information

1. Name (Dr. Rev. Mr. Mrs. Ms.) _____ Membership Number _____
2. Address _____
City _____ State _____ Zip _____
3. Telephone Number (Home) (_____) Work (_____)
4. Date of Birth _____ Place _____
5. Social Security Number ____-__-____.
6. Have you ever served on active duty in the Armed Forces, the Reserves, or the National Guard during wartime or during a conflict when military personnel were committed by the president?
Yes No
If yes, you may be eligible for Veteran's preference points to be added to your license examination score. Fill out the Veteran's preference form included with this package.
7. At any time have you held a license in any jurisdiction as a Professional Counselor, Marriage and Family Therapist, Social Worker, Pastoral Counselor, Christian Counselor and/or Therapist, or Temperament Therapist? Yes No

If yes, complete the following:

License Title _____
Jurisdiction _____ License Number _____
Date Issued _____ Expiration Date _____

8. If you have ever held a license per-above (#7), complete the following items. If yes is checked on any item, enclose an explanation and a copy of the order, decree, or other relevant documents.

A. Have you ever had a license revoked, suspended, or annulled?

Yes No

B. Have you ever had any disciplinary action taken against you by the authority issuing the license?

Yes No

C. Have you ever been refused renewal of a license pursuant to disciplinary proceedings?

Yes No

9. Have you ever been denied Licensure pursuant to disciplinary proceedings?

Yes No

If yes, explain and attach the final deposition. (Up to 3 lines)

10. Have you been a defendant in a malpractice suit and either entered into a settlement agreement or paid court awarded damages?

Yes No

If yes, please explain and attach relevant legal documents. (Up to 3 lines)

11. Have you ever been convicted of any felony or any crime involving moral turpitude?

Yes No

If yes, explain and attach the final decree. (Up to 3 lines)

II. Licensure By Reciprocity:

12. If you are applying for License by reciprocity:

Direct the board of Examiners to those jurisdictions in which Licensure is held to complete a reciprocity Information/Verification Form and return it directly to the Board office -and- enclose with the application a copy of those jurisdictions, any relevant Licensing laws and Board rules.

13. List all licenses as a professional Christian Counselor and / or Therapist, and any Professional license which you currently hold.

License Title _____

Jurisdiction _____ License Number _____

Date of License _____ Expiration Date _____

License Title _____

Jurisdiction _____ License Number _____

Date of License _____ Expiration Date _____

PROCEDURE FOR APPLICANTS APPLYING FOR LICENSURE BY RECIPROCITY

The following requirements for Licensure by Examination Waiver (Endorsement) must be met.

1. The applicant must hold a current License as a professional Counselor or Therapist in another State or Jurisdiction. In order to be considered for Licensure as a Christian Counselor and Therapist by Endorsement from the Board of Examiners of the Florida Association of Christian Counselors and Therapists.
2. The Board which issued that License in the other State must have met requirements for Licensure which are substantially equal to those of Florida FACCT.

*** Please note:**

The Board has not had an opportunity to review the licensing requirements in all states or with other licensing organizations. It will do so on a case-by-case basis, only after it receives an application for a person who is currently licensed in a given jurisdiction.

Application for Licensure by reciprocity will proceed as follows:

1. The applicant must submit to the Board:
 - A. The application for Licensure
 - B. A non-refundable application fee (see fee schedule)
 - C. Copies of the current law or rules from each State in which the applicant is licensed as a Counselor and Therapist or licensing organization.

2. The applicant must send a separate Endorsement Information/Verification Form to the Board of each State in which he or she is licensed. This form is returned directly to the Board of Examiners of FACCT.

3. The Board of Examiners of F. A.C.C.T. will review the application for Licensure and all Endorsement/Verification Forms to determine whether the candidate is qualified for Licensure.

4. The Board of Examiners will then review the Licensure requirements of the State to determine if they are substantially equal to those of the FACCT.

*** Please note:**

The Board will only review complete applications. All documents must be received prior to presentation to the Board. The application must be complete within one (1) year after submission to the Board.

RECIPROCITY INFORMATION / VERIFICATION FORM

(Please copy for additional forms)

Mail this form to the Board of each State in which you currently hold a License as a professional Christian Counselor and Therapist.

TO BE COMPLETED BY THE APPLICANT:

To whom it may concern:

I am applying for a license to be issued by the Board of Examiners of the Florida Association of Christian Counselors and Therapists, and hereby give consent to the release of any information, favorable or otherwise, you may have concerning my License or Practice. Please return the completed form directly to the Board of Examiners of the Florida Association of Christian Counselors and Therapists, the address is listed below:

Florida Association of Christian Counselors and Therapists

Dr. Bryan "Buddy" Morrow, Jr.

Licensure Board Chairman

2603 SW Brim St.

Lake City, FL 32024

Telephone: 386-963-4495

Email: BBMorrow@FACCCA.com

Applicants Signature _____ Date _____

Print Full Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Social Security Number ____-____-____

Description of License held in other jurisdictions:

Jurisdiction _____ License Number _____

Title of License _____

Date Issued _____ Expiration Date _____

TO BE COMPLETED BY THE BOARD OR REGULATORY AGENCY:

Does the information above agree with your records?

Yes No

If no, please give an explanation. _____

TO BE COMPLETED BY THE BOARD OR REGULATORY AGENCY:

I, _____ Board Chair or Designated Official of
the _____ Board,
certify that _____ was
granted a professional License, that License number being _____
on this _____ day of _____ (Year) _____
and that said Certificate (s) / License (s) have never been revoked and have been renewed for
the year ending on the _____ day of _____ (Year) _____.

Do you consider the applicant to be in good standing at this time?

Yes No If no, please give explanation.

According to your records, has the applicant ever been disciplined by the Board, any State agency, or by any professional organization?

Yes No If yes, please attach an explanation, copy of the order or Decree and other relevant documents.

Signature Of Board, Chair, Or Official

Title Of Board

Board Seal

Address

City

State

Zip

III. LICENSURE BY GRANDFATHER CLAUSE

(JUNE 30, 2015 LAST DATE TO FILE)

14. If you are applying for Licensure under the FACCT Grandfather Clause:

- A. Direct the Board of Examiners to those jurisdictions in which License is held, or previously held, to complete a Grandfather information/verification form and return it directly to the Board office.
- B. Obtain letters of endorsement, experience, and recommendations from those who have supervised, pastored, or who employ you in the area of Counseling.

15. List all Licenses as a professional Christian Counselor and/or Therapist you currently hold or have held.

License Title _____

Jurisdiction _____ License Number _____

Date of Issue _____ Expiration Date _____

License Title _____

Jurisdiction _____ License Number _____

Date of Issue _____ Expiration Date _____

License Title _____

Jurisdiction _____ License Number _____

Date of Issue _____ Expiration Date _____

16. If you are applying for Licensure as a Christian Counselor and Therapist and your degree is in counseling, theology, marriage and family, or Bible, complete the section below. Indicate the titles of courses from your transcript which satisfy the content area requirements. List one course.

CONTENT AREA

COURSE TITLE

DSM IV	_____
Temperament Theory & Therapy or Theocratic Theory & Therapy	_____
Family Mediation	_____
Theology or Biblical Studies	_____
Christian Counseling Theory &/or Therapy	_____
Human Growth and Development	_____
The Helping Relationship, Group Dynamics, Processing, & Counseling	_____
Lifestyle and Career Development	_____
Research and Evaluation	_____
Professional Orientation	_____

17. After June 30, 2000, applicants for Licensure as a Counselor and Therapist must have completed a minimum of four (4) graduate level courses in the principles and practice of Christian Counseling and Therapy. List these courses below and document the program in which they were completed.

Institution _____ Date _____

Course _____ Program _____

Institution _____ Date _____

Course _____ Program _____

(See Next Page)

Institution _____ Date _____

Course _____ Program _____

Institution _____ Date _____

Course _____ Program _____

Institution _____ Date _____

Course _____ Program _____

GRANDFATHER INFORMATION / VERIFICATION FORM

(Please copy for additional forms)

Mail this form to the Board of each State in which you currently hold a License as a professional Christian Counselor and Therapist.

TO BE COMPLETED BY THE APPLICANT:

To whom it may concern:

I am applying for a license to be issued by the Board of Examiners of the Florida Association of Christian Counselors and Therapists, and hereby give consent to the release of any information, favorable or otherwise, which you may have concerning my License or Practice. Please return the completed form directly to the Board of Examiners of the Florida Association of Christian Counselors and Therapists, the address is listed below:

*Florida Association of Christian Counselors and Therapists
Dr. Bryan "Buddy" Morrow, Jr.
Licensure Board Chairman
2603 SW Brim St.
Lake City, FL 32024*

*Telephone: 386-963-4495
Email: BBMorrow@FACCCA.com*

Applicants Signature Date

Print Full Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Social Security Number ____-____-____.

Description of License held in other jurisdiction:

Jurisdiction _____ License Number _____

Title of License _____

Date Issued _____ Expiration Date _____

TO BE COMPLETED BY THE BOARD OR REGULATORY AGENCY:

Does the information above agree with your records?

Yes No

If no, please give an explanation. _____

TO BE COMPLETED BY THE BOARD OR REGULATORY AGENCY:

I, _____ Board Chair or Designated Official of
the _____ Board,
certify that _____ was
granted a professional License, that License number being _____
on this _____ day of _____ (Year) _____
and that said Certificate (s) / License (s) have never been revoked and have been renewed for
the year ending on the _____ day of _____ (Year) _____.

Do you consider the applicant to be in good standing at this time?

Yes No If no, please give explanation.

According to your records, has the applicant ever been disciplined by the Board, any State agency, or by any professional organization?

Yes No If yes, please attach an explanation, copy of the order or Decree and other relevant documents.

Signature Of Board, Chair, Or Official

Title Of Board

Board Seal

Address

City

State

Zip

IV. PRACTICUM /INTERNSHIP EXPERIENCE

Applicants for Licensure as a professional Christian Counselor and Therapist must have completed a practicum/internship or its equivalent according to the rules established by the board. Certain individuals may apply up to one year of practicum or internship experience, or its equivalent, towards the professional experience requirement for Licensure. See rules for detail

18. Complete A and B below. Check each practicum or internship you intend to apply toward the professional experience requirement and submit a separate Practicum/Internship Verification Form for each one checked.

A. Have you completed a practicum or internship *as part of* a degree program?

Yes No If yes, complete the following:

Degree _____ Program _____

Date From _____ To _____ Site _____

Total Hours Of On-Site Experience _____

Degree _____ Program _____

Date From _____ To _____ Site _____

Total Hours Of On-Site Experience _____

B. Have you completed a practicum or internship *apart from* a degree program?

Yes No If yes, complete the following:

Date From _____ To _____ Site _____

Total Hours Of On-Site Experience _____

Date From _____ To _____ Site _____

Total Hours Of On-Site Experience _____

C. Do you intend to apply these toward your Professional Experience requirements?

Indicate Which Ones _____

PRACTICUM EXPERIENCE VERIFICATION FORM

(Please copy for additional forms)

The total duration of documented experience in the practice of Christian Counseling and Therapy must meet the minimum requirements for Licensure as described in the rules for Licensure.

TO BE COMPLETED BY THE APPLICANT:

1. Applicant's Name _____

2. Agency or Employer _____

3. Address _____

City _____ State _____ Zip _____

4. Telephone Number _____

5. Position _____

6. Describe Responsibilities _____

7. Dates of Experience: From: _____ To: _____

8. Duration: Total number of Hours _____

9. Itemize the number of hours spent in direct experience in the practice of Christian Counseling and Therapy during this time period.

A. Client contact as counselor or co-counselor _____

B. Case staffing (group discussion of a case) _____

C. Supervision as a supervisor or supervisee _____

Applicant's Signature

Date

V. PROFESSIONAL EXPERIENCE

The number of years of professional experience required for licensure as a professional Christian Counselor and Therapist depend upon the graduate degree you hold and whether or not you have completed an applicable practicum or internship. See rules for details.

19. List in chronological order all professional experience acquired after you obtained your Masters Degree. Check those items you are using to fulfill the experience requirement for Licensure and submit a separate Professional Experience Verification Form for each item checked.

Dates: From _____ To _____

Duration: Years _____ Months _____

Agency or Employer _____

Position _____

Dates: From _____ To _____

Duration: Years _____ Months _____

Agency or Employer _____

Position _____

Dates: From _____ To _____

Duration: Years _____ Months _____

Agency or Employer _____

Position _____

Dates: From _____ To _____

Duration: Years _____ Months _____

Agency or Employer _____

Position _____

Check here if you are applying any practicum/internship towards the professional experience requirement.

PROFESSIONAL EXPERIENCE VERIFICATION FORM
(Please copy for additional forms)

The total duration of documented experience in the practice of Christian Counseling and Therapy must meet the minimum requirements for Licensure as described in the rules for Licensure.

TO BE COMPLETED BY THE APPLICANT:

10. Applicant's Name _____

11. Agency or Employer _____

12. Address _____

City _____ State _____ Zip _____

13. Telephone Number _____

14. Position _____

15. Describe Responsibilities _____

16. Dates of Experience: From: _____ To: _____

17. Duration: Total number of Hours _____

18. Itemize the number of hours spent in direct experience in the practice of Christian Counseling and Therapy during this time period.

D. Client contact as counselor or co-counselor _____

E. Case staffing (group discussion of a case) _____

F. Supervision as a supervisor or supervisee _____

Applicant's Signature

Date

TO BE COMPLETED BY THE DIRECTOR

The Director is the administrating person providing ongoing oversight of the applicant's work for the purpose of assuring quality for the service rendered.

10. Please review the applicant's description of responsibilities and experience in the practice of Counseling and Therapy. Please comment, and add anything that would assist the Board in making a decision on Licensure for this applicant.

Comments _____

I attest that I provide and/or have provided direction of the professional experience described above and that this description is a true and accurate representation of the applicant's experience.

Director's Signature _____ Date _____

Name _____

Address _____

City _____ State _____ Zip _____

IN THE EVENT THE PERSON WHO PROVIDED DIRECTION CANNOT BE CONTACTED, THE CURRENT DIRECTOR MAY ATTEST TO THE APPLICANT'S EXPERIENCE BASED ON THE REVIEW OF AVAILABLE RECORDS.

Current Director's Signature _____ Date _____

Print Name _____

Signature Must Be Notarized _____ Notary's Signature _____

Date Term Expires _____

VI. SUPERVISION

The number of hours and type of supervision required for Licensure depends upon the graduate degree you hold. Supervision may have been obtained before, during, or after your degree program, or during a practicum or internship. See rules for details.

TO BE COMPLETED BY THE APPLICANT:

20. Complete the following for each supervisor whose supervision you are using to fulfill this requirement.
Submit a separate Supervision Verification Form for each supervisor.

1st Supervisor's Name _____

Total hours of supervision in the practice of Christian Counseling and Therapy, _____

2nd Supervisor's Name _____

Total hours of supervision in the practice of Christian Counseling and Therapy, _____

3rd Supervisor's Name _____

Total hours of supervision in the practice of Christian Counseling and Therapy. _____

**CHRISTIAN COUNSELING AND THERAPY
SUPERVISION VERIFICATION FORM**
(Please copy for additional forms)

All applicants for Licensure as a Christian Counselor and Therapist must document a minimum number of hours of experience in the field of Psychology. This must be in association with or under the supervision of a Licensed Christian Psychologist meeting the academic and experience requirements set by this board.

- *The specialist level must document a minimum of two (2) years or 4000 hours of experience in the field of Psychology.*
- *The Masters level requires not less than three (3) years of clinical experience in discipline, two (2) years of which must be at a post-masters level under the supervision of a Licensed person practicing in the discipline with at least five (5) years experience in said discipline. Of the three (3) years required experience for Licensure, the applicant must demonstrate 1,000 hours of direct individual, group, see 202.005 5 (c). Prior to June 30, 2000 this supervision may have been obtained in a counseling practicum or internship, or it's equivalent, which was part of the masters degree program.*

TO BE COMPLETED BY THE APPLICANT

1. Applicant's Name _____

2. Supervisor's Name _____

3. Number of supervision hours in the practice of Christian Counseling and Therapy provided by the supervisor.

A. Individual Supervision _____

B. Group Supervision _____

4. List the dates supervision was provided:

From _____ To _____

From _____ To _____

Brief description of supervision types:

5. Total hours of experience in the practice of Christian Counseling and Therapy during this time period:

Client contact as counselor or co-counselor, number hours _____

Case staffing (group discussion of a case), number hours _____

Supervision as supervisor or supervisee, number hours _____

6. Sub-specialty area in which the supervision was provided, career, mental health,
pastoral, counseling, etc.

I attest that the above information is a true and accurate representation of this supervision.

Applicant's Signature

Date

VII. TO BE COMPLETED BY THE SUPERVISOR

Supervision means the direct review, for the purpose of training or teaching the applicant interaction with clients. Supervision may include, without being limited to, the review of case presentations, audio tapes, video tapes, and direct observation.

Individual supervision may include one or two persons, while group supervision may include up to twelve.

For supervision provided after June 30, 2000 in addition to the above, the supervisor must have been Licensed as a professional Christian Counselor and Therapist, a Professional Counselor, a Certified Social Worker, a Marriage and Family Therapist, or a Psychiatrist. They must have credentials in the specific sub-specialty area in which the supervision was provided and have had thirty (30) hours of supervision, fifteen (15) in the sub-specialty area) or be receiving supervision in the skill of Christian Counseling and Therapist Supervision.

7. Supervisor's Current Address _____

City

State

Zip

Telephone Number () _____

8. List your professional credentials in the sub-specialty area in which the supervision was provided.

Career _____ or

Mental Health _____ or

Pastoral _____ or

Etc. _____

9. Prior to the time you began the supervision documented above, how many years experience did you have in the practice of Christian Counseling and Therapy?

Number of Years _____ Dates From _____ To _____

VII PERSONAL REFERENCES

21. List below the names of three (3) persons that are or have been your teacher, supervisor, and/or your Pastor in the area in which you are seeking Licensure and who will support your application for Licensure. Provide each with a **Personal Reference Form** and ask them to return it directly to the Board Office.

Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number () _____

Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number () _____

Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number () _____

PERSONAL REFERENCE FORM

This document automatically becomes the property of the Board of Examiners of the Florida Association of Christian Counselors and Therapists.

You are being asked to supply a letter of reference for _____
Applicant's Name

who signs the following disclaimer:

"I willingly waive my right of access to see this recommendation, knowing that this waiver is not required as a condition of admission."

Applicant's Signature

This applicant has requested Licensure or Certification and is in the process of completing the application requirements for the Board of Examiners of the Florida Association of Christian Counselors and Therapists. We ask that you please take a few minutes to provide us with your personal information on the applicant.

Your Name _____ Phone Number (____) _____

How long have you known the applicant? _____

What is your relationship with them? _____

Did you know the applicant was applying for Licensure / Certification? _____

Please send a personal letter along with this form stating your opinion about the applicant and your work history with the applicant, if any, to the address below. Please sign and date the letter. Thank you for your cooperation.

***Florida Association of Christian Counselors and Therapists
Dr. Bryan "Buddy" Morrow, Jr.
Licensure Board Chairman
2603 SW Brim St.
Lake City, FL 32024***

*Telephone: 386-963-4495
Email: BBMorrow@FACCCA.com*

RELEASE OF INFORMATION FORM
BOARD OF EXAMINERS

I, _____ authorize
The Board of Examiners of the Florida Association of Christian Counselors and Therapists,
their address being,

Florida Association of Christian Counselors and Therapists
Dr. Bryan "Buddy" Morrow, Jr.
Licensure Board Chairman
2603 SW Brim St.
Lake City, FL 32024

Telephone: 386-963-4495
Email: BBMorrow@FACCCA.com

to release any and all information regarding my education, training, experience, supervision, conduct, qualifications, credentials, or any other information necessary for completion of this application for Licensure as a Christian Counselor and Therapist. I release from all harm any and all persons, supervisors, administrators, organizations, and institutions that shall provide such information as required for the above named Licensure application procedure.

Applicant's Signature _____ Date _____

Print Applicant's Name _____

Address _____

City _____ State _____ Zip _____

VETERAN'S PREFERENCE FORM

1. Applicant's name _____

Address _____

City _____ State _____ Zip _____

2. Check the branch of service in which you served.

U.S. Army U.S. Navy

U.S. Air Force U.S. Marines

Reserves – Branch _____

Other – Name _____

3. Dates of service. From _____ To _____

4. Highest rank achieved _____

5. Type of discharge received _____

6. Did you serve during any war (declared or undeclared), military conflict, or police action?

(i.e. Vietnam, Korea, Persian Gulf, etc.)

If so, which _____

7. Did you retire from professional military service and receive a pension for your years of service?

Yes No

8. Were you declared disabled because of military service, and what percentage of disability did you receive?

9. I attest the information provided on this form is true and accurate to the best of my knowledge.

Applicant's Signature

Date

10. Attach a copy of your final discharge and DD214

OATH

I acknowledge that I may be required to furnish additional information promptly in order for this application to be processed. I attest that information provided is true and accurate to the best of my knowledge. I attest that I am a resident of Florida or that I intend to be within one year of this application. I release from all harm, the Board of Examiners of the Florida Association of Christian Counselors and Therapists, and authorize them to investigate and gather all information relevant to my application for Licensure.

Applicant's Signature

Date

NOTARY

Applicant must have this application notarized, with the Notary's Seal covering a portion of the applicant's photograph.

Notary's Signature

Attach Photo Here

Print Notary's Name

Date Term Expires