



Attach a clear, full-face passport-style photograph (2"x 2") of your head and shoulders, taken within the past six months.

A photo is required with each application.

Do not use staples to attach the photo.

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Marriage and Family Therapy Examiners
Art Therapists Advisory Committee
124 Halsey Street, 6th Floor, P.O. Box 45055
Newark, New Jersey 07101
(973) 504-6299

What are you applying for?

- Licensure as an Associate Art Therapist
Licensure as a Professional Art Therapist
Licensure by Reciprocity
Art Therapy Credentials Board Examination

Application for Licensure
Professional Art Therapist/Associate Art Therapist

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

A nonrefundable application filing fee of \$75, in the form of a check or money order made out to the State of New Jersey, must be submitted with this application.

The Division is precluded by law from disclosing to the public the place of residence of licensees or applicants, without their consent. However, you are required to provide an address that may be released to the public in our directories or in response to other requests (by putting a check in the appropriate box).

Information that you provide on this application may be subject to public disclosure as required by the Open Public Records Act (OPRA).

Please print clearly. You must answer all of the questions on this application.

Personal Information

Date of birth: \_\_\_\_\_
Month Day Year

Place of birth: \_\_\_\_\_
City State Country

1. Name [ ] Mr. [ ] Mrs. [ ] Ms.
Last name First name Middle initial Maiden name

2. Address [ ] Home:
Street or P.O. Box City State ZIP code County
Telephone number (include area code) E-mail address

[ ] Business:
Name of company Telephone number (include area code)
Street City State ZIP code County

[ ] Mailing:
Street or P.O. Box City State ZIP code County

**Application Categories**

I hereby apply for the following type of license: (Please check the appropriate boxes.)

**Licensed Associate Art Therapist (LAAT)**

*Educational Requirements:* Please refer to N.J.A.C. 13:34D-2.4.

*Supervised Experience:* Not required for licensure as a Licensed Associate Art Therapist.

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**Licensed Professional Art Therapist (LPAT)**

*Educational Requirements:* Please refer to N.J.A.C. 13:34D-2.2.

*Supervised Experience:* Pursuant to N.J.A.C. 13:34D-2.5.

3. Have you taken the ATCB Examination?  Yes  No When: \_\_\_\_\_

If "Yes," did you pass the examination?  Yes  No

A copy of your exam scores is required. Please have the ATCB forward an official copy directly to the Committee.



7. Illegal Use of Controlled Dangerous Substances

The question below pertains to the illegal use of controlled dangerous substances. Please read the definitions carefully. Your responses will be treated confidentially and retained separately. Please be aware that you have the right to elect not to answer this question if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing. You must fully respond to all other questions on the application. Your application for licensure or certification will be processed if you claim the Fifth Amendment privilege against self-incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question that you have refused to answer on the basis on the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law, (N.J.S.A. 45:1-20).

**“Currently”** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, or within the previous 365 days, whichever is longer.

**“Illegal use of controlled dangerous substance”** means the use of a controlled dangerous substance obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

- a. Are you currently engaged in the illegal use of controlled dangerous substances? (As stated above, “currently” is defined as “recently enough... [to] have an ongoing impact...” or “within the previous 365 days,” whichever is longer.)

Yes  No

If you answered “Yes,” are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?

Yes  No

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Applicant’s signature

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Date

8. Have you ever been summoned; arrested; taken into custody; indicted; tried; charged with; admitted into pre-trial intervention (P.T.I.); or pled guilty to any violation of law, ordinance, felony, misdemeanor or disorderly persons offense, in New Jersey, any other state, the District of Columbia or in any other jurisdiction? (Parking or speeding violations need not be disclosed, but motor vehicle violations such as driving while impaired or intoxicated must be.)  Yes  No

9. Have you ever been convicted of any crime or offense under any circumstances? This includes, but is not limited to, a plea of guilty, non vult, nolo contendere, no contest, or a finding of guilt by a judge or jury.  Yes  No

If "Yes," provide a copy of the judgment of conviction and the release from parole or probation. Please provide a complete explanation. (Attach additional sheets of paper to this application.)

10. Do you currently hold, or have you ever held a professional license or certificate of **any** kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction?  Yes  No

If "Yes," for each license or certificate held, provide the date(s) held and the number(s). If the license or certificate was issued under a different name, please provide that name. \_\_\_\_\_

		Last name	First name	Middle initial
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate		Date issued/expired
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate		Date issued/expired
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate		Date issued/expired
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate		Date issued/expired

11. Have you ever been cited for disciplinary reasons or denied a professional license or certificate of any kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction?  Yes  No

12. Have you ever had a professional license or certificate of any type suspended, revoked or surrendered in New Jersey, any other state, the District of Columbia or in any other jurisdiction?  Yes  No

13. Has any action (including the assessment of fines or other penalties) ever been taken against your professional practice by any agency or certification board in New Jersey, any other state, the District of Columbia or in any other jurisdiction?  Yes  No

14. Have you ever been named as a defendant in any litigation related to the practice of counseling or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction?  Yes  No

15. Are you aware of any investigation pending against a professional license or certificate issued to you by a professional board in New Jersey, any other state, the District of Columbia or in any other jurisdiction?  Yes  No

16. Are there any criminal charges now pending against you in New Jersey, any other state, the District of Columbia or in any other jurisdiction?  Yes  No

17. Have you ever been sanctioned by or is any action pending before any employer, association, society, or other professional group related to the practice of counseling or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction?  Yes  No

If the answer to any of the above questions, numbers 11 through 17, is "Yes," provide a complete explanation of the circumstances leading to the action, and any supporting documentation, on separate sheets of paper.

## Education

1. List the regionally accredited graduate school(s) you have attended, beginning with the most recent.

**Note:** All graduate degrees and course work must be documented by a certified true copy of the official transcript.

Check one:       Enclosed       Requested, to be sent separately

No action will be taken on your application until all transcripts have been received.

Month	Year	Month	Year	Name and address of college or university	Degree, Diploma or Certificate (if any)
_____	_____	to	_____	_____	_____
				_____	_____
				_____	_____
_____	_____	to	_____	_____	_____
				_____	_____
				_____	_____
_____	_____	to	_____	_____	_____
				_____	_____
				_____	_____
_____	_____	to	_____	_____	_____
				_____	_____
				_____	_____
_____	_____	to	_____	_____	_____
				_____	_____
				_____	_____

## Experience

(To be completed by applicants who seek to become a Licensed Professional Art Therapist only; see attached supervision form.)

a.

Employer's name		Street address	
City	State	ZIP code	Telephone number (include area code)
Name of supervisor(s)		Title(s)	License designation
Total hours of supervised experience	Total hours of individual supervision	Total hours of group supervision	
From _____	to _____		
Month Year	Month Year		

Description of job functions and responsibilities:

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b.

Employer's name		Street address	
City	State	ZIP code	Telephone number (include area code)
Name of supervisor(s)		Title(s)	License designation
Total hours of supervised experience	Total hours of individual supervision	Total hours of group supervision	
From _____	to _____		
Month Year	Month Year		

Description of job functions and responsibilities:

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c.

Employer's name		Street address	
City	State	ZIP code	Telephone number (include area code)
Name of supervisor(s)		Title(s)	License designation
Total hours of supervised experience	Total hours of individual supervision		Total hours of group supervision

From \_\_\_\_\_ to \_\_\_\_\_  
 Month Year Month Year

Description of job functions and responsibilities:

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d.

Employer's name		Street address	
City	State	ZIP code	Telephone number (include area code)
Name of supervisor(s)		Title(s)	License designation
Total hours of supervised experience	Total hours of individual supervision		Total hours of group supervision

From \_\_\_\_\_ to \_\_\_\_\_  
 Month Year Month Year

Description of job functions and responsibilities:

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## Licensed Associate Art Therapist Course Work Check Sheet

As set forth in N.J.A.C. 13:34D-2.4, the 60 graduate semester hours in course work shall include courses in nine of the following areas. Please list which courses indicated on your transcript(s) satisfy the relevant areas. Do not list a course more than once.

Area	Course title and Course number	Hours <small>(Indicate semester or quarter hours)</small>	College/University
The art therapy profession.	a. _____	_____	_____
Theory and practice of art therapy.	a. _____	_____	_____
Human growth and developmental dynamics in art.	a. _____	_____	_____
Application of art therapy with people in different treatment settings	a. _____	_____	_____
Art therapy appraisal, diagnosis, and assessment.	a. _____	_____	_____
Ethical and legal issues of art therapy practice.	a. _____	_____	_____
Matters of cultural and social diversity bearing on the practice of art therapy.	a. _____	_____	_____
Standards of good art therapy practice.	a. _____	_____	_____
Group art therapy.	a. _____	_____	_____
		Total hours _____	

# AFFIDAVIT

**This affidavit is to be executed by the applicant before a notary public:**

State of: \_\_\_\_\_ }  
County of: \_\_\_\_\_ } ss.

I, \_\_\_\_\_, in making this application to the Art Therapists Advisory Committee for licensure or certification under the provisions of Title 45 of the General Statutes of New Jersey and the Rules of the Art Therapists Advisory Committee, swear (or affirm) that I am the applicant and that all information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny licensure or certification or to withhold renewal of or suspend or revoke a license or certificate issued by the Committee.

I further swear (or affirm) that I have read N.J.S.A. 45:8B-51 et seq., together with the Rules and Regulations of the Art Therapists Advisory Committee, at N.J.A.C. 13:34D, and fully understand that in receiving licensure from the Committee, I bind myself to be governed by them.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for licensure or certification. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Committee.

\_\_\_\_\_  
Signature of applicant

Sworn and subscribed to before me this \_\_\_\_\_  
day of \_\_\_\_\_, \_\_\_\_\_  
Month Year

\_\_\_\_\_  
Name of Notary Public (please print)

\_\_\_\_\_  
Signature of Notary Public



**Official Use Only**

Dual License

License Type 1

Applicant's Number

License Type 2

Applicant's Number



**New Jersey Office of the Attorney General**  
Division of Consumer Affairs  
State Board of Marriage and Family Therapy Examiners  
Art Therapists Advisory Committee  
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**Official Use Only**

Resubmit

Board or Committee

## CERTIFICATION AND AUTHORIZATION FORM FOR A CRIMINAL HISTORY BACKGROUND CHECK

**Directions:** Answer all of the questions on this form.

1. Name  Mr.  Mrs.  Ms. \_\_\_\_\_ ( \_\_\_\_\_ )  
Last First Middle Maiden Name

2. Address \_\_\_\_\_  
Street or P.O. Box City State ZIP code

3. Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female  
Month Day Year

4. Social Security number \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

5. Have you completed the fingerprinting process for any **Board or Committee of the New Jersey Division of Consumer Affairs** since November 2003?  Yes  No

If "No," you will receive a separate mailing from the Board or Committee regarding the criminal history record background check process. No payment is necessary as of now.

If "Yes," please provide the following information and follow the instructions outlined below:

\_\_\_\_\_  
Board or committee requiring the fingerprinting

\_\_\_\_\_  
Month and year you were fingerprinted

If you were fingerprinted after November 2003 as part of the criminal history background process for licensure or certification by any other **Board or Committee of the New Jersey Division of Consumer Affairs** (a background check conducted for the Department of Education, another state agency or another state does not apply) you will not be required to be fingerprinted a second time. However, the Division must perform a criminal history background check each time you apply for licensure or certification. **The fee for this service is \$18.75.** Payment should be made in the form of a check or money order payable to the State of New Jersey and should accompany your application packet.

6. Have you ever been arrested and/or convicted of a crime or offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.)  Yes  No

**Every such conviction on record must be disclosed.** A true copy of every police report, judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in the denial of an initial application.**

**Note:** Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.

**Your continuing responsibility to disclose convictions of crimes or offenses:** You **must** notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.

## CERTIFICATION

I, \_\_\_\_\_, in making this application to the Board or Committee for certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

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Signature of applicant

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Date