

**Regular Mailing Address**  
**STATE BOARD OF MEDICINE**  
**P.O. BOX 2649**  
**HARRISBURG, PA 17105-2649**  
**Email: [st-medicine@pa.gov](mailto:st-medicine@pa.gov)**

**Courier Delivery Address**  
**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 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." <b>FEES ARE NOT REFUNDABLE.</b> 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.	Provide an official notification of information (Self Query) from the National Practitioner Data Bank Data Bank. Please refer to the NPDB website for additional information. <b>When you receive the "Response to your Self Query," forward the entire report directly to the Board Office.</b> <u>You should make a copy for your records.</u>
5.	<b>CURRICULUM VITAE/RESUME</b> – Attach a current Curriculum Vitae listing <b>all</b> 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.
6.	The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services (DHS), is providing notice to all health-related licensees and funeral directors that are considered "mandatory reporters" under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete 3 hours of DHS-approved training in child abuse recognition and reporting requirements as a condition of licensure. Please review the Board website for further information on approved CE providers. Once you have completed a course, the approved provider will electronically submit your name, date of attendance, etc., to the Board. <a href="#">Child Abuse Continuing Education Providers Information can be found here.</a>
<b>IMPORTANT INFORMATION REGARDING BACKGROUND CHECKS – If any of the background checks become more than 90 days from the date the document was issued and all of the other 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.</b>	
7.	<p>Contact the state police in which you currently reside or work and have resided or worked during the previous 10 years and request a Criminal History Record Information Report (CHRI) be completed. The report(s) are valid for no more than 90 days from the date the document was issued.</p> <ul style="list-style-type: none"> <li>• The CHRI must contain the applicant's <b>date of birth and/or social security number</b>.</li> <li>• The CHRI must either state "No Record" or "Record Exists." Background checks that reflect "Pending", "Under Review", or "Under Request" cannot be submitted.</li> <li>• Questions regarding the status of a CHRI must be directed to the State Police.</li> <li>• If "Records Exist", submit <b>originals</b> of the following for <b>EACH</b> conviction: <ul style="list-style-type: none"> <li>a) The conviction summary information provided by the State Police;</li> <li>b) Certified copies of court documents;</li> <li>c) Letter from Probation Officer, dated within 90 days, indicating current probationary status/completion date;</li> <li>d) Police reports;</li> <li>e) Detailed description (in applicant's words) of the circumstances surrounding the conviction, the basis for the conviction and the disposition of the conviction.</li> </ul> </li> <li>• Pennsylvania background checks may be obtained from the Pennsylvania State Police Central Repository, 1800 Elmerton Avenue, Harrisburg, PA 17110-9785.</li> </ul>

8.	<p>Contact the Department of Human Services or equivalent agency for each state in which you currently reside or work and have resided or worked during the previous 10 years and request a Child Abuse History Clearance be completed. The report(s) are valid for no more than 90 days from the date the document was issued.</p> <p><b>PLEASE NOTE: VOID/UNACCEPTABLE IF COPIED---Originals will NOT be returned.</b></p> <p>The Pennsylvania Child Abuse History Clearance Form (CY 113) is available on the Department of Human Services' website. Questions regarding the status of a request for Child Abuse Clearance must be directed to the Department of Human Services.</p>
9.	<p>Contact the Federal Bureau of Investigation (FBI) through their website at <a href="https://www.fbi.gov/about-us/cjis/identity-history-summary-checks">https://www.fbi.gov/about-us/cjis/identity-history-summary-checks</a> to obtain an FBI Criminal Background Check. You should follow the steps outlined on this website to obtain the report(s). The report(s) are valid for no more than 90 days from the date the document was issued.</p> <p><b>PLEASE NOTE: VOID/UNACCEPTABLE IF COPIED- Originals will NOT be returned.</b></p> <p>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 <a href="http://www.pa.cogentid.com/index.htm">http://www.pa.cogentid.com/index.htm</a> and register through the <b>Department of Human Services only</b>.</p>
<p><b>The following items may come from multiple sources and can be submitted separately as they become available:</b></p>	
10.	<p><b><u>VERIFICATION OF MASTER'S (or Higher) DEGREE OR POST MASTER'S CERTIFICATE</u> – Form 2</b> – 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).</p> <ul style="list-style-type: none"> <li>• The verification form and an official school transcript must be sent to the Board.</li> <li>• 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.</li> <li>• <b>The verification form(s) must be completed and returned, along with an official school transcript, <u>directly</u> to the Board by the college/university in an official school envelope.</b></li> </ul>
11.	<p><b><u>VERIFICATION OF FUNCTIONAL BEHAVIOR ASSESSMENT EXPERIENCE</u> – Form 3</b> – 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.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• <b>The verification form must be completed by the applicant's employer or clinical supervisor and returned <u>directly</u> to the Board from the employer or supervisor in a sealed envelope.</b></li> <li>• If more than one employer or supervisor, please make copies of the form and distribute, as necessary.</li> </ul>
12.	<p><b><u>VERIFICATION OF CLINICAL/IN-PERSON EXPERIENCE</u> – Form 4</b> – 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.</p> <ul style="list-style-type: none"> <li>• The employer or supervisor must verify completion of at least 1,000 hours of in-person experience with individuals with behavioral challenges or autism spectrum disorders.</li> <li>• <b>The verification form must be completed and returned <u>directly</u> to the Board from the employer or clinical supervisor in a sealed envelope.</b></li> <li>• If more than one employer or supervisor, please make copies of the form and distribute, as necessary.</li> </ul>
13.	<p><b><u>VERIFICATION OF 90 HOURS OF EVIDENCE-BASED COURSEWORK</u> – Form 5</b> – (IF APPLICABLE: See Form 2 for details) – Complete Section 1 of the Verification of Evidence-Based Coursework form.</p> <ul style="list-style-type: none"> <li>• For university coursework, forward to the school for completion of Section 2A. <b>The verification form must be returned <u>directly</u> to the Board in a sealed envelope.</b></li> <li>• For BACB continuing education or BAS-approved trainings, the applicant should complete section 2B. <b>The verification form and supplemental documentation verifying completion of <u>approved</u> trainings can be returned to the Board by the applicant.</b></li> </ul>
14.	<p><b><u>VERIFICATION THAT MASTER'S DEGREE/POST MASTER'S CERTIFICATE AWARDED IS A RELATED FIELD</u> – Form 6</b> – (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. <b>The verification form must be completed and returned <u>directly</u> to the Board in an official school envelope. DO NOT</b> 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.</p>

15.	<p><b><u>VERIFICATION OF LICENSURE</u></b> – Contact the state board office(s) where you hold or have ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation and request letters of good standing. The 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 Board.</p>
<p><b><u>PLEASE NOTE:</u></b> If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee. In order to complete the application process, many of the supporting documents associated with the application cannot be more than six months from the date of issuance.</p> <p style="text-align: center;"><b>PLEASE ALLOW AT LEAST 30-60 DAYS FOR PROCESSING</b></p>	

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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)

<b>NAME:</b>	Last			First			Middle					
<b>ADDRESS*:</b>	Street											
City				State				ZIP				
<b>DATE OF BIRTH:</b>	Month	Day	Year	<b>SOCIAL SECURITY NUMBER:</b>								
<b>TELEPHONE NUMBER:</b>												
<b>EMAIL ADDRESS:</b>												
If your supporting documents are listed under another name or names, please list below:												
Last			First			Middle						
<b>NAME OF MASTER'S DEGREE, POST MASTER'S CERTIFICATE OR OTHER PROGRAM:</b>												
<b>NAME OF SCHOOL:</b>												
<b>ADDRESS OF SCHOOL:</b>		Street										
City				State				ZIP				
<b>DATES OF ATTENDANCE:</b>	<b>FROM</b>	Month	Day	Year	<b>TO</b>	Month	Day	Year	<b>DATE OF GRADUATION:</b>	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 #12, provide complete details on a separate sheet as well as certified copies of relevant documents.

		Yes	No
1	Do you hold or have you ever held a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction? <b>If you answered yes, provide the profession and state or jurisdiction.</b> <b>LIST:</b> _____		
2	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
3	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		
4	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
5	Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		
6	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		
7	Have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?		
8	Have you had your DEA registration denied, revoked or restricted?		
9	Have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
10	Have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
11	Have you engaged in, the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?		
12	Have you been the subject of a civil malpractice lawsuit? <b>If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you.</b>  <b>**If you previously reported the complaint to the Board provide the docket number _____</b>		

### SIGNED STATEMENT

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards 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). At the request of the Department of Human Services, the licensing boards must provide to the Department of Human Services information prescribed by the Department of Human Services about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa. C.S. Section 4911. 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. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Applicant

# VERIFICATION OF EDUCATION – Form 2

## SECTION 1 – TO BE COMPLETED BY APPLICANT

<b>NAME:</b>	Last	First	Middle
<b>NAME OF COLLEGE/UNIVERSITY:</b>			
<b>ADDRESS:</b>	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

<b>NAME OF DEGREE PROGRAM:</b>			
<b>MAJOR COURSE OF STUDY:</b>	<input type="checkbox"/> Behavioral Analysis	<input type="checkbox"/> Special Education	<input type="checkbox"/> Speech Therapy
<input type="checkbox"/> Psychology: (School; Clinical; Counseling or Developmental)	<input type="checkbox"/> Professional Counseling	<input type="checkbox"/> Social Work	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Nursing Specialty _____	<input type="checkbox"/> Another Related Field (List Specific Field): _____ <i>If this box is checked, the university agent must sign below and complete and submit Form 6.</i>		
<b>NAME OF STUDENT:</b>	Last	First	Middle
<b>DATE STUDENT BEGAN TO ATTEND THIS PROGRAM:</b>	Month	Day	Year
	<b>DATE OF GRADUATION:</b>		Month Day Year

### CHOOSE ONLY ONE OPTION BELOW

**Option 1**  I CERTIFY THAT THE APPLICANT COMPLETED 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 CERTIFICATE 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.*

<b>SIGNATURE OF UNIVERSITY AGENT:</b>	<p>Upon completion, the school must return the form(s) and transcripts directly to the Pennsylvania State Board of Medicine in an official school envelope.</p> <p style="text-align: center;"><b>DO NOT RETURN THE ORIGINAL FORM TO THE APPLICANT</b></p> <p style="text-align: center;"><i>(A COPY of this form can be provided to the applicant upon request.)</i></p>	
<b>DATE:</b>		Month Day Year
<p style="text-align: center;">Seal of college/university <i>(If the college/university does not have a seal, please submit a letter signed by the university agent attesting to that.)</i></p>		

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**PENNSYLVANIA STATE BOARD OF MEDICINE**

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

**SECTION 1 – TO BE COMPLETED BY APPLICANT**

<b>NAME OF APPLICANT:</b>	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**

<b>NAME OF EMPLOYER or SUPERVISOR:</b>	Last	First	Middle

<b>ADDRESS:</b>	Street		
	City	State	ZIP

<b>CERTIFICATION/LICENSE #</b>		<b>PROFESSION:</b>		<b>STATE:</b>	
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<b>NUMBER OF MONTHS OF FUNCTIONAL BEHAVIOR ASSESSMENT EXPERIENCE THE ABOVE-NAMED INDIVIDUAL COMPLETED UNDER MY SUPERVISION/DIRECTION:</b>	# 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.

<b>SIGNATURE OF EMPLOYER or SUPERVISOR:</b>	
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<b>DATE:</b>	Month	Day	Year	<p>Upon completion, please return this completed form directly to the Pennsylvania State Board of Medicine.</p> <p><b>DO NOT RETURN THE ORIGINAL FORM TO THE APPLICANT</b></p> <p><i>(A COPY of this form can be provided to the applicant upon request.)</i></p>

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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
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CERTIFICATION or LICENSE #	PROFESSION:	STATE:
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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 WITH BEHAVIORAL CHALLENGES OR AUTISM SPECTRUM DISORDERS.

SIGNATURE OF EMPLOYER or SUPERVISOR:

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

**DO NOT RETURN THE ORIGINAL FORM TO THE APPLICANT**

*(A COPY of this form can be provided to the applicant upon request.)*

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# 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 – INSTRUCTIONS

Every application must include verification that ALL 90 hours of evidence-based coursework have been completed. These hours can be completed through undergraduate, graduate or post-grad coursework taken 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
- 18 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.

**FORM 5 - SECTION 2A – TO BE COMPLETED BY A UNIVERSITY AGENT TO DOCUMENT THAT THE COLLEGE/UNIVERSITY COURSEWORK INCLUDED SOME OR ALL OF THE REQUIRED NUMBER OF HOURS LISTED IN EACH CONTENT AREA**

**THE TOTAL NUMBER OF REQUIRED HOURS IN EACH CONTENT AREA IS NOTED BELOW**

- Verify the required number of hours for each content area that were completed through college/university coursework.
- Submit this document to the Board with all supporting coursework verifications.

<b>NAME OF APPLICANT:</b>		Last	First	Middle			
<b>NAME OF COLLEGE/UNIVERSITY or TRAINING PROGRAM:</b>							
<b>ADDRESS OF COLLEGE / UNIVERSITY: (if applicable)</b>			Street				
City			State	ZIP			
<input type="checkbox"/>	<b>Professional Ethics (3 hours)</b>	<input type="checkbox"/>	<b>Autism-Specific (18 hours)</b>	<input type="checkbox"/>	<b>Assessments (16 hours)</b>	<input type="checkbox"/>	<b>Crisis Intervention (8 hours)</b>
<input type="checkbox"/>	<b>Family Collaboration (5 hours)</b>	<input type="checkbox"/>	<b>Instructional Strategies &amp; Best Practices (16 hours)</b>	<input type="checkbox"/>	<b>Co-Morbidity &amp; Medications (8 hours)</b>	<input type="checkbox"/>	<b>Addressing Specific Skill Deficits (16 hours)</b>

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

<b>NAME OF UNIVERSITY AGENT (Print)</b>				Last	First	Middle
<b>SIGNATURE OF UNIVERSITY AGENT</b>						
<b>DATE:</b>	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.  <b>DO NOT RETURN THE ORIGINAL FORM TO THE APPLICANT</b>  <b>(A COPY of this form can be provided to the applicant upon request.)</b>		
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.)						

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 717-783-1400/717-787-2381

**Courier Delivery Address**  
 STATE BOARD OF MEDICINE  
 2601 NORTH THIRD STREET  
 HARRISBURG, PA 17110

<b>Name of Applicant:</b>	Last	First	Middle
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**FORM 5 - SECTION 2B: SUMMARY LIST OF SUPPLEMENTAL TRAININGS  
TO BE COMPLETED BY THE APPLICANT TO DOCUMENT ONLY SUPPLEMENTAL TRAININGS  
THAT HAVE BEEN APPROVED BY EITHER THE BACB OR THE BUREAU OF AUTISM SERVICES**

List the Course Number, Course Title and number of hours awarded in the applicable content area for each of the supplemental trainings. Documentation must be attached for each course listed below when submitted to the Board office.

**IF YOU DO NOT HAVE ENOUGH SPACE AND NEED TO REPORT ADDITIONAL COURSES,  
PLEASE MAKE A COPY OF THIS FORM**

Content Area	Course Number	Course Title	Hours Awarded
Professional Ethics (3 hours)			
Autism-Specific (18 hours)			
Assessments (16 hours)			
Crisis Intervention (8 hours)			
Family Collaboration (5 hours)			
Instructional Strategies & Best Practices (16 hours)			
Co-Morbidity & Medications (8 hours)			
Addressing Specific Skill Deficits (16 hours)			

I verify that I have completed all of the BAS/BACB approved supplemental trainings indicated above.

Signature of Applicant

Date

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# VERIFICATION THAT MASTER'S DEGREE/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 REQUIRED 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:	
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ADDRESS:	Street
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City	State	ZIP
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NAME OF UNIVERSITY AGENT: <small>(Print)</small>	Last	First	Middle
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SIGNATURE OF UNIVERSITY AGENT:	
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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.  <p style="text-align: center;"><b>DO NOT RETURN THE ORIGINAL FORM TO THE APPLICANT</b></p> <p style="text-align: center;"><i>(A COPY of this form can be provided to the applicant upon request.)</i></p>
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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.)*

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