The University of the State of New York
The State Education Department
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Mental Health Practitioner Form 2D
Certification of Education for a Diagnostic Privilege

ONLY USE THIS FORM to Certify Education Required for the Diagnostic Privilege
Education taken to meet the Continuing Education Requirement of Your Original Mental Health Practitioner License WILL NOT BE ACCEPTED

Applicant Instructions

1. Complete Section I and sign and date item 8.
2. Send the entire Form 2D to the institution(s) where you completed program(s) providing you with semester hours or the equivalent required for the diagnostic privilege. Have the registrar complete Section II and submit all pages of the form directly to the Office of the Professions at the address at the end of this form. Be sure to include any fee required by the institution. Form 2D will not be accepted if submitted by the applicant.

Check what privilege you are applying for (**check one**): ☐ Marriage and Family Therapist ☐ Mental Health Counselor ☐ Psychoanalyst

Section I: Applicant Information

1. Social Security Number
(Leave this blank if you do not have a U.S. Social Security Number)

2. Birth Date Month Day Year

3. Print Name Last
First
Middle

5. Telephone/Email Address
Daytime Phone
☐ Home or ☐ Business
Area Code Phone

Licensee business address, phone and email address are public information. Failure to indicate business or home on this form for each item will deem it public information.

4. Mailing Address ☐ Home or ☐ Business
(You must notify the Department within 30 days of any address or name changes)
Line 1
Line 2
Line 3
City
State ZIP Code
Country/ Province

Email Address (please print clearly)
☐ Home or ☐ Business

6. New York State DMV ID Number (Driver or Non-Driver ID)
(Leave this blank if you do not have a New York State DMV ID Number)

7. Name of institution attended

Address of institution

Attendance from mo. yr. to mo. yr. Completion date mo. yr.

If awarded, title of Degree/Diploma/Certificate awarded (in original language)

If awarded, Date Degree/Diploma/Certificate awarded mo. yr.

8. I request and give my permission to the institution listed in item 7 above to complete Section II of this form and mail it to the Office of the Professions at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application.

Signature Date

Section II: Certification of Education

Instructions to the Registrar: Complete Parts A, B or C then complete Part D. Sign the certification before returning the entire form along with any required documentation directly to the Office of the Professions at the address at the end of this form. **You must submit a new/ updated transcript or marksheet with this form. Form 2 will not be accepted if submitted by the applicant.**

Name of the applicant _____
(see Section I, item 3)

Part A - A Program* Registered by the New York State Education Department (NYSED) as licensure qualifying or accredited by an agency acceptable to the Department: To be completed only by those institutions whose program was, at the time the applicant's degree was awarded, registered by, or accredited by an agency acceptable to NYSED or as licensure qualifying for the mental health profession of:
☐ Marriage and Family Therapy ☐ Mental Health Counseling ☐ Psychoanalysis

***Important Note:** Part A is **ONLY** for documenting the completion of a degree program. Additional coursework completed outside the degree program meant to satisfy the education requirements for the diagnostic privilege should documented in Part C.

It is certified that the applicant:

☐ completed the program on ____ (mo.) ____ (day) _____ (yr.) and was awarded the degree/diploma/certificate of _____ (Title of degree/diploma/certificate)

in the program area or major of _____ (Title) on the date of ____ (mo.) ____ (day) _____ (yr.)

Was this program comprised of at least 60 semester hours, or its equivalent in the mental health profession indicated? ☐ Yes ☐ No

If "no", number semester hours, or its equivalent completed: _____

Part B - All other Programs: To be completed only by those institutions whose program was, at the time the applicant's degree was awarded, determined by the Department to be substantially equivalent to a program registered as leading to licensure for the mental health profession of:
☐ Marriage and Family Therapy ☐ Mental Health Counseling ☐ Psychoanalysis

Date of applicant's entrance, and either the applicant's date of completion of studies or withdrawal from the school.

Entrance Date ____ (mo.) ____ (day) _____ (yr.) ☐ Completion Date ____ (mo.) ____ (day) _____ (yr.) ☐ Withdrawal Date ____ (mo.) ____ (day) _____ (yr.)

Was this program comprised of at least 60 semester hours, or its equivalent in the mental health profession indicated? ☐ Yes ☐ No

If "no", number semester hours, or its equivalent completed: _____

Degree/diploma/certificate awarded _____

Date degree/diploma/certificate awarded ____ (mo.) ____ (day) _____ (yr.)

Name of the accrediting body or official organization that recognizes this program

_____

Date of Accreditation ____ (mo.) ____ (day) _____ (yr.)

Address of the accrediting body or official organization that recognizes this program

_____

Part C - An Institution Offering a Non-Degree/Diploma/Certificate Conferring Course to provide the Applicant with Required Coursework in the Mental Health Profession of: ☐ Marriage and Family Therapy ☐ Mental Health Counseling ☐ Psychoanalysis

The applicant began the course on the date of ____ (mo.) ____ (yr.) The applicant completed the course on the date of ____ (mo.) ____ (yr.)

Name of the course: _____

Number of semester hours, or the equivalent provided by the course _____

Is the institute offering this course a Psychotherapy Institute? ☐ Yes ☐ No

Does this course provide acceptable clinical education towards the indicated mental health profession as defined in Section 79-9.6 (mental health counseling), 79-10.6 (marriage and family therapy), or 79-12.6 (psychoanalysis)? ☐ Yes ☐ No

Section II - Certification of Education (Continued)

Part D - List the course(s) that meets the requirement for the mental health profession indicated on page 2 (document where areas A through D are represented in the curriculum). *The course(s) listed must be included on the official transcript provided institution. If the content was covered in more than one course, specify the areas covered in each course.*

Required Content Area	Course Number, Title and Semester Hours
A. diagnosis and assessment-based treatment planning in the practice of the mental health profession indicated on page 2 and psychotherapy; B. assessment, evaluation and diagnosis using accepted classification systems in the practice of the mental health profession indicated on page 2; C. developing and implementing assessment-based treatment plans for the provision of mental health profession indicated on page 2; and D. clinical interventions with diverse populations using the mental health practitioner profession indicated on page 2.	

Certification - To be completed by the Registrar. This form will not be accepted if the date below precedes the date in either Part A, Part B or Part C.

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the educational record of the individual named on this form.

Signature of Registrar _____ Date _____

Print Name _____

Title or official position _____

Institution _____ Seal

Address _____

_____

Telephone _____ Fax _____

Email _____

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Mental Health Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000. OR, Submit this form to the Department by E-mail at **DPLSEDUC@nysed.gov**.