	The University of the State of New York The State Education Department Office of the Professions vision of Professional Licensing Services <u>www.op.nysed.gov</u>	Mental Health Professions Form 5CS-D Certification of Supervisor for Diagnostic Limited Permit						
Us	e this form ONLY if you are applyi	ng/have applied for a New York Sta	te Diagnostic Limited Per	mit using Online Fo	rm 5D.			
1. 2.	Applicant Instructions							
Check what mental health profession for which you are applying for the diagnostic privilege (check one): Mental Health Counselor Marriage and Family Therapist Psychoanalyst								
Section I: Applicant Information								
1. 3.	Social Security Number (Leave this blank if you do not have a L Print Name Last		Birth Date Month	Day Year				
	First Middle							
4.	Renewal							
5.	I am licensed and currently registered to practice in New York State as a							
	New York State License number							
Se	ction II: Supervisor's Certification							
A diagnostic limited permit may be issued to a NYS licensed mental health counselor, marriage and family therapist, or psychoanalyst who is gaining supervised experience for the diagnostic privilege under supervision. The permit is valid for two years, and may be renewed, at the discretion of the Department, for up to two additional one-year periods.								
Supervising Instructions: Complete this section to certify that the applicant named above will be under your direction and supervision at the setting named on this form. You must also attach a copy of the operating certificate or certificate of incorporation authorizing the proposed setting to employ licensed professionals and provide services that are restricted under Title VIII of the Education Law.								
Su	pervisor's Name							
I am licensed and currently registered to practice in New York State as a (check one): Licensed Clinical Social Worker Psychologist who is educated and trained in psychotherapy Physician who is ABPN certified in psychiatry Mental Health Practitioner who, on or after June 24, 2024 holds the diagnostic privilege in (check one): Marriage and Family Therapy Mental Health Counseling Psychoanalysis								
Ne	w York State License number		Registratio	n Expiration Date				
Employer (Employer and practice site must be located in New York State.): mo. day yr. mo. day yr.								
Business Name								
(Spell out/No abbreviation) Business Address								
Street								
		City		State	Zip Code			
	Telephone	Fax		Email				

Section II: Super	visor's Certification (continue	ed)						
Setting in New York State where supervised experience will take place (if different than employer):								
Setting Name(Spell out/No abbreviation)								
Setting Address								
	Ig Address Street							
		City	State	Zip Code				
	Telephone	Fax	Email					
Check the type o	f setting where the supervise	ed experience is to take place (ch	eck one):					
Office of M	Office of Mental Health (OMH) approved setting							
Office for I	Office for People with Developmental Disabilities (OPWDD) approved setting							
Office of A	Office of Alcoholism and Substance Abuse Services (OASAS) approved setting							
Department of Health (DOH) approved setting								
Office of C	Office of Children & Family Services (OCFS) approved setting							
🗌 Departmei	Department of Corrections and Community Supervision (DOCCS) approved setting							
Office of a	C Office of a licensed Marriage and Family Therapist, Mental Health Counselor, or Psychoanalysis (not owned by the applicant)							
Office of a	Office of a licensed physician, clinical social worker, or psychologist (PLLP, PLLC)							
State Offic	State Office for the Aging approved setting							
Not-for-pro	Not-for-profit or educational corporation issued a waiver by the State Education Department							
Public hea	Ith agency or setting approved	by the social services district						
	Office of a licensed Marriage and Family Therapist, Mental Health Counselor, or Psychoanalysis (not owned by the applicant)							
Office of a	a licensed physician, clinical social worker, or psychologist (PLLP, PLLC)							
Other setti	ing (describe):							
Attestation								
I declare and affirm that the information provided in the foregoing certification is true, complete and correct. Any false or misleading information in, or in connection with this certification may be cause for denial of permit and licensure and disciplinary action against my license and may result in criminal prosecution.								
Supervisor Signat	ure		Date					
Print Name								
Address								
Telephone								
Fax								
Email								
Submitting this f	orm							
application, upload		.nysed.gov/professions/wf/documer	ady submitted your online diagnostic lin <u>nt</u> . You will need the Application ID of yo					
You can submit it	by email to <u>DPLSExperience@</u>	nysed.gov.						
	form along with any required do r Unit, 89 Washington Avenue,		ducation Department, Office of the Profe	essions, Mental				