

KENTUCKY BOARD OF LICENSURE FOR PROFESSIONAL ART THERAPISTS
P.O. BOX 1360
FRANKFORT, KY 40602
<http://pat.ky.gov>

APPLICATION FOR LICENSED PROFESSIONAL ART THERAPIST

CHECKLIST FOR SUBMISSION

- ___ \$___ Fee made payable to the Kentucky State Treasurer
- ___ Proof of current registration or certification by the ATCB
- ___ Official Transcript

PLEASE TYPE OR PRINT ALL INFORMATION

SECTION 1: GENERAL INFORMATION

1. _____ 2. _____
Name: Last First Middle Social Security Number

3. _____
Mailing Address: Street City State Zip

4. _____ 5. ____/____/____
Home Telephone Number Date of Birth

6. _____ 7. _____
Work Telephone Number Email Address

8. Name of degree earned: _____

9. Name of Educational Institution: _____

10. Present Place of Employment: _____

_____ Address City State Zip

Job Title _____

_____ Email address of present employer Telephone number

11. Have you ever been convicted of a misdemeanor or a felony (other than minor traffic violations) under the laws of any state in the United States? _____ Yes _____ No
If yes, what offense(s)? Give details and attach any supporting documentation you may have.

12. Are you credentialed as a professional art therapist in any other state? _____ Yes _____ No
If yes, please list the state(s) and the title of the credential(s).

13. Has your certification or licensure in KY or certification or licensure in any other state ever been suspended or revoked? _____ Yes _____ No
If yes, please give details:

14. Have you ever been discharged or forced to resign for misconduct or unsatisfactory service from any position, professional training program or from the program of any university?
_____ Yes _____ No If yes, please give details:

15. Do you hold **registration** (ATR) _____ or **certification** (ATR-BC) _____ with the Art Therapy Credentials Board? _____ Yes _____ No If yes, please check appropriate level and send verification.

16. Have you ever been disciplined by the ATCB, AATA or by any other professional association?
_____ Yes _____ No If yes, please give details: _____

APPLICANT'S AFFIDAVIT

I, the applicant named in the above, do hereby certify under penalty of law, that the information contained herein is true, correct and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected or my licensure revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

Date _____ Applicant's Signature _____
(Sign your name—do not print or type)

SECTION 2: PART A---- EDUCATION AND PRACTICUM / INTERNSHIP (Please review instructions)

School	Name & Location	Dates Attended		Date of Graduation		# of Hours or Credits	Degrees obtained/ Major
		From	To	Month	Year		
Under grad							
Graduate							

ART THERAPY PRACTICUM / INTERNSHIP

Educational Institution (not practicum site)	Course Number	Faculty Supervisor(s)	Dates From/To	Total # of Prac Hours

SECTION 2: PART B ---- EXPERIENCE

Begin with your present or most recent job and list fully and accurately the details of each job you have held relating to your professional experience. If you have additional sites of experience, please copy and complete this section.

<p>Name of Employer: _____</p> <p>Employed: From: Mo. _____ Yr. _____ To: Mo. _____ Yr. _____</p> <p>Title of Position: _____</p> <p>Name of Supervisor: _____</p>	<p>Describe Your Duties: _____ _____ _____ _____</p> <p>Total Cumulative number of Client Contact Hours for Duration of Employment: _____</p>
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Name of Employer: _____ Employed: From: Mo. _____ Yr. _____ To: Mo. _____ Yr. _____ Title of Position: _____ Name of Supervisor: _____	Describe Your Duties: _____ _____ _____ _____ Total Cumulative number of Client Contact Hours for Duration of Employment: _____
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SECTION 2: PART C ----- VERIFICATION OF SUPERVISION

Supervisor's Name: _____ ATR-BC # _____
LPAT # _____ Other Licensure # _____

Signature of Supervisor

Daytime Telephone: (_____) _____ Date: _____

Number of Hours of Supervision: _____

Additional Supervisor (If applicable):

Supervisor's Name: _____ ATR-BC # _____
LPAT # _____ Other Licensure # _____

Signature of Supervisor

Daytime Telephone: (_____) _____ Date: _____

Number of Hours of Supervision: _____

SECTION 3: CURRICULUM GUIDELINES

A minimum of twenty-four (24) graduate credit hours in art therapy are required. Please list courses completed for each component and appropriate other information.

Component	Educational Institution	Course # & Title	Dates From/To	Credit Hours
History of Art Therapy				
Theory of Art Therapy				
Techniques of Practice in Art Therapy				
Application of Art Therapy with People in Different Settings				
Psychopathology in the practice of art therapy				
Assessment of patients & Diagnostic Categories				
Ethical & Legal Issues of Art Therapy Practice				
Standards of Good Practice in Art Therapy				
Matters of Cultural Diversity bearing on the practice of Art Therapy				

ART THERAPY PRACTICUM / INTERNSHIP

Practicum Site	Course Number	Site Supervisor(s)	Dates From/To	Total # of Prac Hours