



Commonwealth of the Northern Mariana Islands
HEALTH CARE PROFESSIONS LICENSING BOARD
P.O. Box 502078, Bldg., 1242 Pohnpei Court
Capitol Hill, Saipan, MP 96950
Tel No: (670) 664-4809 Fax: (670) 664-4814
Email: cnmi@cnmibpl-hcplb.net
Website: cnmibpl-hcplb.net



General Information

Completion of the Application Forms

Help us to do a good job processing your application. Type or print legibly all application documents. Please read the instructions and give careful thought before answering the questions in the application. Remember, you are certifying that the information is truthful and correct. Make sure all documents are originals or a certified or notarized true copy of original documents. Provide all documents requested in the application; incomplete applications will delay processing. Application fees must accompany applications before initial review can begin.

Each question in the application must be answered. Attach separate sheets of paper, labeled with your name and signed by you, for any question for which you provided a "yes" response.

Failure to answer all questions completely and accurately, or the omission or falsification of information may be cause for denial of your application or disciplinary action if the board subsequently issues you a license.

The application cannot be altered, changed, modified or added to unless approved by the Board.

Confidentiality

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

Documents sent by Fax or Email

Fax copies or documents sent via email are not accepted for documentation or verification in our licensing process. If copy of document is sent via fax or email, the original must be sent via U.S. Postal Service to the Board's office.

Foreign Language Documents

All documents submitted in a foreign language shall be accompanied by an accurate translation in English. Each translated document shall bear the affidavit of the translator certifying that the translator is competent in both the language of the document and the English language and that the translation is a true and complete translation of the foreign language original, and sworn to before a notary public. Translation of any document relative to a person's application shall be at the expense of the applicant.

Personal Interviews

Applicants for licensure may be required to have a personal interview either with an individual board member or with the full board. Should an interview be required, you will be notified and an interview scheduled. An interview may be required if, during the processing of your application, a question arises for which the board determines it requires additional information from you.

Processing Time

In general, average processing time for a permanent license is 3 - 4 weeks. Application processing time depends to a large extent on the response time from other organizations, our workload and the volume of applications being processed.

License Renewal

All licenses issued by the Board expired every two years following its issuance or renewal and becomes invalid after that date. Notification for license renewal is mailed or emailed to licensees at least sixty (60) days before the expiration date. You are required by regulations to keep your current address on file with the Board. There is a late fee of \$25.00 charged for every 1st of the month after the expiration date. Licenses, which have expired for failure to renew on or before the date required may be reinstated within one year of the expiration date. Each licensee whose license has expired and lapsed for more than one year by failure to renew must file a new application, meet present day requirements for licensure, and receive board approval.

Continuing Medical Education (CME)

(a) All L.B.S.W., L.M.S.W., or L.C.S.W. licensed to practice in the CNMI are required to complete the following CE hours as a prerequisite to the renewal of their biennial license:

- (1) L.B.S.W. - 20 hours;
- (2) L.M.S.W. - 25 hours;
- (3) L.C.S.W. - 30 hours.

It shall be the responsibility of the licensee to obtain documentation, satisfactory to the Board, from the organization or institution, of his or her participation in the CME, and the number of credits earned. Licensure renewal shall be denied to any licensee who fails to provide satisfactory evidence of completion of CME requirements, or who falsely certifies attendance at and/or completion of the CME, as required herein.

License Denial

If for any reason you are denied the license you are applying for, you are entitled to a hearing pursuant to the Commonwealth Administrative Procedures Act, 1 CMC § 9108-15.

Abandonment of Application

Your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for one (1) year. If the application is deemed abandoned the applicant shall be required to reapply for licensure and comply with the licensing requirements in effect at the time of the reapplication.

Schedule of Fees

Application Fee	\$100.00	Replacement of License	\$75.00
License Fee	\$100.00	Replacement of Card	\$25.00
Temporary License Fee	\$100.00	Verification of License	\$25.00
Renewal License Fee	\$100.00	Letter of Good Standing	\$25.00
Delinquent Fee (each month)	\$25.00		

Requirements for Initial Licensure - U.S. or Canada

LBSW

- Has a Bachelor's degree in social work from a college or university accredited by or deemed to be equivalent to an accredited program by the Council on Social Work Education, or the Canadian Association of Schools of Social Work or from a college or university accredited by an accrediting organization recognized by the Board, or a social work education program approved by the Board; and
- Has passed the basic examination administered by the Association of Social Work Boards, or an examination in social work approved by the Board.

LMSW

- Has a Master's degree in social work from a college or university accredited by or deemed to be equivalent to an accredited program by the Council on Social Work Education, or the Canadian Association of Schools of Social Work or from a college or university accredited by an accrediting organization recognized by the Board, or a social work education program approved by the Board; and
- Has passed the intermediate examination administered by the Association of Social Work Boards, or an examination in social work approved by the Board.

LCSW

- Has a master's or doctoral degree in social work from a college or university accredited by or deemed to be equivalent to an accredited program by the Council on Social Work Education, or the Canadian Association of Schools of Social Work or from a college or university accredited by an accrediting organization recognized by the Board, or a social work education program approved by the Board;
- Has passed the clinical examination administered by the Association of Social Work Boards, or an examination in social work approved by the Board; and
- Has provided evidence of successful completion of at least two (2) years of continuous full-time employment in postgraduate clinical social work under the supervision of a licensed clinical social worker, a licensed physician or a licensed osteopathic physician who has completed a residency in psychiatry, a licensed clinical mental health counselor, a diplomate in clinical social work, a designated member of the ACSW, a licensed psychiatrist, or a licensed psychologist.

Items/Documents required when applying:

- Application form
- Applicant's 2x2 photograph taken within 6 months from date of application
- Application non-refundable fee of \$100
(Cashier's Check or Money Order made payable to "CNMI Treasurer")
- Original, certified or notarized copy of Degree
- Original, certified or notarized copy of post-graduate training, if any
- Original, certified or notarized copy of Examination scores

Applicants for Licensure by Endorsement

HCPLB may issue a LBSW, LMSW or LCSW license to an applicant by endorsement if you hold an active, unrestricted license of the same category from another U. S. state, territory or Canada and the requirements in the other jurisdiction are at least as stringent as the requirements in the CNMI.

Items/Documents required when applying:

- Application form
- Applicant's 2x2 photograph taken within 6 months from date of application
- Application non-refundable fee of \$100
(Cashier's Check or Money Order made payable to "CNMI Treasurer")
- Original, certified or notarized copy of Degree
- Original, certified or notarized copy of post-graduate training, if any
- Original, certified or notarized copy of current/active license



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Attach a recent 2x2 ID photo here taken within 6 months of the application.

APPLICATION FOR BACCALAUREATE, MASTER'S OR CLINICAL SOCIAL WORKER LICENSE

<input type="checkbox"/> Initial	<input type="checkbox"/> Endorsement	<input type="checkbox"/> Temporary
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<input type="checkbox"/> Baccalaureate Social Worker	<input type="checkbox"/> Master's Social Worker	<input type="checkbox"/> Clinical Social Worker
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APPLICATION INFORMATION – Please Type or Print

1. Last:	First:	Middle:	2. Social Security No:
3. Birthdate: (Mo/Day/Yr)	4. Color of Eyes: Color of Hair:	5. Height: Weight:	6. Sex:
7. Mailing Address:		8. Email Address:	
9. Residence Address:		10. Phone No: (W): (H):	
11. NPI # (if available):		12. Citizenship: ___ U.S. ___ Other Specify:	

13. EDUCATION *(List all Bachelor's or Master's programs attended & provide an original, notarized or certified copy of your degree)*

Name of Schools	Location (City/State or Country)	Degree Earned	Dates (Mo/Yr)	
			From	To

14. EXAMINATIONS – *(List examination(s) you have taken and passed with ASWB or any other examinations)*

Examination	Date	Result (Pass/Fail)

15. EXPERIENCE (List all relevant or related post graduate training or employment, if any)

Employer	Location (City/State or Country)	Dates (Mo/Yr)		Supervisor's Name
		From	To	

16. LICENSES (list all states/territory where you currently hold or held a license or certification to practice)

Name of Jurisdiction	Date Issued	Expiration Date	License Number	Current Status

17. Name/Address of Intended Employment within the CNMI:

If you answer "yes" for any of items 18-32 you must attach a detailed explanation on a separate sheet, which includes state or country where action is pending or took place, relevant dates, action taken and reasons for such action. (Include Findings of Fact, Conclusion of Law, Final Order and whether you have been reinstated. If reinstated, date and conditions of license.)

18. Have you ever been charged with, or been found to have committed dishonorable, unprofessional conduct, negligence, incompetence, misconduct, or repeated negligent acts by any licensing board, other agency, or clinic?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
19. Has a claim or an action ever been filed against you for your profession which resulted in a settlement, judgment, or arbitration award of \$25,000 or more?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
20. Has any licensing board, other agency, or disciplinary authority refused to issue you a license, renew your license, suspended, revoked, accepted surrender of your license, placed on probation or conditioned your license, held by you now or previously, or ever fined or otherwise disciplined you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
21. Is there any ongoing or pending investigation against you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
22. Is there any disciplinary action pending against you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

23. Has any clinic or training program restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
24. Has your ability to practice your profession in a competent and safe manner ever been impaired or limited by any condition, behavior, impairment, or limitation of a physical, mental, or emotional nature?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
25. Have you used or are you currently using any chemical substances(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice your profession in a safe and competent manner?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
26. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
27. Have you been treated for or had a recurrence or a diagnosed addictive disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
28. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice your profession safely?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
29. Do you have any other condition in which in any way impairs or limits your ability to practice your profession safely?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
30. Have you ever been found guilty, pleaded guilty, no contest, or nolo contendere to a crime involving moral turpitude or crime related to your profession, or felony in any court?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
31. Is criminal action pending against you in any court?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
32. Are you required to register as a Sex Offender?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

33. DECLARATION:

I hereby certify that I am the person herein named subscribing to this application. I have read the complete application, and I know the full content hereof. I declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct. I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto or falsification or misrepresentation of credentials to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license to practice a health profession in the Commonwealth of the Northern Mariana Islands. I further certify that I have read and will abide by P.L. 15-105 and the HCPLB Regulations.

Signature of Applicant

Date

Please complete the application form and attach all original, certified or notarized documents and a non-refundable application fee of \$100.00 (money order or cashier's check make payable to "CNMI Treasurer"). Do not send cash.

Eff 8/2018

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (print name), do hereby authorize a disclosure of records concerning myself to the Health Care Professions Licensing Board (HCPLB). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the HCPLB may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the HCPLB relating to substance abuse or dependence and/or mental health.

I further agree that the HCPLB may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, and fellowship) records, including records or any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the HCPLB deems reasonably necessary for the purposes set forth in this release.

Release of Liability:

I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the HCPLB pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the HCPLB, the Commonwealth of the Northern Mariana Islands, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

I have read and fully understand the contents of this "Authorization to Release Information".

Signature of Applicant

Date

AFFIDAVIT

I, the undersigned, being duly sworn, say that I am the person referred to in the foregoing application for license to practice _____ in the Commonwealth of the Northern Marianas, that the statements therein are true to the best of my knowledge and belief.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice as a _____ in the Commonwealth of the Northern Marianas.

Signature of Applicant

FOR NOTARY PUBLIC ONLY

Subscribed and sworn to before me this _____ day of _____, 20_____.

Signature of Notary Public

My commission expires _____