

\*\*\*FOR OFFICE USE ONLY\*\*\*

**Board of Music Therapist Checklist**

- Application
- Application Fee
- CBMT Certification
- Proof of Age/Photo ID
- O/S License Verification



\*\*\*FOR OFFICE USE ONLY\*\*\*

Application Approved:

License Number:

Issue Date:

Signature of Board Administrator

ID#:

Receipt #:

**Rhode Island  
Board of Music Therapy**

Room 104  
3 Capitol Hill  
Providence, RI 02908-5097

***Instructions and Application For***

**License As A**

Music Therapist  
by

**Application**

FOR OFFICE USE ONLY

License # \_\_\_\_\_  
Name \_\_\_\_\_

**MILITARY STATUS ELIGIBILITY**

*(Documentation Required)  
see next page for instructions*

Please check ONE of the following criteria for expedited application:

- I am in active military duty or a reservist
- I am a military veteran with honorable discharge
- I am the spouse of someone in active military duty or the spouse of a reservist

*Applicant - Print Name*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*LAST NAME*

*FIRST NAME*

*MI*

Phone: (401) 222-2828

TTY/TDD: (800) 745-5555

Fax: (401) 222-1272

# LICENSURE REQUIREMENTS

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- Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.
- Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **\$90.00** and attached to the upper left-hand corner of the first (Top) page of the application. **THIS APPLICATION FEE IS NONREFUNDABLE.** Please be advised that this is an application fee and includes the first license **only** up until the next expiration date. All Music Therapists licenses expire on the 31st of January in each odd-numbered year.
- Proof of Age - Copy of your driver's license or other state issued ID verifying you are 18 years of age or older
- Active Certification sent directly from the Certification Board for Music Therapists or proof of being transitioned into board certification mailed directly to the Department.
- If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that purpose)
- If applying for expedited military status, please complete the Military Expedition Form at the end of this application packet.

## Licensure Information

Please visit the RIDOH website at <http://www.health.ri.gov/licenses> to Verify your license, download Rules and Regulations/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.

## License Certificates

RIDOH will be providing wallet license cards **ONLY** on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of \$30.00 made payable to RI General Treasurer.

- I would like to receive a license certificate. I have enclosed a separate check in the amount of \$30.00



# State of Rhode Island Music Therapist

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

## 1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/Permit/Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

## 2. Social Security Number

U.S. Social Security Number

**"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State."**

## 3. Gender

 Male Female

## 4. Date of Birth

Month

Day

Year

## 5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

Home Phone

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

## 6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

***This address will appear on the Department of Health web site.***

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

Business Phone

Extension

Business Fax

Applicant: Print your complete last name >

**7. Preferred Mailing Address**

Please check ONE

Please use my **Home Address** as my preferred mailing address

Please use my **Business Address** as my preferred mailing address

**8. Qualifying Education**

Please list the name and information about the school that you attended that qualifies you for this license.

\_\_\_\_\_

Type of School (University, College, Technical School, etc.)

\_\_\_\_\_

Name of School

Date Graduated:

Month

Year

\_\_\_\_\_

Degree Received (Bachelor of Arts, Master of Science, Diploma, etc. )

**9. Other State License(s)**

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state as a Music Therapist?

Yes  No

If the answer to this question is **“yes”**, enter all other state licenses in Question 10 (below):

**10. Licensure**

List all states or countries in which you are now, or ever have been licensed to practice your profession.

State/Country:

\_\_\_\_\_  Active  Inactive

\_\_\_\_\_  Active  Inactive

\_\_\_\_\_  Active  Inactive

\_\_\_\_\_  Active  Inactive

\_\_\_\_\_  Active  Inactive

\_\_\_\_\_  Active  Inactive

\_\_\_\_\_  Active  Inactive

\_\_\_\_\_  Active  Inactive

\_\_\_\_\_  Active  Inactive

State/Country:

\_\_\_\_\_  Active  Inactive

\_\_\_\_\_  Active  Inactive

\_\_\_\_\_  Active  Inactive

\_\_\_\_\_  Active  Inactive

\_\_\_\_\_  Active  Inactive

\_\_\_\_\_  Active  Inactive

\_\_\_\_\_  Active  Inactive

\_\_\_\_\_  Active  Inactive

\_\_\_\_\_  Active  Inactive

**DOCUMENTATION NEEDED for Endorsement Applicants:**

**YOU** must send an “Interstate Verification Form” (See page 7) to each state in which you are, or ever have been, licensed as a Music Therapist (Make copies as needed).

**11. Criminal Convictions**

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending?

Yes  No

Abbreviation of State and Conviction<sup>1</sup> (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year
	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

**12. Disciplinary Questions**

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are formal charges pending?

Yes  No

2. Have you ever been denied a license, certificate, registration or permit in any state?

Yes  No

**Note:** If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper. Any applicant, whose criminal records check reveals a conviction for any sexual offense, shall be denied a license.

**13. Affidavit of Applicant**

Complete this section and sign.

Make sure that you have completed all components accurately and completely.

I, \_\_\_\_\_, affirm that the information provided on my application form and documentation provided to support my application is true, accurate and unaltered. I acknowledge that pursuant to R.I.G.L. 11-18-1, knowingly making a false statement on my application form is punishable as a misdemeanor and that such an act shall constitute cause for denial, suspension or revocation of my license/ permit to practice as an Electrologist Instructor in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Music Therapy of any change in the answers to these questions after this application and this affidavit is signed.

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

\_\_\_\_\_  
Date of Signature (MM/DD/YY)



# Rhode Island Board of Music Therapy

Room 104, 3 Capitol Hill  
 Providence, RI 02908-5097  
 (401) 222-2828

## INTERSTATE VERIFICATION FORM - OTHER STATE LICENSURE

I am applying for a license to practice as a Music Therapist in the State of Rhode Island. The Rhode Island Board of Music Therapy requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Music Therapy at the above address.

Print/Type Full Name	Signature	Date
Previous Names Used	Social Security Number	Date of Birth
License Number	Date Issued	

### THIS SECTION TO BE COMPLETED BY THE MUSIC THERAPY BOARD

Music Therapy Program Completed:	Location:	Graduation Date:
Licensed by Examination? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has completed and passed the National Certification Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No	
License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	Original Date Issued:	Expiration Date:

**Questions:**

1. Has this licensee ever been investigated by your Board?  Yes  No
2. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending?  Yes  No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?  Yes  No
4. Do you know of any information that may discredit this person?  Yes  No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

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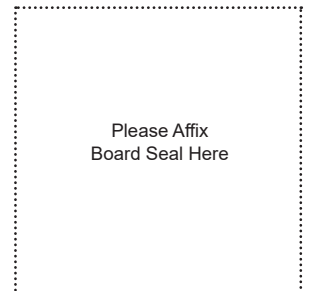
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### Certification:

Signature	Date
Type or Print Name	
Title	
Full Name and State of Licensing Board	



*Please return directly to the Board at the above address. Thank you for your prompt cooperation.*



## Rhode Island Department of Health Military Expedition Form

Please attach this form to the *front* of your completed application and mail to the address shown on the application cover.

Pursuant to Rhode Island General Laws § [5-88-1](#) et seq., upon application, this state may recognize occupational licenses, certificates or permits obtained from other states for military members and their spouses who relocate to this state pursuant to military orders. The Rhode Island Department of Health (RIDOH) will expedite your or your spouse's health professional license application provided the following conditions are met.

### I. PROFESSION/LICENSE TYPE

Please indicate the profession and/or license type you are applying for so that your application can be routed to the correct office:

Profession/License Type: \_\_\_\_\_

### II. MILITARY STATUS

Please check ONE of the following criteria for expedition:

I am in active military duty or a reservist.

I am the spouse of someone in active military duty or the spouse of a reservist.

I am a military veteran with honorable discharge. *You do not need to complete the rest of this application – please skip to the signature line.*

### III. PROOF OF MILITARY STATUS

Please attach a copy of proof of your military status such as one of the following: Leave Earning Statement (LES), Letter from Command, or Copy of Orders

### IV. MILITARY CHANGE OF STATION ORDER

Permanent Change of Station Order

### V. PROOF OF GOOD STANDING

Proof of good standing from the board in the other state in which the person has a license.

### VI. Criminal Background Check (a "BCI") (*unless required in the initial license application*)

BCI completed from the RI Attorney General's Office.

### VII. ATTESTATIONS:

Check all that apply:

No board in any other state has revoked the license for which I am applying as a result of negligence or intentional misconduct.

I have never surrendered an occupational license, certificate, or permit because of negligence or intentional misconduct.

I do not have a complaint, allegation, or investigation currently pending before a board in another state which relates to unprofessional conduct or an alleged crime.

I attest that the above responses and information are true and accurate to the best of my knowledge and that none of the information set forth above is false, erroneous, or defective in any important, as set forth in R.I. Gen. Laws § 11-18-1. I understand that this application is being made to the Rhode Island Department of Health, which shall rely upon my attestation and the information provided in this document.

Signature of Applicant

Date

*On a case-by-case basis RIDOH may grant a temporary license should the military member or spouse need additional time to complete education, training, and/or experience for the licensure in Rhode Island. RIDOH will contact the applicant directly should that be needed.*