



Board of Behavioral Sciences
1625 North Market Blvd., Suite S-200
Sacramento, CA 95834
(916) 574-7830

Submit application to: ExamSME@dca.ca.gov

SUBJECT MATTER EXPERT APPLICATION

Section A: PERSONAL INFORMATION

| | | | | | | | | | | | |
|----------------|--|-----|----------------|-------|------------|-----------------|--------|--|----------------|----|--|
| Last Name | | | | | First Name | | | | | MI | |
| Street Address | | | | | | | City | | | | |
| State | | Zip | | Phone | | | E-Mail | | | | |
| License Type | | | License Number | | | Expiration Date | | | Other Licenses | | |

Section B: MAILING ADDRESS FOR FEDEX/UPS SHIPMENTS

Same as above? ☐ Yes ☐ No If NO, provide your mailing address below:

| | | | | | | | | | | | |
|-----------------|--|--|--|--|------|--|--|-------|--|-----|--|
| Mailing Address | | | | | City | | | State | | Zip | |
|-----------------|--|--|--|--|------|--|--|-------|--|-----|--|

Section C: REQUIREMENTS

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| Do you currently perform a minimum of 20 hours of training, supervision, education, or clinical experience per week? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| How many hours of face-to-face therapy do you perform per week? | Hours: |
| How long have you been working in the field under your license? | Years: |

Section D: QUESTIONNAIRE

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|--|--|--|--|
| Have you ever participated in an exam development workshop for the Board? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If YES, when did you last participate in a workshop? | |
| Are you currently engaged in providing formal or informal instruction to individuals pursuing Clinical Social Worker, Marriage and Family Therapist, or Professional Clinical Counselor licensure (i.e., university professor, exam preparation training, etc.)? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If YES, please describe the setting and subject matter taught: | | | |
| Do you currently provide supervision to registered Associates? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If YES, how many Associates do you supervise? | |

Section E: CERTIFICATION

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|--|--|
| Were you ever denied a professional health care license or had such a license or privilege suspended, revoked or otherwise disciplined or voluntarily surrendered in California or any other state or territory of the US or by any other government agency? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|

I declare under penalty of perjury that all information provided on this application is true and correct. I understand that if I am hired, I will be required to comply with the terms of an examination security/confidentiality agreement.

| | | |
|-----------|------------|------|
| Signature | Print Name | Date |
|-----------|------------|------|