Douglas J. W. Bartholomew, Application file LH00003582			
Beginning Page	**Ending Page**	**Entire page or group of pages withheld**	**Exemption**
1		Licensee's residential address, phone number and social security number	RCW 42.56.350(2) and 42.56.050. RCW 42.56.350(1), and 42 USC Section 405(c)(2)(C)(vii)(1).
2		Personal data answers	RCW 42.56.360(2) and RCW 70.02.020.
3	5		None

Washington State Department of Health

Health Professions Quality Assurance
Counselor Programs
P.O. Box 1099
Olympia, WA 98507-1099

Background Check Processed

JUN 18 2001

DEPARTMENT OF HEALTH
INVESTIGATION SERVICE UNIT

For Office Use Only	
LICENSE NO: LH00003582	LIC. DATE: 7-9-01
APPROVED BY:	
VALIDATION INFORMATION:	

LICENSE # LH00003582

APPLICATION FOR MENTAL HEALTH COUNSELOR

Please Type or Print Clearly - Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

1. DEMOGRAPHIC INFORMATION

APPLICANT'S NAME — LAST: BARTHOLOMEW — FIRST: DOUGLAS — MIDDLE INITIAL: Jerry

RESIDENTIAL ADDRESS

CITY — STATE — ZIP — COUNTY

... will show this address and all correspondence from the Department will be sent to this address until you notify us of a change.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)

SOCIAL SECURITY NUMBER

GENDER: ☐ Female ☒ Male

BIRTHDATE: 1-13-50

PLACE OF BIRTH: Spokane WA

Have you ever been known under any other name? ☐ Yes ☒ No

If yes, other name(s):

2. PREVIOUS CERTIFICATION/LICENSURE/REGISTRATION

List all states (including Washington) where certifications/licenses/registrations are or were held. Specifically list certifications/licenses/registrations granted by examination, endorsement, or grandparenting.

STATE	CERTIFICATION/LICENSE TYPE	License/Registration/Certification YEAR ISSUED	License/Registration/Certification NUMBER	METHOD OF LICENSURE EXAM	METHOD OF LICENSURE END	METHOD OF LICENSURE GP
WA	Cert MH Cnslr	1988	020703-MH30000460			

An "Out of State Verification for Registration/Certification/Licensure" form is enclosed and must be sent to each state listed above. Enter your full name and birthdate at the top of the form so the state may identify you. Also contact each state board listed for any fees they might charge you for processing the verification form.

3. EXAMINATION DATA

Have you taken and passed the National Board of Certified Counselors?

NCE ☐ Yes ☒ No Year? _____

NCMHCE ☐ Yes ☒ No Year? _____

4. PERSONAL DATA

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?

4. Are you currently engaged in the illegal use of controlled substances?

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you must answer "yes" to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ☐ ☒

   b. a charge of a sex offense? ☐ ☒

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☒

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☒

   b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☒

   c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☒

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ☐ ☒

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☒

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☒

Washington State Department of Health

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LTH COUNSELOR

REVENUE SECTION

rtholomew, D

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CE

5. EDUCATION

Please provide a chronological listing of graduate school(s) attended, major, and month and year the degree was granted. A transcript is to be requested from the graduate school(s) and sent **directly** from the graduate school to the Department of Health, Mental Health Licensure Section per instructions.

GRADUATE SCHOOL	DEGREE AND MAJOR	DEGREE GRANTED	
		MONTH	YEAR
Western WA University	MS, Psychology	12	1978

6. GRADUATE LEVEL COURSEWORK

Requirement: Graduation from a master's or doctoral level educational program in mental health counseling or related discipline from an accredited college or university based on nationally recognized standards.

National Board of Certified Counselors requires a minimum of 48 semester or 72 quarter hours of graduate level coursework with at least one course in the following areas:

COURSE	COURSE #	COURSE TITLE	SEM/QTR HRS
a) Human Growth and Development			
b) Social and Cultural Foundations			
c) Helping Relationships			
d) Group Work			
e) Career and Lifestyle Development			
f) Appraisal			
g) Research and Program Evaluation			
h) Professional Orientation and Ethics			

7. AIDS EDUCATION AND TRAINING ATTESTATION

I certify I have completed the minimum of 4 hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE
DB	6/6/1

8. APPLICANT'S ATTESTATION

I, Douglas J. Bartholomew, certify that I am the person described and identified in
Name of Applicant

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice in the State of Washington.

Signature of Applicant Douglas J Bartholomew Date 6/6/1

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