Counselor, Social Worker & Marriage and Family Therapist Board

77 S High St., 24th Flr, Rm 2468 Columbus, Ohio
43215-6171 614-466-0912 & Fax 614-728-7790
www.cswmft.ohio.gov & cswmft.info@cswb.ohio.gov

NEW CERTIFICATE REQUEST FORM

You may FAX this form if notary not required

A $15 fee is required for new wall certificates. Please include a $15 money order, cashier or business check made out to the "Treasurer State of Ohio". You may also pay the fee with a credit card see page 2. Do not email your credit card # on this form; if emailed we will call you.

COMPLETE THIS SECTION IF YOUR NAME HAS CHANGED. A marriage certificate, drivers license (in your new name) or court record is required (photocopies are acceptable) OR for name changes without proof simply complete the affidavit at the bottom of this form, and have this form notarized. Please note, original documents will NOT be returned or kept on file.

Replaced certificates must be destroyed– Note the notarized statement below states you will do so. PRINT CLEARLY your name exactly the way you want your certificate to read, including middle initial, or hyphenated last name. Please note that the Board uses your middle initial so do not spell out your middle name.

*Amount of money order or cashiers check $_____ Payable to the **Treasurer State of Ohio** *(No personal checks)*	Check box here if paying by credit card ☐

ORIGINAL INFORMATION:		CORRECTED INFORMATION:	
NAME:		NAME:	
ADDRESS:		ADDRESS:	
CITY:	STATE/ZIP:	CITY:	STATE/ZIP:
LICENSE #:		OHIO COUNTY:	DAYTIME PHONE #:
EMAIL:		EMAIL:	

COMPLETE THIS SECTION IF YOUR CERTIFICATE WAS DAMAGED, MISPLACED OR NEVER RECEIVED OR FOR A DUPLICATE CERTIFICATE
PLEASE COMPLETE THE FOLLOWING AFFIDAVIT & NOTARIZE AND RETURN BY MAIL

NAME:	LICENSE #:
ADDRESS:	EMAIL:
CITY:	STATE/ZIP:
DAYTIME PHONE #:	OHIO COUNTY:

The undersigned, being duly sworn, deposes and says that their name has changed, their certificate was damaged, he/she has lost, or never received their license certificate issued to him/her by the CSWMFT Board, or he/she is requesting a duplicate certificate for a second office. The undersigned deposes that he/she shall destroy the certificate, if it is being replaced.

State of _____ County of_____

Sworn to before me and subscribed in my presence this _____ day of_____20_____

_____ _____

Signature of Licensee Notary Signature

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Credit Card Payment Authorization Form

Please check one: ☐ Master Card ☐ Visa ☐ Discover

Cardholder Name: _____

Address: _____

City, State, Zip: _____

Telephone #: _____

Email Address (for receipt): _____

Credit Card Number: _____

Expiration Date: _____

CVV2/CID Code # (Three digit number on back of card): _____

Payment Amount: _____

Payment for (exam, application, etc): _____

Signature: _____ Date: _____

Credit Card Payments may be mailed, faxed, or phoned in to the Board office. Do not email; email is not secure.

614-466-0912(phone) 614-728-7790(fax) www.cswmft.ohio.gov Email: cswmft.info@cswb.ohio.gov

This document will be shredded after your payment is processed.