



## Counselor, Social Worker & Marriage and Family Therapist Board

50 West Broad St, Suite 1075 Columbus, Ohio 43215-5919  
614-466-0912 & Fax 614-728-7790  
www.cswmft.ohio.gov & cswmft.info@cswb.state.oh.us

### **NEW CERTIFICATE REQUEST FORM**

**You may FAX this form if notary not required**

**Beginning April 1, 2012, 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**.

*Amount of money order or cashiers check \$ _____ Payable to the <b>Treasurer State of Ohio</b> (No personal checks)	Check box here if paying by credit card <input type="checkbox"/>
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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  
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. The undersigned deposes that he / she shall destroy the certificate that 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

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.**

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**This document will be shredded after your payment is processed.**