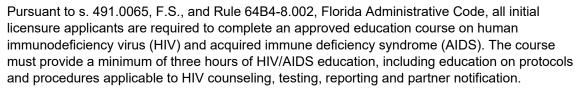
Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling

HIV/AIDS AFFIDAVIT





An applicant who has not taken the course at the time of licensure shall, upon submission of an affidavit showing good cause, be allowed six months to complete this requirement. If you have already completed this course, please send proof with your application. If you have not yet completed the course, please fill out this affidavit, have it notarized, and return with your application.

Your application is incomplete without this affidavit or proof of completion of the HIV/AIDS course.

APPLICANT AFFIRMATION					
, am of legal age and have personal knowledge of the matters s (Applicant Full Name)					
this affidavit. I will complete a					
the first six months of my lice	nsure by the Departmer	nt of Health.			
Applicant Signature			Date	Date	
				MM/DD/YYYY	
NOTARY SIGNATURE					
Before me, the undersigned a	authority, personally app	peared		who	
deposes and affirms the above			(Applicant Full Name)		
State of	County of _				
Sworn to and/or subscribed b	efore me this	day of _		, 20	
Ву	whose identity is known to me by				
Notary Signature		Printed Nam	ne of Notary		
[NOTARY SEAL]					