Mental Health Counselor Form 2

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Certification of Professional Education

Applicant Instructions

1. Complete Section I. In item 3, enter your name exactly as it appears on your Application for Licensure (Form 1). Be sure to sign and date item 9.
2. Send the entire form to the institution where you completed your Mental Health Counseling studies and ask the Registrar to complete the appropriate parts of Section II and forward both pages of the form directly to the Office of the Professions at the address at the end of the form. Be sure to include any fee required by the institution. **This form will not be accepted if submitted by the applicant.**
3. An official transcript or marksheets are required if you completed a program that is not registered by the Department as licensure qualifying.

Section I: Applicant Information

1 **Social Security Number** ☐☐☐ ☐☐ ☐☐☐☐
(Leave this blank if you do not have a U.S. Social Security Number)

2 **Birth Date** Month ☐☐ Day ☐☐ Year ☐☐

3 **Print Name as It Appears on Your Application for Licensure (Form 1)**

Last
First
Middle

4 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1
Line 2
Line 3
City
State Zip Code
Country/ Province

5 Print your name as it appears on your degree or diploma.

Name: _____

6 School attended: _____
(Name) *(city/state or country)*

7 Name of degree/diploma: _____

8 Date degree/diploma awarded: _____ / _____ / _____
mo. day yr.

9 I request and give my permission to the school listed in item 6 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure.

_____ _____ / _____ / _____
Applicant's Signature mo. day yr.

Section II: Certification of Professional Education

Instructions to the Registrar: Please complete Parts A, B and C before sending both pages of this form in an official school envelope directly to the Office of the Professions at the address at the end of the form. **This form will not be accepted if submitted by the applicant or any other party.**

Name of applicant: _____
(Section I, item 5)

Part A - Mental Health Counseling Program Registered by the New York State Education Department (NYSED) as licensure qualifying: To be completed only by those schools whose Mental Health Counseling program was, at the time the applicant's degree was (or will be) awarded, registered by the NYSED as licensure qualifying.

☐ Completed the program on _____ / _____ / _____ and was awarded the degree/diploma of _____
mo. day yr. (Title of degree/diploma)

In the program area or major of _____ on the date of _____ / _____ / _____.
(Title) mo. day yr.

OR

☐ on _____ / _____ / _____ this institution determined that the above-named student met all requirements for the degree and
mo. day yr.

the institution has agreed to award the degree/diploma of _____ on _____ / _____ / _____.
(Title of degree/diploma) mo. day yr.

Part B - All Other Programs. An official transcript or marksheet giving courses completed by year and grades and a syllabus of the course of studies completed must be attached.

1. Date of applicant's entrance, and either the applicant's date of completion of studies or withdrawal from the school:

   Entrance date: _____ / _____ / _____ Completion date: _____ / _____ / _____ Withdrawal date: _____ / _____ / _____
   mo. day yr. mo. day yr. mo. day yr.

2. Degree/diploma awarded: _____

3. Date degree/diploma awarded: _____ / _____ / _____
   mo. day yr.
   Name of accrediting body or official organization that recognizes this program: _____

   _____

   Date of Accreditation: _____ / _____ / _____
   mo. day yr.
   Address of accrediting body or official organization that recognizes this program: _____

   _____

PART C - Certification (To be completed by ALL schools)

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the educational record of the individual named on this form.

Signature of Registrar: _____ Date: _____ / _____ / _____
mo. day yr.

Print or Type Name: _____

Title or official position: _____

Institution: _____

Address: _____ **(INSTITUTION SEAL)**

City: _____ State _____ Zip Code _____

Telephone: _____ Fax: _____

E-mail Address: _____

Return Directly to: **New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Mental Health Counseling Unit, 89 Washington Avenue, Albany, NY 12234-1000.**