



**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.**