

Section II: Verification of Other Professional Licensure/Certification

Instructions to the Licensing/Certifying Authority: Please complete items 1-4, sign and date the certification and return both pages of this form in an official envelope **directly** to the Office of the Professions at the address below. **This form will not be accepted if returned by the applicant.** Attach additional sheets if necessary.

1. Name of applicant: _____
(Section I, item 6)

2. Professional title on license/certificate: _____
License/certificate number: _____ Date of licensure/certification: _____ / _____ / _____
mo. day yr.

3. Verification of licensure/certification
What requirements did the applicant meet to become licensed/certified in your jurisdiction?
Education: Degree: _____

Examination:
Oral Examination Title: _____ Date: _____ / _____ / _____ Score: _____
mo. day yr.
Written Examination Title: _____ Date: _____ / _____ / _____ Score: _____
mo. day yr.

Experience:
 None _____ hours Describe (i.e., clock hours) _____
 Endorsement of license/certificate from or reciprocity with: _____
(name of jurisdiction)
 Grandparented

4. A. Has the applicant identified in Section I been subject to any disciplinary action? Yes No
B. Are any charges pending against this individual? Yes No
If the answer to either A or B is "yes," please attach a complete explanation with any supporting documentation.

Certification

I hereby certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the applicant named on this form. I further certify that, except as noted in item 4 above or in any attachments, this licensing authority has never taken any disciplinary action against this person and that in so far as the licensing authority has knowledge, there have been no charges preferred nor has any information been presented relating to any question of unprofessional or immoral conduct.

Signature: _____ Date: _____ / _____ / _____
mo. day yr.
Print name: _____
Title: _____
Licensing/certifying authority: _____ (SEAL)
Address: _____
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.