# Mental Health Counselor Form 4
# Applicant Experience Record

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

**Applicant Instructions**

1. Complete both pages of this form. In item 3, enter your name exactly as it appears on your Application for Licensure (Form 1). Be sure to sign and date item 8 and send this form directly to the Office of the Professions at the address at the end of the form.

2. For your experience to be considered, **you must also complete Section I of Form 4B and forward the entire form and a copy of Appendix A to *each supervisor* you list in item 7 on this form**.

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 Your Name Exactly 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. Telephone/Email Address

Daytime Phone
Area Code Phone

Email Address (please print clearly)

6. Give any other names by which you have been known

7. List supervisor(s) who will verify your experience for licensure as a Mental Health Counselor.

- You must document 3,000 clock hours of supervised Mental Health Counseling experience.
- The supervisor(s) must meet the qualifications in Appendix A.
- The supervisor(s) listed must have supervised your experience in assessment and evaluation, treatment planning, completing psychosocial histories and progress notes, individual counseling, group counseling, psychotherapy, and consultation.
- If a supervisor is deceased, you should list a licensed colleague who will attest to your supervised experience and to the qualifications of the deceased supervisor

| Assigned Number | Name of Supervisor and Address of Experience Setting | Dates of Experience | |
|---|---|---|---|
| | | From | To |
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |

8. Attestation

I declare and affirm that the statements made in the foregoing application, including accompanying statements are true, complete and correct. I understand that any false or misleading information in, or in connection with my application may be cause for denial of licensure and may result in criminal prosecution.

Applicant Signature _____ Date _____

**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.



Reset Form