Mental Health Counselor Form 4

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 Experience Record

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 this form.
2. You must also complete Section I of **Form 4B** and forward the entire form to each supervisor you list on page 2 of this form.

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 **Telephone/E-Mail Address**

Daytime phone
Area Code Phone

E-mail Address (please print clearly)

6 Have you ever changed your name? ☐ Yes ☐ No

If Yes, please print former name(s): _____

7 List the 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	
1		From:	To:
		Total clock hours:	
2		From:	To:
		Total clock hours:	
3		From:	To:
		Total clock hours:	
4		From:	To:
		Total clock hours:	
5		From:	To:
		Total clock hours:	
6		From:	To:
		Total clock hours:	

8 **Attestation**

I declare and affirm that the statements made in this application, including accompanying documents, 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 or loss of licensure and may result in criminal prosecution.

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

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.**