Mental Health Counselor Form 4B

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

Assigned No.	
(From Form 4)	

Certification of Supervised Experience

Applicant Instructions

1.	Complete Section I	I. In item 3, er	nter your name as	s it appears on you	Application for	Licensure (Forn	n 1). Be sure to sig	n and date item
	6							

2. Send this entire form **and** a copy of Appendix A to your supervisor(s) to complete Section II. The supervisor(s) must return both pages of the form directly to the Office of the Professions at the address at the end of the form. The form must bear an original notarized signature of the supervisor(s) and date. If additional copies are needed, you may photocopy this form. **This form will not be accepted if returned by the applicant.**

	if returned by the applicant.																																		
Sec	Section I: Applicant Information																																		
1	Sittle Bate Month																																		
	(Leave this blank if you do not have a U.S. Social Security Number)																																		
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 1																																		
	Line 2																																		
Line 3																																			
	City																																		
	State Zip Code																																		
	Country/ Province																																		
	Name at	time	of er	nplo	yme	ent ((if d	ffere	ent fr	om a	abov	ve): _																							
5	Name of	supe	rviso	r: _																				/	Assi	gne	d nu	ımb	er f	ron	n Fo	rm	4		
	I practice	d Me	ntal	Hea	ılth (Cou	nse	ing :	as de	efine	d be	elow	:																						
	I practiced Mental Health Counseling as defined below: Mental Health Counseling is the evaluation, assessment, amelioration, treatment, modification, or adjustment to a disability, problem, or disorder of behavior, character, development, emotion, personality or relationships by the use of verbal or behavioral methods with individuals, couples, families or groups in private practice, group, or organized settings; and the use of assessment instruments and mental health counseling and psychotherapy to identify, evaluate and treat dysfunctions and disorders for purposes of providing appropriate mental health counseling services.																																		
	Duration	of su	pervi	ised	l exp	erie	ence)																											
	Date	begi	nnin	g: _					_/_					Dat	e er	ndin	g: _			_/_			_/			_									
	Total	hour	s pra	actio	mo			day Hea	lth C	yr. oun:		ng: _						mo	ο.		da <u>y</u> 	У		У	r.										
6	Total hours practicing Mental Health Counseling: I request and give my permission to the individual listed in item 5 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. I also 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.																																		
	Signature	of a	pplic	ant																						ate _	r	no.	′		da	у	′ —	yr	<u> </u>
	Mental Health Counselor Form 4B, Page 1 of 2, Rev. 11/15																																		

	ction II: Certification of Supervised Experience												
ado retu	structions to Supervisor: Complete Section II, Items A and B, sign and or dress at the end of this form. Your signature on this form must be not a surned by the applicant. If the supervised experience occurred outsicense and an operating certificate or authorization for the entity to preserve the supervised and an operating certificate or authorization for the entity to preserve the supervised and supervised	arized by a Notary Publi de of New York State, yo	c. This form will not ou must include a co	be accepted if									
A.	Supervisor's Qualifications: I have reviewed Appendix A and I meet the	he qualifications as a sup	ervisor.										
	I am a licensedProfessional Title	ir	າ										
	Professional Title		State										
	License number (Attach a copy of your license if other than New York)	Date licensed											
В.	Experience Information: I am attesting that I supervised			for									
	at least one hour per week or two hours every other week in the pro-		it Name ounseling (defined be	low) as follows.									
	Address of setting where experience took place	City	State	Zip Code									
	Dates of Experience: From / / To To mo.	/ / yr.	☐ Present										
	Total hours practicing Mental Health Counseling:												
	The practice of Mental Health Counseling is defined as the evaluation, assessment, ame of behavior, character, development, emotion, personality or relationships by the use of verb practice, group, or organized settings; and is the use of assessment instruments and Menta and disorders for purposes of providing appropriate Mental Health Counseling services.	al or behavioral methods with in	dividuals, couples, families	or groups in private									
Aff	fidavit with Acknowledgement (Notarization required.)												
	Supervisor												
	I declare and affirm that the statements made in the foregoing application correct and that the experience I am attesting to meets the requirement must be signed and dated in the presence of a Notary Public.												
	☐ Check here if you are attaching additional information.												
	Signature:		Date: / mo.	/ day yr.									
	Print Name:		_	j									
	Address:												
	Phone: Fax:												
	E-mail:												
	Notary												
	State of	County of											
	On the in the year in the year , personally known to me or proved to		-										
	whose name is subscribed to this application and acknowledged to me statements made by him/her in the application and all supporting mater	that he/she executed the	application and swore										
	Notary Public signature												
	Notary ID number												
	Expiration date / /	ary Stamp											
	Month Day Year		-										
Ret	turn Directly to: New York State Education Department, Office of th Mental Health Counseling Unit, 89 Washington Ave			ensing Services,									
	Mental Health Counselor Form 4B	, Page 2 of 2, Rev. 11/15	j										