Mental Health Counseling Form 4B
Certification of Supervised Experience

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

Assigned Number (from Form 4): _____

1. Complete Section I. In item 3, enter your name exactly as it appears on your Application for Licensure (Form 1). Be sure to sign and date item 7.
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. **This form will not be accepted if returned by the applicant.**

Section I - Applicant Information

1. Social Security Number ☐☐☐☐☐☐☐☐☐ 2. Birth Date Month ☐☐ Day ☐☐ Year ☐☐☐☐

(Leave this blank if you do not have a U.S. Social Security Number)

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. Name at time of employment (if different than above) _____

6. Name of supervisor _____ Assigned number from Form 4 _____

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 supervised experience

Date beginning ___ ___ ___ (mo. day yr.) Date ending ___ ___ ___ (mo. day yr.)

Total hours practicing Mental Health Counseling _____ (no more than 50% of the total hours may consist of indirect hours)

7. 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.

_____ _____

Applicant's Signature Date

Section II - Certification of Supervised Experience

Instructions to Colleague: Complete Section II, sign and date the attestation and send both pages of this form directly to the Office of the Professions at that address at the end of this form. This form will not be accepted if returned by the applicant. **If the supervised experience occurred outside of New York State, you must include a copy of your license and an operating certificate or authorization for the entity to provide professional services.**

Name of the applicant _____
(see Section I, item 3)

I am a licensed _____ in _____
Professional title *Jurisdiction*

License number (attach a copy of your license if other than New York State) _____ Date licensed ____ ____ ____
mo. day yr.

I am attesting that I supervised the above named applicant for at least one hour per week or two hours every other week in the practice of mental health counseling (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."

Dates of experience From ____ ____ ____ To ____ ____ ____ ☐ Present
mo. day yr. mo. day yr.

Total hours practicing Mental Health Counseling _____

Identify the employment setting below and attach the operating certificate, NYSED waiver or certificate of incorporation that authorizes the entity to employ Licensed Mental Health Counselors.

Agency/Practice Name _____

Type of Setting (check one)

- ☐ Private practice owned by supervisor
- ☐ Professional entity (PLLC, PLLP, P.C.) owned by qualified qualified supervisor (attached consent from SED)
- ☐ Sole proprietorship or other entity authorized under law (attach certificate of corporation)
- ☐ Program approved by the New York State Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD),Office of Alcoholism & Substance Abuse Services (OASAS), Office of Children & Family Services (OCFS), Department of Corrections and Community Supervision (DOCCS), State Office for the Aging, or local social service or mental hygiene district (attach operating certificate)
- ☐ Department of Health (DOH) approved hospital or nursing home (attach copy of operating certificate)
- ☐ Psychotherapy institute chartered by Board of Regents and authorized to provide psychotherapy to the public (attach copy of Regents Charter)
- ☐ Elementary, middle, high school or college authorized to provide psychotherapy services to students (attach copy of authorization)
- ☐ Not-for-profit or other entity authorized by waiver from the State Education Department to employ licensed professionals and provide services (attach waiver and certificate of incorporation)
- ☐ Other (describe) _____

Agency/Practice address _____

Agency/Practice Phone _____ Fax _____ Email _____

Agency/Practice web site _____

The supervisor must be employed by the same agency as the applicant and have access to all patient files and records; have responsibility for the assessment, evaluation and treatment of each patient diagnosed and treated by the applicant practicing under his/her supervision; and each patient must consent to treatment by the supervised applicant.

_____ _____
Signature of agency representative Date

Attestation

I hereby certify that I have read Appendix A and that I meet the requirements to supervise a LMHC applicant. I hereby declare and affirm that I am knowledgeable about, and qualified to attest to, the applicant's work and the work experience and ability and that the work experience described is true and accurate. I understand that any false or misleading information on this form, or related to verification of this applicant's experience, may be cause for charges of misconduct and/or criminal prosecution.

_____ _____
Supervisor Signature Date

Print Name _____

Address _____

_____

Telephone _____ Fax _____

Email _____

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