

Mental Health Counselor Form 4E

Endorsement 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

This form is for applicants seeking licensure in New York State by endorsement of a license to practice Mental Health Counseling issued from another jurisdiction. You must have at least 5 years of licensed experience in Mental Health Counseling in the 10 Year period prior to applying for licensure

Applicant Instructions

1. Complete and send both pages of this form directly to the Office of the Professions at the address at the end of the form. Be sure to sign and date item 8.
2. For your experience to be considered, you must also complete Section I of Form 4F and forward the entire form and a copy of Appendix A to each colleague 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

Email Address (please print clearly)

Area Code

Phone

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

8. List colleague(s) who will verify your experience for licensure as a Mental Health Counselor. Attach additional sheets if necessary. The colleague(s) listed must have knowledge of your experience in Mental Health Counseling for at least 5 years in the 10 years prior to your application.

Assigned Number	Name of Colleague and Address of Experience Setting	Dates of Licensed Experience	
		From	To
1			
2			
3			
4			
5			
6			
7			

9. 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 qualification and may lead to a filing of charges of professional misconduct.

Signature of Registrar

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.