



**7** List the licensed colleague(s) who will verify your experience for licensure as a Mental Health Counselor.

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 and Address of Colleague Verifying Licensed Experience	Dates of Experience	
		From	To
1			
2			
3			
4			
5			
6			
7			

**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.**