Mental Health Counselor Form 4F

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 4E)
_____

Certification of Licensed Experience

This form is for applicants seeking licensure in New York State by endorsement of a license to practice Mental Health Counseling issued by 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 in New York State.

Applicant Instructions

1. Complete Section I. In item 3, enter your name as it appears on your Application for Licensure (Form 1). Be sure to sign and date item 6.
2. Send this entire form to a licensed colleague to complete Section II. The licensed colleague 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 licensed colleague and date. If additional copies are needed, you may photocopy this form. **This form will not be accepted if returned by the applicant.**

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

Name at time of employment (if different from above): _____

5 Name of licensed colleague: _____ Assigned number from Form 4E _____

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.

Jurisdiction where I practiced Mental Health Counseling: _____

Date of licensure: _____ / _____ / _____ License number _____
mo. day yr.

6 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.

_____ Date _____ / _____ / _____
Signature of applicant mo. day yr.

Section II: Certification of Licensed Experience

Instructions to Licensed Colleague: Complete Section II, Items A and B, sign and date the affidavit and send both pages of this form directly to the address at the end of this form. **Your signature on this form must be notarized by a Notary Public. This form will not be accepted if returned by the applicant. You must include a copy of your license.**

A. Licensed Colleague's Qualifications:

I am a licensed _____ in _____
Professional Title State

_____ _____
License number (Attach a copy of your license if other than New York) Date licensed

B. Experience Information: I am attesting that _____
Applicant Name

practiced Mental Health Counseling (defined below) as follows.

_____
Address of setting where experience took place City State Zip Code

Dates of Experience: From _____ / _____ / _____ To _____ / _____ / _____
mo. day yr. mo. day yr.

The practice of Mental Health Counseling is defined as 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 is 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.

Affidavit with Acknowledgement (Notarization required.)

Licensed Colleague

I declare and affirm that the statements made in the foregoing application, including any attached statements, are true, complete and correct and that the experience I am attesting to meets the definition of Mental Health Counseling. **This form 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: _____

Address: _____

_____

Phone: _____ Fax: _____

E-mail: _____

Notary

State of _____ County of _____

On the _____ day of _____ in the year _____ before me, the above signed, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature _____

Notary ID number _____

Notary Stamp

Expiration date _____ / _____ / _____
Month Day Year

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.**