Mental Health Counseling Form 4F
Certification of Licensed 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

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 | Assigned Number (from Form 4E): ____

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 to your licensed colleague(s) to complete Section II. The licensed colleague(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 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.

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 Licensed 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.**

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 the above named applicant practiced 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."

Address of setting where applicant practiced mental health counseling

_____

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

Attestation

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. 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