



**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 \_\_\_\_\_

Expiration date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

**Notary Stamp**

**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.**