

Mental Health Counselor Form 2INT Certification of Supervised Internship and Practicum

This form IS NOT REQUIRED for graduates of 60 semester hour CACREP accredited or New York State registered licensure qualifying Mental Health Counseling Programs. Also, submission of a Form 2INT DOES NOT replace any requirement for submission of a Form 2.

The Bureau of Comparative Education must conduct an individual transcript evaluation of an applicant for licensure as a mental health counselor who graduated from a program that, at the time of graduation, was not a masters or higher degree in mental health counseling of 60 semester hours (or more) that was either:

- Registered by the State Education Department as leading to licensure in mental health counseling; or
- Accredited as a **clinical mental health counseling program** by the Council for Accreditation of Counseling & Related Educational Programs (CACREP) under its 2009 standards.

In addition to verifying the required courses content, Comparative Education must determine if the applicant completed a supervised internship in mental health counseling and psychotherapy as part of the degree program. This evaluation requires information that is not on the transcript, so the applicant must ask the Chair or Director of the academic department to complete and submit the Form 2INT Certification of Supervised Internship and Practicum. Failure to submit this form will delay the evaluation of the applicant's education and his/her eligibility for a limited permit and admission to the licensing examination.

Applicant Instructions

1. Complete Section I and sign and date item 9.
2. Send the entire Form 2INT to the institution where your supervised internship and practicum in Mental Health Counseling was part of your graduate program and ask the Chair or Director of that academic department to complete Section II and forward all pages of the form along with any other required documentation directly to the Office of the Professions at the address at the end of the form. Be sure to include any fee required by the institution. **This form will not be accepted if submitted 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 Last
 First
 Middle
5. Telephone/Email Address
Daytime Phone
 Home or Business

Licenses business address, phone and email address are public information. Failure to indicate business or home on this form for each item will deem it public information.

4. Mailing Address Home or Business
(You must notify the Department within 30 days of any address or name changes)
Line 1
Line 2
Line 3
City
State ZIP Code
Country/
Province
- Area Code Phone
Email Address (please print clearly)
 Home or Business
6. New York State DMV ID Number
(Driver or Non-Driver ID)

(Leave this blank if you do not have a New York State DMV ID Number)

7. Name as it appears on institution records (if different from above)

8. Name of institution where you completed your graduate program that included a supervised internship and practicum in Mental Health Counseling

Address of institution _____

9. I request and give my permission to the institution listed in item 8 above to complete Section II of this form and mail it to the Office of the Professions 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.

Signature

Date

Section II: Certification of Supervised Internship and Practicum

Instructions to the Chair or Director: Complete Section II, and complete and sign the Certification. Return the entire form along with any required documentation in an official school envelope directly to the Office of the Professions at the address at the end of this form. **Form 2INT will not be accepted if submitted by the applicant. Note: Syllabi cannot be accepted in lieu of completion of this form.**

Name of the applicant _____
(see Section I, item 3)

Name on Institution Records _____

Course Number(s) _____ Semesters Taken _____

Name of Institution _____

Name of internship/practicum _____

Location of internship/practicum (include city/state) _____

Total number of clock hours _____ Number of direct client contact hours _____

Was the field site approved by the Institution? Yes No

What was the name and qualifications of the on-site supervisor (e.g. State of licensure and licensure number).

How many hours of on-site, face-to-face supervision were there? _____

How often was the on-site supervisor required to submit evaluations to the institution?

How did the institution supervise the internship/practicum?

Please describe the **specific** mental health counseling services provided, including **the population served and the psychotherapeutic interventions used** by the applicant in the internship/practicum. Attach additional sheets if necessary.

Section II: Certification of Supervised Internship and Practicum (Continued)

Please identify the **clinical mental health and psychotherapy diagnostic and assessment tools** that were used by the applicant. Some examples are DSM, SCID, ICD-10. (Attach additional sheets if necessary)

Please explain how the applicant prepared a therapy plan and provided mental health counseling under supervision. (Attach additional sheets if necessary)

Certification - To be completed by the Chair or Director

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the educational record of the individual named on this form.

Signature of Chair or Director

Date

Print Name _____

Title or official position _____

Institution _____

Address _____

Seal

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.