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

Mental Health Counseling Form 4F
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 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. Be sure to sign and date item 9.
2. Send the entire form to your licensed colleague who will certify your licensed experience to complete Section II and forward all pages of this form directly to the Office of the Professions at the address at the end of this form. **This form will not be accepted if submitted by the applicant.**

Section I: Applicant Information

1. Last 4 Digits of 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 Name
   Last
   First
   Middle

5. Telephone/Email Address
   Daytime Phone
   ☐ Home or ☐ Business
   ☐☐☐ ☐☐☐ ☐☐☐☐
   Area Code Phone
   Email Address (please print clearly)
   ☐ Home or ☐ Business

Licensee 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

(NOTE: The address you provide will be used to **update your file** with the Department. Any license parchment and/or registration certificate will be mailed to **your address on file**. You must notify the Department within 30 days of any address or name change.)

Line 1
Line 2
Line 3
City
State ☐☐ ZIP Code ☐☐☐☐☐ ☐☐☐☐
Country/ Province

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 degree or other credentials (if different from above) _____

8. 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 ____ ____ ____ (mo. day yr.) License Number _____

9. I request and give my permission to the individual listed in item 8 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 Signature Date

Section II: Certification of Licensed Experience

Instructions to the Licensed Colleague: Complete Section II, sign and date the attestation and send the entire form along with any additional information directly to the Office of the Professions at the address at the end of this form. **This form will not be accepted if submitted 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 practice mental health counseling

_____

Dates of licensed 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.

_____ _____
Colleague Signature Date

Print Name _____

Address _____

_____

Telephone _____ Fax _____

Email _____

Submit this form by email to DPLSExperience@nysed.gov, or, by mailing: 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.