

P.O. BOX 77819 • GREENSBORO, NC 27417

## **License Verification Form**

The applicant is required to complete Section I of this form and forward to the current licensing board for completion of Section II. The current licensing board should mail to the address listed above.

Section I. To be completed by Applicant			
Applicant's Name			
Last	First	Middle	
Applicant's SS#	Applicant's License #	State of Issue	
Years of Experience as an LCMHC	Date issued	Type of License	
Academic Institution			
Degree	Year Conferred	Credits Ear	ned
I hereby authorize the release of licensure informat	tion to the North Carolina Board of Li	icensed Clinical Mental Health	Counselors.
Applicant's Signature	<del></del>	Date	
Section II. To be completed by the State Licensing	Board where the North Carolina ap	plicant is currently licensed	
Title of License			
Does this license require supervision in order to p	<del></del>		
License status: Active orInactive	Issue date	Expiration date	mm/dd/www
Is this license in good standing? YesNo		'	mm, aa, yyyy
Examination: NCE NC Endorsement From what state Grandfathering			_
Supervised post-degree experience:			
Total # of hours required	Supervisor license/credentials req	uired	
Total direct counseling hours	Total indirect counseling hours		
Total individual supervision hours per week	Total group supervision h	nours per week	
Date range of experience: From:			-
Is there any record of disciplinary action taken aga	mm/dd/yyyy	mm/dd/yyyy  If yes, attach an explanation	
Do you require verification of continuing educatio	<del></del>		
# of contact hours required # of ye	ars in renewal period	# of ethics hours required _	
Board Name			
Address		City/State/ZIP	
Signature of person completing form	(State Seal)	Printed name of person completing form	
Official Title	-	Date form completed	