NORTH CAROLINA BOARD
of LICENSED CLINICAL
MENTAL HEALTH
COUNSELORS

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Verification of Professional Counseling Experience

[To be completed for Applicants applying by Reciprocity]

Indicate to which Applicant this verification form applies: LCMHC (#_____) *North Carolina LCMHCs Only.*

Name: _____ LCMHC or Fully Licensed Equivalent # in the State of _____

Confidentiality Note - The information submitted in this contract is privileged and confidential, and is intended solely for use by the North Carolina Board of Licensed Clinical Mental Health Counselors. N.C.G.S. §132-1.2.

INSTRUCTIONS: FORMS MUST BE MAILED—NO FAXES OR EMAILS

1. **PRINT** or **TYPE** using **BLACK** Ink to complete this verification of professional counseling experience. Person verifying professional counseling experience must be a mental health professional as defined in Rule .0213 and may not be completed by a relative. Use additional pages if needed.
2. **ALL SECTIONS** must be completed or the verification of professional counseling experience will be returned.
3. The verification of professional counseling experience should be enclosed in a sealed envelope and signed across the flap. Mail the signed and sealed envelope to the **NCBLCMHC Board Office at: NCBLCMHC, PO Box 77819; Greensboro, NC 27417**

I. GENERAL INFORMATION - *To be completed by the person verifying professional experience for the applicant. Must be a mental health professional.*

Name (Last, First, Middle):

Title:

Agency:

License Type and Number:

Mailing Address (Street and/or Box Number, City, State, Zip Code):

Business Phone:

-

Email Address:

Mobile Phone:

-

II. PROFESSIONAL COUNSELING EXPERIENCE

Name of Agency where Professional Counseling Experience Occurred:

Address (Street and/or Box Number, City, State, Zip Code):

Business Phone:

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Do you have personal knowledge of the experience? Yes _____ No _____

List ONLY professional counseling experience acquired under a Fully Independent License.

	From (month/day/year)	To (month/day/year)	**Total # of Hours of Direct Client Contact**
Full-time (32—40 hours/week)			
Part-time (8—31 hours/week)			

All other licensed or unlicensed experience does not apply.

I verify that the statements in this verification of professional counseling experience are true and correct to the best of my knowledge.

Signature of Person Verifying: _____ Date: _____

SELF-REPORTING NOT ACCEPTABLE