

Email: LCMHCinfo@ncblcmhc.org Phone: (336)217-9450 Web: www.NCBLCMHC.org Address: PO Box 77819 Greensboro, NC 27417

Good Character Form

Instructions to the Applicant: You must submit completed good character forms from **two** professionals who are familiar with your current counseling related work. Type or print your name and the professional's name where indicated below, and forward the form to the verifier. The completed form must be returned directly to the Board from the verifier by mail or email. If sent by mail submit in a sealed envelope with the verifier's signature over the seal or by email sent directly to the Board from the email listed on the application of designated verifier. Unsigned forms/envelopes will not be accepted.

To		Re:	
10	Verifier's name		Applicant's name
licensed of		ounselor, and has listed you as a verifier	ual has made an application for licensure as a r. The licensed clinical mental health counselor
specific in if necessa verifier by email sen	nformation from you. It iry. Please type or pri y mail or email. If sent	Information must be provided on this for int. The completed form must be returned by mail, submit in a sealed envelope with the complete of th	cant's qualifications, it is seeking the following form, although additional sheets may be attached, arned directly to the NCBLCMHC from the ith the verifier's signature over the seal or by of designated verifier. Unsigned forms/envelopes
1. Th	e time period (dates) d	uring which you have known the applic	eant:
2. Yo	Your professional relationship with the applicant:		
3. Yo	our opinion regarding t	garding the applicant's training, experience, and professional skills:	
4. Th	e applicant's adherence	e to legal and ethical standards:	
5. Ar	eas of concern, further	comments, and recommendations to the	e Board:
V	erifier's Name (type or prin	nt)	Verifier's Signature
D	ate	E-Mail Address	Daytime Telephone Number
	Address	City, Sta	ate, Zip Code
Good Character Form			12/11/2023