



NORTH CAROLINA BOARD
of LICENSED CLINICAL
 MENTAL HEALTH
COUNSELORS

PHONE: 844-622-3572
 FAX: 336-217-9450
 WEB: ncblcmhc.org
 EMAIL: LCMHInfo@ncblcmhc.org

Verification of Professional Counseling Experience

[To be completed for LCMHCS Applicants and Applicants applying by Endorsement]

Indicate to which Applicant this verification form applies:

LCMHC (# _____) *North Carolina LCMHCs Only.*

Name: _____ LCMHC # _____ 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

- 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.
- ALL SECTIONS** must be completed or the verification of professional counseling experience will be returned.
- 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 - *(Supervised experience can be included.)*

Name of Agency where Professional Counseling Experience Occurred: _____

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

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

List ONLY professional counseling experience acquired under a LCMHC/LMHC 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