NORTH CAROLINA BOARD
of LICENSED CLINICAL
MENTAL HEALTH
COUNSELORS

PHONE: 844-622-3572
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Verification of Graduate Counseling Experience

[To be completed by University Faculty for LCMHCA/LCMHC Applicants]

Indicate to which Applicant this verification form applies:

Name: _____

VERIFICATION OF GRADUATE COUNSELING EXPERIENCE INSTRUCTIONS

1. **PRINT** or **TYPE** using **BLACK** Ink to complete this verification of graduate counseling experience. Person verifying graduate counseling experience must be a university faculty member as defined in Rule .0206.
2. **ALL SECTIONS** must be completed or the verification of graduate counseling experience will be returned.
3. The verification of graduate 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 person verifying graduate counseling experience.*

Name (Last, First, Middle):

Title:

University: Department or Program Name:

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

Email Address:

II. **VERIFICATION OF GRADUATE COUNSELING EXPERIENCE** - *To be completed by person verifying graduate counseling experience.*

Name of Agency where Graduate Counseling Experience Occurred:

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

Were you the University Supervisor for the graduate counseling experience? Yes☐ No☐ If not, explain how you have verified the graduate counseling experience:

Total hours of Individual clinical supervision received during graduate counseling experience: _____
Total hours of Group clinical supervision received during graduate counseling experience: _____

	From (month/day/year)	To (month/day/year)	Total Hours of Direct Client Contact	Total Hours of Indirect Client Contact
☐ Practicum ☐ Internship				
☐ Practicum ☐ Internship				
☐ Practicum ☐ Internship				
☐ Practicum ☐ Internship				
		Percentage (Board use only)		

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: _____

This version supersedes all previous versions Revised 02/05/2020