STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

PROFESSIONAL COUNSELOR
VERIFICATION OF POSTGRADUATE DEGREE SUPERVISED PROFESSIONAL COUNSELING EXPERIENCE

TO BE COMPLETED BY APPLICANT

APPLICANT: Complete the top portion and forward a copy to the licensee who supervised your postgraduate professional counseling experience.

Applicant's Name: _____ Phone: _____

Date of Birth: ____/____/____ Organization indicated on application form: _____

Dates of postgraduate-degree-supervised professional counseling experience: ____/____/____ to ____/_____/____

Signature of Applicant _____ **Date** _____

TO BE COMPLETED BY SUPERVISOR ONLY

Supervisor's name and title: _____ Telephone: _____

Address where experience completed: _____

Qualification(s) held (check one):

☐ Licensed Physician certified in psychiatry by the American BD of Psychiatry and Neurology
☐ Licensed Psychologist
☐ Licensed Marital and Family Therapist
☐ Licensed Clinical Social Worker
☐ Licensed Professional Counselor
☐ Licensed Advanced Practice Registered Nurse certified as a Clinical Specialist in Adult Psychiatric and Mental Health Nursing with the American Nurses Credentialing Center

State in which licensed: _____ State License Number: _____

Details of candidate's supervised work experience:

Beginning date: _____ Ending date: _____

Total hours of postgraduate-degree professional counseling experience applicant completed: _____

During this experience, total hours of <u>direct</u> supervision you provided to applicant: _____

NOTE: For purposes herein, professional counseling is defined as the application, by persons trained in counseling, of established principles of psycho-social development and behavioral science to the evaluation, assessment, analysis and treatment of emotional, behavioral or interpersonal dysfunction or difficulties that interfere with mental health and human development. "Professional counseling" includes, but is not limited to individual, group, marriage and family counseling, functional assessments for persons adjusting to a disability, appraisal, crisis intervention and consultation with individuals or groups.

Do you have any derogatory information regarding the competency or conduct of this individual? **YES** ☐ **NO** ☐.

If yes, please explain: _____

Print Name:_____

Signature _____ Date _____

This form must be returned directly by the supervisor directly to:

Professional Counselor Licensure
410 Capitol Ave., MS# 12APP
P.O. Box 340308
Hartford, CT 06134-0308
Fax: (860) 707-1980