STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
VERIFICATION OF COURSE STUDY

TO BE COMPLETED BY CANDIDATE

Applicant: Please complete the top portion of this form and forward it to the educational program from which you completed coursework.

Applicant Name: ________________________________ Social Security Number: ____________________

Educational Program Location: ____

TO BE COMPLETED BY EDUCATIONAL INSTITUTION ONLY

The applicant named above is applying for Connecticut licensure as a professional counselor. Please provide the following information regarding the course of study that such applicant completed while enrolled in your institution.

I certify that the candidate named above has completed coursework related in the following subject areas (check all that apply):

☐ Human Growth and Development

☐ Social and Cultural Foundations

☐ Counseling Theories and Techniques

☐ Group Counseling

☐ Addiction and substance abuse counseling

☐ Career Counseling

☐ Appraisals or Tests and Measurements for Individuals and Groups

☐ Research and Evaluation

☐ Professional Orientation to Mental Health Counseling

☐ Trauma and crisis counseling

☐ Diagnosis and Treatment of Mental and Emotional Disorders

Was the program regionally accredited at the time the student was enrolled? **YES** ☐ **NO** ☐

Date Matriculated: ____________________

Did the applicant complete 60 semester hours, or 90 quarter hours of graduate counseling coursework in or related to the discipline of professional counseling? **YES** ☐ **NO** ☐ If no, how many credits were completed _________

Did the applicant complete a one-hundred-hour practicum in counseling taught by a faculty member licensed or certified as a professional counselor or its equivalent in another state? **YES** ☐ **NO** ☐

Did the applicant complete a six-hundred-hour clinical mental health counseling internship taught by a faculty member licensed or certified as a professional counselor or its equivalent in another state? **YES** ☐ **NO** ☐

_______________________________________ _______________________________

Signature of Authorized Representative Date

_______________________________________ _______________________________

Title Institution

Daytime Telephone Number: _______________________ Email: _________________________________

Please complete and return this form to:

Department of Public Health
Professional Counselor Licensure
410 Capitol Avenue MS# **12APP**
P.O. Box 340308
Hartford, CT 06134-0308