Secretary of State
Office of Professional Regulation

ALLIED MENTAL HEALTH
Verification of Licensure

Complete the applicant section of this form and have the state from which you obtained your initial license and your most recent state of licensure complete the rest.

Licensed as a:		**Date of Birth:**

Applicant

First Name	**MI**	**Last Name & Title (Jr., Sr., II, III, etc.)**	**Former/Maiden**

Mailing Address	**P.O. Box**	
	Street/Apt #	
	City/State/Zip	
	Country	

I hereby authorize the License Agency to furnish to the Vermont Office of Professional Regulation the information requested below.

Signature_____ **Date** _____

Information Below to be Completed by the Licensing Agency:

License #		**Date Issued**		**Date Expired**	
License as a:					

Licensed By		**Examination/Education**	**License Status**		**Active**
		Endorsement/Reciprocity			**Inactive**
		Waiver			**Lapsed**

Has this license ever been encumbered in anyway (revoked, suspended, limited, surrendered, restricted, placed on probation)? ***If "Yes," attach a copy of the decision.***	**Yes**	**No**

LICENSING/CERTIFICATION STANDARDS

What are your State's current standards for Licensure?

Do you require that an applicant take a state board written examination?	Yes	No
If "Yes," list the subjects and the passing score for each subject.		

Do you require that an applicant take the National Board of Certified Counselors (NBCC) Examination: the National Counselors Exam (NCE)?				Yes	No
If “Yes,” indicate the passing score:_____					
Do you require that an applicant take the National Board of Certified Counselors (NBCC) Examination: the National Clinical Mental Health Examination (NCMHE)?				Yes	No
If “Yes,” indicate the passing score:_____					
Do you require applicants to have a master's or doctoral degree in counseling from an accredited educational institution?				Yes	No
Did the course of study leading to the degree include 3 credits in each category below?					
Diagnosis, Assessment & Treatment	Yes	No	Human Growth & Development	Yes	No
Theories	Yes	No	Counseling Skills	Yes	No
Groups	Yes	No	Measurement	Yes	No
Ethics	Yes	No	Treatment Modalities	Yes	No
Marriage, Couples & Family Counseling	Yes	No	Human Sexuality for Counselors	Yes	No
Crisis Intervention	Yes	No	Addictive Disorders	Yes	No
Psychopharmacology	Yes	No	Multi-Cultural Studies	Yes	No
Research & Evaluation	Yes	No	Career Development / Lifestyle Appraisal	Yes	No
Do you require a supervised counseling practicum/internship/or field experience of 700 hours in a clinical mental health counseling setting?				Yes	No
Do you accept programs accredited by other accrediting bodies?				Yes	No
If “Yes,” what bodies? _____					
Do you require an applicant complete 3,000 hours (with at least 2,000 hours being direct service), post master’s, supervised practice, over a period of no less than 2 years.				Yes	No

If "No," what do you require? _____		
Do you require that the 3,000 hours include 100 hours of face-to-face supervision, at least 50 hours of which must be in an individual setting?	Yes	No
If "No," what do you require? _____		
Do you require the clinical supervision to be under either a licensed physician or a licensed psychiatric nurse practitioner, a licensed psychologist, a licensed clinical mental health counselor, or a licensed independent clinical social worker, or a licensed marriage and family therapist?	Yes	No
Do you accept supervision by other supervisors?	Yes	No
If "Yes," who: _____		
Signature of person completing form	**Date**	
State Completing this form	**Telephone**	
STATE LICENSING AUTHORITY: **Mail to** **Office of Professional Regulation** **89 Main Street, 3rd Floor** **Montpelier, VT 05620-3402** **Attn: (Profession)**	**(OFFICIAL SEAL)**	