The University of the State of New York
The State Education Department
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Mental Health Practitioner Form 4D
Certification of Experience

Applicant Instructions: Complete Section I. Be sure to sign and date item 10. Send the entire form 4D to the individual who will certify your experience to complete Section II and forward all pages of this form directly to the Office of the Professions at the address at the end of this form. **This form will not be accepted if submitted by the applicant.**

Check what privilege you are applying for (**check one**): ☐ Marriage and Family Therapist ☐ Mental Health Counselor ☐ Psychoanalyst

Section I: Applicant Information

1. Last 4 Digits of Social Security Number
   (Leave this blank if you do not have a U.S. Social Security Number)

2. Birth Date Month Day Year

3. Print Name Last
   First
   Middle

Licensee business address, phone and email address are public information. Failure to indicate business or home on this form for each item will deem it public information.

4. Mailing Address ☐ Home or ☐ Business
   (You must notify the Department within 30 days of any address or name changes)
   Line 1
   Line 2
   Line 3
   City
   State ZIP Code
   Country/ Province

5. Telephone/Email Address
   Daytime Phone
   ☐ Home or ☐ Business
   Area Code Phone
   Email Address (please print clearly)
   ☐ Home or ☐ Business

6. New York State DMV ID Number (Driver or Non-Driver ID)
   (Leave this blank if you do not have a New York State DMV ID Number)

7. I am licensed in New York State as a ______
   (You must be licensed in the same profession that you are applying for the diagnostic privilege.)
   New York State license No. Date license issued ___ mo. ___ day ___ yr. Date registration ends ___ mo. ___ day ___ yr.

8. Name as it appears on degree or other credentials (if different from above) ______

9. To meet the experience requirements for the diagnostic privilege, you must submit verification of either:
   - Three years (36 months) of supervised experience engaged in direct client contact that shall include, but not be limited to, diagnosis, psychotherapy and the development of assessment-based treatment plans, under supervision in a setting acceptable to the Department, as defined in regulation. **Important Note:** A mental health counselor, marriage and family therapist or psychoanalyst licensed in New York prior to June 24, 2024 shall submit the application to the Department within 3 years of the effective date of this law and meet all requirements by June 24, 2027. This option is only available if you were licensed **BEFORE** June 24, 2024

     Or
   - 2,000 hours of supervised, direct client contact that shall include, but not be limited to, diagnosis, psychotherapy and the development of assessment-based treatment plans, satisfactory to the Department;

   Name of individual I am asking to certify my experience ______
   Name of setting where experience took place ______
   Setting address ______

10. I request and give my permission to the individual listed in item 9 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure. I also declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution.

______ Applicant Signature ______ Date

Section II: Certification of Experience

Instructions to the Attesting Individual: Complete Section II, sign and date the attestation and send the entire form along with any additional information directly to the Office of the Professions at the address at the end of this form. **This form will not be accepted if submitted by the applicant. If the experience occurred outside of New York State, you must include a copy of your license and an operating certificate or authorization for the entity to provide professional services.**

Name of the applicant ____________________
(see Section I, item 3)

During the period of experience I am attesting to on this form, I was licensed/certified and in good standing as a:

- ☐ Licensed Clinical Social Worker
- ☐ Psychologist who is education and trained in psychotherapy
- ☐ Physician who is a diplomate in psychiatry of the American Board of Psychiatry and Neurology, Inc. or who has the equivalent training and experience.
- ☐ A mental health practitioner who, on or after June 24, 2024 holds the diagnostic privilege in (**check one**, the profession must match the profession the applicant is applying for the diagnostic privilege in):
  - ☐ Marriage and Family Therapist ☐ Mental Health Counselor ☐ Psychoanalyst
- ☐ Other (describe) ____________________

License/Certificate Number __________ Jurisdiction where licensed/certified ____________________

Date licensed/certified ____ ____ ____
mo. day yr.

I am (check one):

- ☐ attesting to the above applicant's supervised practice of (only check this is you are certifying up to 36 months of experience)
  - ☐ Marriage and Family Therapy ☐ Mental Health Counseling ☐ Psychoanalysis

  which included diagnosis, psychotherapy and assessment-based treatment planning.

  Dates of experience From ____ ____ ____ To ____ ____ ____ ☐ Present
  mo. day yr. mo. day yr.

- ☐ attesting that I supervised the above applicant in the practice of (only check this if you are certifying up to 2000 hours of experience)
  - ☐ Marriage and Family Therapy ☐ Mental Health Counseling ☐ Psychoanalysis

  wherein I have reviewed the applicant's diagnosis and treatment of each client and provided oversight, guidance and direction to the applicant to develope skills in diagnosis, psychotherapy and assessment-based treatment plans.

  Dates of experience From ____ ____ ____ To ____ ____ ____ ☐ Present Total Hours practicing __________
  mo. day yr. mo. day yr.

Identify the employment setting below and attach the operating certificate, NYSED waiver or certificate of incorporation that authorizes the entity to employ the indicated mental health professionals.

Setting Name ____________________

Type of Setting (check one)

- ☐ Private practice owned by supervisor
- ☐ Professional entity (PLLC, PLLP, P.C.) owned by qualified supervisor (attached consent from SED)
- ☐ Sole proprietorship or other entity authorized under law (attach certificate of corporation)
- ☐ Program approved by the New York State Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD),Office of Alcoholism & Substance Abuse Services (OASAS), Office of Children & Family Services (OCFS), Department of Corrections and Community Supervision (DOCCS), Department of Health (DOH), State Office for the Aging, or local social service or mental hygiene district (attach operating certificate)
- ☐ Psychotherapy institute chartered by Board of Regents and authorized to provide psychotherapy to the public (attach copy of Regents Charter)
- ☐ Elementary, middle, high school or college authorized to provide psychotherapy services to students (attach copy of authorization)

Section II: Certification of Experience (Continued)

☐ Not-for-profit or other entity authorized by waiver from the State Education Department to employ licensed professionals and provide services (attach waiver and certificate of incorporation)

☐ Other (describe) ______________________________

Setting address ______________________________

Setting Phone ______________ Fax ______________ Email ______________________

Setting web site ______________________________

Attestation

I hereby certify that I meet the requirements to supervise the applicant named on this form or have personal knowledge of the applicants professional practice. I hereby declare and affirm that I am knowledgeable about, and qualified to attest to, the applicant's work and the work experience and ability and that the work experience described is true and accurate. I understand that any false or misleading information on this form, or related to verification of this applicant's experience, may be cause for charges of misconduct and/or criminal prosecution.

______________________________ ______________

Signature of Attesting Individual Date

Print Name ______________________________

Address ______________________________

____

Telephone ______________ Fax ______________

Email ______________________________

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Mental Health Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000, or by email to **DPLSExperience@nysed.gov**.