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 Counselor Form 2
Certification of Professional Education

Applicant Instructions

1. Complete Section I and sign and date item 9.
2. Send the entire Form 2 to the institution(s) where you completed your Mental Health Counseling studies, including any fee required by the institution, and have the registrar complete Section II and return all pages in an official school envelope directly to the Office of the Professions at the address at the end of this form. Form 2 will not be accepted if submitted by the applicant or if it is received in a personal envelope.
3. If you completed a program that is not registered by the Department as licensure qualifying or CACREP accredited, **you must attach a Form 2INT** to also be completed and submitted by the Registrar. **To verify that a program is licensure qualifying, please go to** www.nysed.gov/heds/IRPSL1.html **for New York State Programs,** www.cacrep.org/directory/ **for out-of-state programs.**

Section I: Applicant Information

1. 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. Name as it appears on your Degree/Diploma/Certificate _____

8. Name of institution attended _____

Address of institution _____

Title of Degree/Diploma/Certificate awarded (in original language) _____

Date Degree/Diploma/Certificate awarded ____ mo. ____ yr.

9. I request and give my permission to the institution listed in item 8 above to complete Section II of this form and mail it to the Office of the Professions 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.

_____ _____
Signature Date

Section II: Certification of Professional Education

Instructions to the Registrar: Complete Part A or Part B, and complete and sign the Certification. Return the entire form along with any required documentation in an official school envelope directly to the Office of the Professions at the address at the end of this form. **Form 2 will not be accepted if submitted by the applicant.**

Name of the applicant _____
(see Section I, item 7)

Part A - Mental Health Counseling Program Registered by the New York State Education Department (NYSED) as licensure qualifying: To be completed only by those schools whose Mental Health Counseling program was, at the time the applicant's degree was awarded, registered by the NYSED as licensure qualifying, or accredited as a 60 semester hour **clinical mental health counseling program** by the Council on Accreditation of Counseling and Related Educational Programs (CACREP).

It is certified that the applicant:

☐ completed the program on ____ (mo.) ____ (day) _____ (yr.) and was awarded the degree/diploma/certificate of _____ (Title of degree/diploma/certificate)

in the program area or major of _____ (Title)

on the date of ____ (mo.) ____ (day) _____ (yr.)

Part B - All other programs. An official transcript or marksheet giving courses completed by year and grades and a syllabus on the course of studies completed must be attached.

1. Date of applicant's entrance, and either the applicant's date of completion of studies or withdrawal from the school

Entrance Date ____ (mo.) ____ (day) _____ (yr.) ☐ Completion Date ____ (mo.) ____ (day) _____ (yr.)

☐ Withdrawal Date ____ (mo.) ____ (day) _____ (yr.)

Did the applicant complete a field practicum of at least 600 clock hours in clinical mental health (check one) ☐ Yes ☐ No

If "no", number of clock hours completed: _____ Program must submit Form 2INT for all degree programs.

2. Degree/diploma/certificate awarded _____

3. Date degree/diploma/certificate awarded ____ (mo.) ____ (day) _____ (yr.)

Name of the accrediting body or official organization that recognizes this program

_____

Date of Accreditation ____ (mo.) ____ (day) _____ (yr.)

Address of the accrediting body or official organization that recognizes this program

_____

Section II - Certification of Professional Education (Continued)

Part B (continued) - List the course(s) that meets the requirement for professional counseling orientation and ethics (document where areas A through J are represented in the curriculum. *The course(s) listed must be included on the official transcript provided by the graduate program. If the content was covered in more than one course, specify the areas covered in each course.*

Required Content Area	Course Number, Title and Semester Hours
A. History and philosophy of the counseling profession; B. professional roles, functions, and relationships with other human service providers, including strategies for interagency/ interorganizational collaboration and consultation; C. counselors' roles and responsibilities as members of interdisciplinary community outreach and emergency management response teams; D. self-care strategies appropriate to the counselor role; E. counseling supervision models, practices, and processes; F. professional organizations, including membership benefits, activities, services to members, and current issues; G. professional credentialing, including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues; H. the role and process of the professional counselor advocating on behalf of the profession; I. advocacy processes needed to address institutional and social barriers that impede access equity, and success for clients; and J. ethical standards of professional organizations and credentialing bodies, and applications of ethical and legal considerations in professional counseling.	

Certification - To be completed by the Registrar. This form will not be accepted if the date below precedes the date in either Part A or Part B.

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the educational record of the individual named on this form.

Signature of Registrar _____ Date _____

Print Name _____

Title or official position _____

Institution _____ Seal

Address _____

_____

Telephone _____ Fax _____

Email _____

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Mental Health Counseling Unit, 89 Washington Avenue, Albany, NY 12234-1000.