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 4
Applicant Experience Record

Applicant Instructions

1. Complete both pages of this form. Be sure to sign and date item 9 before sending this form to the Office of the Professions at the address at the end of the form.
2. For your experience to be considered, **you must also complete Section I of Form 4B and forward the entire form and a copy of Appendix A to each supervisor you list in Item 8 of this form**.

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. Give any other names by which you have been known

8. List supervisor(s) who will verify your experience for licensure as a Mental Health Counselor. Attach additional sheets if necessary.

- You must document 3,000 clock hours of supervised Mental Health Counseling experience.
- The supervisor(s) must meet the qualifications in Appendix A.
- The supervisor(s) listed must have supervised your experience in assessment and evaluation, treatment planning, completing psychosocial histories and progress notes, individual counseling, group counseling, psychotherapy, and consultation.
- If a supervisor is deceased, you should list a licensed colleague who will attest to your supervised experience and to the qualifications of the deceased supervisor.

Assigned Number	Name of Supervisor and Address of Experience Setting	Dates of Experience		Total Clock Hours
		From	To	
1				
2				
3				
4				
5				
6				

9. Attestation

I declare and affirm that the statements made in the foregoing application, including accompanying statements 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 of licensure and may result in criminal prosecution.

Applicant Signature _____ Date _____

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.