

Mental Health Counselor Form 4E Endorsement Applicant Experience Record

This form is for applicants seeking licensure in New York State by endorsement of a license to practice Mental Health Counseling issued from another jurisdiction. You must have at least 5 years of licensed experience in Mental Health Counseling in the 10 year period prior to applying for licensure.

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 4F and forward the entire form to each colleague 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 Email Address (please print clearly) Home or Business
Area Code Phone _____
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 colleague(s) who will verify your experience for licensure as a Mental Health Counselor. Attach additional sheets if necessary.

The colleague(s) listed must have knowledge of your experience in Mental Health Counseling for at least 5 years in the 10 years prior to your application.

Assigned Number	Name of Colleague and Address of Experience Setting	Dates of Licensed Experience	
		From	To
1			
2			
3			
4			
5			
6			
7			

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.