



Board of Behavioral Sciences
 1625 North Market Blvd., Suite S200, Sacramento, CA 95834
 Telephone: (916) 574-7830 TTY: (800) 326-2297
www.bbs.ca.gov



LICENSED PROFESSIONAL CLINICAL COUNSELOR EXPERIENCE VERIFICATION

“GRANDPARENT” METHOD FOR NON-BBS-LICENSED APPLICANTS

Applicant: Your supervisor must complete this form (unless experience is verified by an out-of-state licensing agency). Use a separate form for each person verifying hours of supervised counseling experience toward licensure as a professional clinical counselor and for each employment setting. Submit this form with your application for licensure eligibility.

Supervisor: You must complete this form. **Make certain that this form is complete and correct prior to signing. Any change should be initialed by you and is subject to verification.** Return the completed form to the applicant.

(Please type or print clearly in ink)

| | | | | |
|------------|------|-------|--------|------------------------|
| Applicant: | Last | First | Middle | Social Security Number |
|------------|------|-------|--------|------------------------|

SUPERVISOR: (Please type or print clearly in ink)

| | | | | | |
|---|-------------------|----------------|-----------------------|--------------------------|--|
| 1. Supervisor: | Last | First | Middle | 2. Business Phone: | |
| 3. Address: | Number and Street | | City | State | Zip Code |
| 4. Name of Applicant's Employer: | | | | 5. Business Phone: | |
| 6. Employer's Address: | Number and Street | | City | State | Zip Code |
| 7. Was this counseling experience gained in a supervised clinical setting? | | | | | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 8. Dates of the experience being claimed | | From: _____ | To: _____ | | |
| | | mm/dd/yyyy | mm/dd/yyyy | | |
| 9. How many <u>hours</u> of supervised experience are being claimed? _____ | | | | | |
| 10. Supervisor License Information (If not licensed, see #11): | | | | | |
| Type of License | Specialty, if any | License Number | State of Licensure | Date Originally Licensed | |
| 11. If master's level counselor or therapist, were you certified by a national certifying or registering organization during the period of supervision (Non-licensurees only)*? | | | | | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | |
| Certifying Organization: _____ | | | Date certified: _____ | | |
| <i>I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct</i> | | | | | |
| Signature of Supervisor: _____ | | | | Date: _____ | |

*Provide verification of master's degree and certification.