



**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  
 IN-STATE EXPERIENCE VERIFICATION  
 OPTION 2 – PRE-EXISTING MULTIPLE CATEGORY METHOD**

This form is to be completed by the applicant's California supervisor and submitted by the applicant with his or her *Application for Licensure and Examination*. All information on this form is subject to verification.

- Use this "Option 2" form for reporting hours under the PRE-EXISTING method (multiple categories)
- Use separate forms for each supervisor and each employment setting
- Ensure that the form is complete and correct prior to signing. Have the supervisor initial any changes.
- Do not submit your *Weekly Summary* forms unless specifically requested by the Board
- For your hours to qualify under "Option 2," your *Application for Licensure and Examination* MUST be postmarked by December 31, 2020.

**APPLICANT NAME:**

Last	First	Middle	Associate/Intern # APC/PCI
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Dates of experience being claimed:	From: _____ mm/dd/yyyy	To: _____ mm/dd/yyyy
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**SUPERVISOR INFORMATION:**

Supervisor's Name		Telephone	
License Type	License Number	State	Date First Licensed

- Physicians: Were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision?

No  Yes: Date Board Certified: \_\_\_\_\_ Certification Number: \_\_\_\_\_

- LPCCs: If the applicant is reporting experience with couples or families, did you meet the qualifications to treat couples and families, as specified in California law?

N/A  No  Yes: Date you met the qualifications: \_\_\_\_\_

**APPLICANT'S EMPLOYER INFORMATION:**

Name of Applicant's Employer			Telephone*	
Address	Number and Street	City	State	Zip Code

Applicant:	Last	First	Middle
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- Was this experience gained in a setting that lawfully and regularly provides mental health counseling or psychotherapy?  Yes  No
- Was this experience gained in a private practice setting?  Yes  No
- Was this experience gained in a hospital or community mental health setting?  Yes  No  
(Minimum 150 hours required overall)
- Was this experience gained in a setting that provided oversight to ensure that the applicant's work meets the experience and supervision requirements and is within the scope of practice?  Yes  No
- Was the applicant receiving pay? *If YES, attach a copy of the applicant's W-2 statement for each year experience is claimed. If a W-2 has not yet issued for this year, attach a copy of the current paystub. If applicant volunteered, submit a letter from the employer verifying volunteer status for these dates.*  Yes  No  
 Volunteer

**EXPERIENCE INFORMATION:**

1. How many weeks of supervised experience are being claimed? _____ weeks		
2. Hours of Experience:		<b>Logged Hours</b>
a. Direct Counseling with Individuals, Groups, Couples or Families (Minimum 1,750 hours overall)		
• Of the hours recorded on line "a.", how many hours were gained while working with Couples, Families or Children?		
b. Group Therapy or Counseling (Maximum 500 hours overall)		
c. Telehealth Counseling (Maximum 375 hours overall)		
<i>NOTE: Combined Maximum for # d, e, f and # 3 below is 1,250 hours</i>		
d. Administering and evaluating psychological tests of counselees, writing clinical reports and progress or process notes (Maximum 250 hours overall)		
e. Workshops, seminars, training sessions, or conferences directly related to professional clinical counseling (Maximum 250 hours overall)		
f. Client-Centered Advocacy		
3. Face-to-face Supervision:		<b>Hours Per Week</b>
a. Individual		
b. Group (group contained no more than 8 persons)		
<p><b>NOTE: Knowingly providing false information or omitting pertinent information may be grounds for denial of the application. The Board may take disciplinary action on a licensee who helps an applicant obtain a license by fraud, deceit or misrepresentation. All information on this form is subject to verification.</b></p> <p>Signature of Supervisor: _____ Date: _____</p> <p style="text-align: center;"><b>ORIGINAL SIGNATURE REQUIRED</b></p>		