



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



LICENSED PROFESSIONAL CLINICAL COUNSELOR IN-STATE EXPERIENCE VERIFICATION

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

- Use separate forms for each supervisor and each employment setting.
- Ensure that your form is complete and correct prior to signing.
- Provide an original or electronic signature and have your supervisor initial any changes.
- Do not submit your *Weekly Log* forms unless specifically requested by the Board.

APPLICANT NAME:

Last	First	Middle	Associate Number APC
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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*
Email Address			

- 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: _____

**If licensed in California for less than two years on the first date of experience claimed, attach your out-of-state license information*

APPLICANT'S EMPLOYER INFORMATION:

Name of Applicant's Employer		Business Phone	
Address:	Number and Street	City	State Zip Code

Applicant:	Last	First	Middle
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APPLICANT'S EMPLOYER INFORMATION (continued):

1. Was this experience gained in a setting that lawfully and regularly provides mental health counseling or psychotherapy? Yes No
2. Was this experience gained in a private practice or professional corporation setting? Yes No
3. 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
4. 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

EXPERIENCE INFORMATION:

1. How many weeks of supervised experience are being claimed? _____ Weeks											
2. Hours of Experience:		Logged Hours									
a. Total Direct Counseling Experience <i>(Minimum 1,750 hours overall)</i>											
b. Total Non-Clinical Experience <i>(Maximum 1,250 hours overall)</i>											
<ul style="list-style-type: none"> • Of the above hours, how many were Face-to-Face Supervision? <table border="1" style="width: 100%; margin-left: 20px;"> <tr> <td></td> <td style="text-align: center;">Hours Per Week</td> <td style="text-align: center;">Logged Hours</td> </tr> <tr> <td>○ Individual or Triadic</td> <td></td> <td></td> </tr> <tr> <td>○ Group (group contained no more than 8 persons)</td> <td></td> <td></td> </tr> </table> 		Hours Per Week	Logged Hours	○ Individual or Triadic			○ Group (group contained no more than 8 persons)				
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<p><i>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.</i></p> <p>Signature of Supervisor: _____ Date: _____</p> <p style="text-align: center;">ORIGINAL OR ELECTRONIC SIGNATURE REQUIRED</p>											