



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
OPTION 1 – STREAMLINED METHOD

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 this "Option 1" form to report hours under the streamlined method.
- 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.

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*

- 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: _____

**If licensed in California for less than two years on the first date of experience claimed, attach 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 setting? Yes No
3. Was this experience gained in a hospital or community mental health setting? Yes No
(Minimum 150 hours required overall)
4. 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
5. 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>		
<ul style="list-style-type: none"> • Of the above hours, how many were gained while working with Couples, Families or Children? 		
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? 		Hours Per Week
<ul style="list-style-type: none"> ○ Individual or Triadic 		
<ul style="list-style-type: none"> ○ Group (group contained no more than 8 persons) 		
<p>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.</p>		
Signature of Supervisor: _____		Date: _____
ORIGINAL SIGNATURE REQUIRED		