



APPLICATION FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC) OR A MENTAL HEALTH COUNSELOR ASSOCIATE (LMHCA)

State Form 50319 (R9 / 9-21)

Approved by State Board of Accounts, 2017

**BEHAVIORAL HEALTH AND HUMAN SERVICES LICENSING BOARD
PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2054
E-mail: pla8@pla.IN.gov
www.pla.in.gov

- INSTRUCTIONS:**
1. The fee for this application is \$50.00, payable to the Indiana Professional Licensing Agency, in accordance with 839 IAC 1-2-5.
 2. If applying for a temporary permit, please include your fee of \$25.00 in accordance with 839 IAC 1-2-5.
 3. Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.
 4. All fees are non-refundable and non-transferable.
 5. Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

FOR OFFICE USE ONLY

Application Fee	Permit fee
Date fee paid (month, day, year)	Date fee paid (month, day, year)
Receipt number	Receipt number
License number issued	Permit number issued
License issuance date (month, day, year)	Permit issuance date (month, day, year)

DO NOT WRITE ABOVE THIS LINE

BASIS FOR LICENSURE

License Type (check only one):
 Mental Health Counselor Mental Health Counselor Associate Obtained by Method: Associate applicants must apply by examination.
 Examination Reciprocity

Do you wish to apply for a Temporary Permit? Only Examination applicants are eligible to request the temporary permit. One permit allowed per applicant.
 Yes No

If you have passed mental health counseling examination, provide the following information for the most recent examination passed:

Date (month, day, year): _____ State: _____

Level of the Examination (select one): NCE NCMHCE Other (Specify): _____

APPLICANT INFORMATION

Name of applicant (last, first, middle)		Social Security Number	
Date of birth (month, day, year)	Gender** <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone number (daytime) ()	E-mail address
Address of applicant (number and street or rural route)		City, state, and ZIP code	

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: (Please select one of the following.)

I am a United States Citizen. I am a qualified alien (as defined under 8 U.S.C. § 1641). I am authorized by the federal government to work in the United States.

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? (Optional)
 Yes No Are you an active duty member of the military? (Optional)
 Yes No

GRADUATE EDUCATION (MASTER'S OR DOCTORAL)

Name of academic institution	Department	Program title
Location (city and state)	Dates attended (mm/yy - mm/yy)	Degree earned
Name of academic institution	Department	Program title
Location (city and state)	Dates attended (mm/yy - mm/yy)	Degree earned
Name of academic institution	Department	Program title
Location (city and state)	Dates attended (mm/yy - mm/yy)	Degree earned

EMPLOYMENT HISTORY FOR THE PAST FIVE (5) YEARS

Please list all places of professional employment, including self-employment.

Name of employer	Position or title	Name of supervisor
Location (<i>city and state</i>)	Dates employed (<i>mm/yy - mm/yy</i>)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location (<i>city and state</i>)	Dates employed (<i>mm/yy - mm/yy</i>)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location (<i>city and state</i>)	Dates employed (<i>mm/yy - mm/yy</i>)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location (<i>city and state</i>)	Dates employed (<i>mm/yy - mm/yy</i>)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location (<i>city and state</i>)	Dates employed (<i>mm/yy - mm/yy</i>)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location (<i>city and state</i>)	Dates employed (<i>mm/yy - mm/yy</i>)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location (<i>city and state</i>)	Dates employed (<i>mm/yy - mm/yy</i>)	Average hours per week
Duties or responsibilities		

STATES LICENSED

List all states and territories, **including Indiana**, in which you have been licensed to practice any regulated health occupation. Verification of all listed licenses must be submitted directly to the board from the state/territory that issued each license. *Licenses issued by the Indiana Professional Licensing Agency will not need verifications.*

Type of License / Certificate / Registration / Permit	State	Number	Date Issued (month, day, year)	Status

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

- | | | |
|---|------------------------------|-----------------------------|
| 1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you ever been denied license, certificate, registration or permit to practice any regulated health occupation in any state (including Indiana), country or U.S. Territory? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Do you have any condition or impairment (including a history of alcohol or substance abuse) that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,
(1) have you ever been arrested; | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| (5) have you ever pled <i>nolo contendere</i> to any offense, misdemeanor, or felony in any state? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have you ever had a malpractice judgement against you or settled any malpractice action? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency or any of its authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency, and the Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I affirm, under penalties for perjury, that the foregoing representations are true.

Signature of applicant

Date (month, day, year)

FORM C**VERIFICATION OF GRADUATE COURSEWORK FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC) OR A MENTAL HEALTH COUNSELOR ASSOCIATE (LMHCA)**

Part of State Form 50319 (R9 / 9-21)

In addition to this form, an official transcript from your degree granting institution and any other educational institutions at which you may have completed coursework or clinical experience must be sent directly from the institution(s) to the Professional Licensing Agency. Delays in the application approval process are often the result of the Board's need to obtain more information from applicants regarding the specifics of individual course content. In order to ensure expediency in the application approval process, the Board suggests, but does not require, that applicants submit course catalog descriptions or course syllabi to accompany Form C. Please indicate the semester/quarter and year in which each course was completed.

COURSEWORK INFORMATION

List the course number and course title of the graduate coursework you have completed in the required content areas as they appear on your transcript. If the course titles as stated on your transcript do not clearly reflect the required content areas, you may be requested to provide additional supporting documentation such as course syllabus, term papers, etc. You may use the same course for more than one content area. Also, each content area may contain more than one course. Please use FORM C-1 to assist you in determining which courses to list in each content area.

HUMAN GROWTH AND DEVELOPMENT

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____
				Year _____

SOCIAL AND CULTURAL FOUNDATIONS

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____
				Year _____

HELPING RELATIONSHIPS

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____
				Year _____

GROUP WORK

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____
				Year _____

CAREER AND LIFESTYLE DEVELOPMENT

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____
				Year _____

APPRAISAL

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____
				Year _____

RESEARCH AND PROGRAM EVALUATION

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____
				Year _____

PROFESSIONAL ORIENTATION

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____
				Year _____

FOUNDATIONS OF MENTAL HEALTH COUNSELING

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____
				Year _____

CONTEXTUAL DIMENSIONS				
Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____ Year _____
KNOWLEDGE AND SKILLS FOR THE PRACTICE OF MENTAL HEALTH COUNSELING				
Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____ Year _____
Applicants for licensure as a mental health counselor must show successful completion of a degree curriculum which shall encompass a minimum of forty-eight (48) semester hours, or seventy-two (72) quarter hours, of graduate study for the master's degree or a minimum of ninety-six (96) semester hours of graduate study for the doctoral degree. Further, the applicant for licensure shall document a minimum of sixty (60) hours of graduate credit in mental health counseling or a related field. Only graduate level courses are acceptable. The board will not accept coursework counted or credited toward an undergraduate degree.				
Applicants for licensure as a mental health counselor must also show successful completion of a one hundred (100) hour practicum, a six hundred (600) hour internship and a three hundred (300) hour advanced internship. Please list these requirements below.				
PRACTICUM				
Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____ Year _____
INTERNSHIP				
Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____ Year _____
ADVANCED INTERNSHIP				
Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____ Year _____
Printed name of applicant			Date of birth	
Signature of applicant			Date (month, day, year)	

FORM C-1
GRADUATE COURSEWORK CONTENT AREAS

Part of State Form 50319 (R9 / 9-21)

HUMAN GROWTH AND DEVELOPMENT

Studies that provide an understanding of the nature and needs of individuals at all developmental levels.

- A. Theories of individual and family development and transitions across the life-span;
- B. Theories of learning and personality development;
- C. Human behavior including an understanding of developmental crises, disability, addictive behavior, psychopathology, and environmental factors as they affect both normal and abnormal behavior;
- D. Strategies for facilitating development over the life span.

SOCIAL AND CULTURAL FOUNDATIONS

Studies that provide an understanding of issues and trends in a multicultural and diverse society.

- A. Multicultural and pluralistic trends including characteristics and concerns of diverse groups;
- B. Attitudes and behavior based on such factors as age, race, religious preference, physical disability, sexual orientation, ethnicity and culture, family patterns, gender, socioeconomic status, and intellectual ability;
- C. Individual, family, and group strategies with diverse populations.

HELPING RELATIONSHIPS

Studies that provide an understanding of counseling and consultation processes.

- A. Counseling and consultation theories including both individual and systems perspectives as well as coverage of relevant research and factors considered in applications;
- B. Basic interviewing, assessment, and counseling skills;
- C. Counselor or consultant characteristics and behaviors that influence helping processes including age, gender and ethnic differences, verbal and nonverbal behaviors and personal characteristics, orientations, and skills;
- D. Client or consultee characteristics and behaviors that influence helping processes including age, gender and ethnic differences, verbal and nonverbal behaviors and personal characteristics, traits, capabilities, and life circumstances.

GROUP WORK

Studies that provide an understanding of group development, dynamics, counseling theories, group counseling methods and skills, and other group work approaches.

- A. Principles of group dynamics including group process components, developmental stage theories, and group members' roles and behaviors;
- B. Group leadership styles and approaches including characteristics of various types of group leaders and leadership styles;
- C. Theories of group counseling including commonalities, distinguishing characteristics, and pertinent research and literature;
- D. Group counseling methods including group counselor orientations and behaviors, ethical standards, appropriate selection criteria and methods, and methods of evaluation of effectiveness;
- E. Approaches used for other types of group work, including task groups, prevention groups, support groups, and therapy groups.

CAREER AND LIFESTYLE DEVELOPMENT

Studies that provide an understanding of career development and related life factors.

- A. Career development theories and decision-making models;
- B. Career, avocational, educational, and labor market information resources, visual and print media, and computer-based career information systems;
- C. Career development program planning, organization, implementation, administration, and evaluation;
- D. Interrelationships among work, family, and other life roles and factors including multicultural and gender issues as related to career development;
- E. Career and educational placement, follow-up and evaluation;
- F. Assessment instruments and techniques relevant to career planning and decision-making;
- G. Computer based career development applications and strategies, including computer-assisted career guidance systems;
- H. Career counseling processes, techniques and resources including those applicable to specific populations.

APPRAISAL

Studies that provide an understanding of individual and group approaches to assessment and evaluation.

- A. Theoretical and historical bases for assessment techniques;
- B. Validity including evidence for establishing content, construct, and empirical validity;
- C. Reliability including methods of establishing stability, internal and equivalence reliability;
- D. Appraisal methods including environmental assessment, performance assessment, individual and group test and inventory methods, behavioral observations, and computer-managed and computer-assisted methods;
- E. Psychometric statistics including types of assessment scores, measures of central tendency, indices of variability, standard errors, and correlations;
- F. Age, gender, ethnicity, language, disability, and culture factors related to the assessment and evaluation of individuals and groups;
- G. Strategies for selecting, administering, interpreting, and using assessment and evaluation instruments and techniques in counseling.

RESEARCH AND PROGRAM EVALUATION

Studies that provide an understanding of types of research methods, basic statistics, and ethical and legal considerations in research.

- A. Basic types or research methods to include qualitative and quantitative research designs;
- B. Basic parametric and non parametric statistics;
- C. Principles, practices, and applications of need assessment and program evaluation;
- D. Uses of computers for data management and analysis.

PROFESSIONAL ORIENTATION

Studies that provide an understanding of all aspects of professional functioning including history, roles, organizational structures, ethics, standards, and credentialing.

- A. History of the helping professions including significant factors and events;
- B. Professional roles and functions including similarities and differences with other types of professionals;
- C. Professional organizations, primarily ACA, its divisions, branches, and affiliates, including membership benefits, activities, services to members, and current emphases;
- D. Ethical standards of the ACA and related entities, ethical and legal issues, and their applications to various professional activities (e.g., *appraisal, group work*);
- E. Professional preparation standards, their evolution, and current applications;
- F. Professional credentialing including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues; and
- G. Public policy processes including the role of the professional counselor in advocating on behalf of the profession and its clientele.

FOUNDATIONS OF MENTAL HEALTH COUNSELING

Studies in this area include, but are not limited to, the following:

- A. Historical, philosophical, societal, cultural, economic, and political dimensions of mental health counseling;
- B. Roles, functions, and professional identity of mental health counselors;
- C. Structures and operations of professional organizations, training standards credentialing bodies, and ethical codes pertaining to the practice of mental health counseling;
- D. Implications of professional issues unique to mental health counseling including, but not limited to, recognition, reimbursement, right to practice, core provider status, access to and practice privileges within managed care systems, and expert witness status; and
- E. Implications of sociocultural, demographic, and lifestyle diversity relevant to mental health counseling.

CONTEXTUAL DIMENSIONS: MENTAL HEALTH COUNSELING

Studies in this area include, but are not limited to, the following:

- A. Assumptions and roles of mental health counseling within the context of the health and human services systems, including functions and relationships among interdisciplinary treatment teams, and the historical, organizational, legal, and fiscal dimensions of the public and private mental health care systems;
- B. Theories and techniques of community needs assessment to design, implement, and evaluate mental health care programs and systems;
- C. Principles, theories, and practices of community intervention, including programs and facilities for inpatient, outpatient, partial treatment, and aftercare, and the human services network in local communities; and
- D. Theoretical and applied approaches to administration, finance and budgeting; management of mental health services and programs in the public and private sectors; principles and practices for establishing and maintaining both solo and group private practice; and concepts and procedures for determining accountability and cost containment.

KNOWLEDGE AND SKILLS FOR THE PRACTICE OF MENTAL HEALTH COUNSELING

Studies in this area include, but are not limited to, the following:

- A. General principles of etiology, diagnosis, treatment, and prevention of mental and emotional disorders and dysfunctional behavior, and general principles and practices of the promotion of optimal mental health;
- B. Specific models and methods for assessing mental status; identification of abnormal, deviant, or psychopathological behavior, and the interpretation of findings in current diagnostic categories [e.g., *Diagnostic and Statistical Manual (DSM)*];
- C. Application of modalities for maintaining and terminating counseling and psychotherapy with mentally and emotionally impaired clients, including crisis intervention, brief, intermediate, and long-term approaches;
- D. Basic classifications, indications, and contraindications of commonly prescribed psychopharmacological medications for the purpose of identifying effects and side effects of such medications;
- E. Principles of conducting an intake interview and mental health history for planning and managing of client caseload;
- F. Specialized consultation skills for effecting living and work environments to improve relationships, communications and productivity, and for working with counselors of different specializations and with other mental health professionals in areas related to collaborative treatment strategies;
- G. The application of concepts of mental health education, consultation, outreach and prevention strategies, and of community health promotion and advocacy; and
- H. Effective strategies for influencing public policy and government relations on local, state, and national levels to enhance funding and programs affecting mental health services in general and the practice of mental health counseling in particular.

FORM P**VERIFICATION OF PRACTICUM FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC) OR A MENTAL HEALTH COUNSELOR ASSOCIATE (LMHCA)**

Part of State Form 50319 (R9 / 9-21)

Complete **SECTION A** and then forward this form to the educational institution at which you have completed your practicum.**SECTION A / APPLICANT INFORMATION**

Name of applicant (<i>last, first, middle, maiden</i>)		Date of birth
My minimum one hundred (100) hour practicum was completed under the auspices of the following educational institution:		
_____ located at _____		_____
<i>(Name of Institution)</i>		<i>(City and State)</i>
I completed the practicum between the following dates:		I completed the practicum at the following location:
_____	_____	_____
<i>Date began (Month/Year)</i>	<i>Date completed (Month/Year)</i>	<i>(Specific location of practicum)</i>

SECTION B / VERIFICATION OF COMPLETION OF THE ONE HUNDRED (100) HOUR PRACTICUM**SECTION B** must be completed by an official of the institution that has granted you the academic credit for this supervised clinical experience.

As an official of the school named above, I certify, that the above-named applicant has completed at least the following experience during the completion of the practicum:

- (1) Applicant has completed at least a one hundred (100) hour practicum that enabled the applicant to develop basic counseling skills and to integrate professional knowledge and skills appropriate to the applicant's program emphasis.
- (2) Applicant has completed a minimum of forty (40) hours of direct service with clients during this practicum and at least one fourth (1/4) of the hours were completed in group work.

As an official of the school named above, I certify that the above-named applicant did receive the following supervision during the completion of the practicum: Applicant received a minimum of one (1) hour per week of individual supervision and a minimum of one and one-half (1 1/2) hours per week of group supervision with other students over a minimum of one (1) academic term. For the purposes of this certification, individual supervision is defined as supervision rendered to one (1) person at a time, and group supervision is supervision rendered to at least two (2) and not more than twelve (12) individuals at one (1) time.

During the completion of this practicum, the applicant did receive the following total number of hours of face-to-face supervision: _____

I further certify that the supervision for this practicum was conducted by either a program faculty member or a supervisor working under the supervision of a program faculty member using audiotape, videotape and / or direct observation. The applicant's supervisor(s) held the following position(s), degree(s), license(s), and / or certification(s) - *[Provide name(s) and qualification(s) below]*:

Program faculty member

Site supervisor

Additionally, I certify the applicant's performance was evaluated throughout the practicum and a formal evaluation was performed at the conclusion of the practicum by the program faculty supervisor, in consultation with the site supervisor, if applicable.

Position held at the institution	Name of institution
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Name (*last, first, middle, maiden or previous name*)

Work telephone number ()	Cellular telephone number ()	E-mail address
Signature		Date (<i>month, day, year</i>)

RETURN THIS FORM TO:
Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, IN 46204

FORM I**VERIFICATION OF INTERNSHIP FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC) OR A MENTAL HEALTH COUNSELOR ASSOCIATE (LMHCA)**

Part of State Form 50319 (R9 / 9-21)

Complete **SECTION A** and then forward this form to the educational institution at which you have completed your internship.**SECTION B** must be completed by an official of the institution that has granted you the academic credit for this supervised clinical experience.**SECTION A / APPLICANT INFORMATION**

Name of applicant (<i>last, first, middle, maiden</i>)		Date of birth
My minimum six hundred (600) hour internship was completed under the auspices of the following educational institution: _____ located at _____ <i>(Name of Institution)</i> <i>(City and State)</i>		
I completed the internship between the following dates: _____ Date began (<i>Month/Year</i>) _____ Date completed (<i>Month/Year</i>)		I completed the internship at the following location: _____ <i>(Specific location of practicum)</i>

SECTION B / VERIFICATION OF COMPLETION OF THE SIX HUNDRED (600) HOUR INTERNSHIP

As an official of the school named above, I certify, that the above-named applicant has completed at least the following experience during the completion of the internship:

- (1) Applicant has completed at least a six hundred (600) hour internship that enabled the applicant to refine and enhance basic counseling skills, to develop more advanced counseling skills and to integrate professional knowledge and skills appropriate to the student's initial post graduation professional placement.
- (2) Applicant has completed a minimum of two hundred forty (240) hours of direct service with clients appropriate to the program of study.
- (3) Additionally, the applicant was provided with the following opportunities:
 - (a) for the student to become familiar with a variety of professional activities other than direct service.
 - (b) for the student to develop audiotapes and/or videotapes of the student's interactions with clients appropriate for use in supervision.
 - (c) for the student to gain supervised experience in the use of a variety of professional resources, such as, assessment instruments; computers; print and nonprint media; professional literature; research; and information and referral to appropriate providers.

As an official of the school named above, I certify that the above-named applicant did receive the following supervision during the completion of the internship: Applicant received a minimum of one (1) hour per week of individual supervision and a minimum of one and one-half (1 1/2) hours per week of group supervision, throughout the internship. For the purposes of this certification, individual supervision is defined as supervision rendered to one (1) person at a time, and group supervision is supervision rendered to at least two (2) and not more than twelve (12) individuals at one (1) time.

During the completion of this internship, the applicant did receive the following total number of hours of face-to-face supervision: _____

I further certify that the supervision for this internship was conducted by either a program faculty member or a supervisor working under the supervision of a program faculty member using audiotape, videotape and/or direct observation. The applicant's supervisor(s) held the following position(s), degree(s), license(s), and/or certification(s) - *[Provide name(s) and qualification(s) below]*:

Program faculty member

Site supervisor

Additionally, I certify the applicant's performance was evaluated throughout the internship and a formal evaluation was performed at the conclusion of the internship by the program faculty supervisor, in consultation with the site supervisor, if applicable.

Position held at the institution

Name of institution

Name (*last, first, middle, maiden or previous name*)

Work telephone number ()	Cellular telephone number ()	E-mail address
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Signature

Date (*month, day, year*)

RETURN THIS FORM TO:
Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, IN 46204

FORM E2**VERIFICATION OF EXPERIENCE FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC)**

Part of State Form 50319 (R9 / 9-21)

Complete **SECTION A** and then forward this form to your previous or current employer(s) for completion of **SECTION B**. You must submit proof that you have acquired at least 3,000 hours of post-graduate clinical experience over a two (2) year period of time. **This form may be duplicated if your 3,000 hours of experience have been completed at more than one place of employment.** If you are no longer able to contact your previous employer(s), you may complete **SECTION C** (on the reverse side of this form) for each previous place of employment. Sign the form(s) and return the form to the Professional Licensing Agency at the address listed on the bottom of this form.

SECTION A / APPLICANT INFORMATION

Name of applicant (<i>last, first, middle, maiden</i>)	Date of birth (<i>month, day, year</i>)
Name of employer	Dates of employment (<i>month/year to month/year</i>)
Location of place of employment or place of practice	

SECTION B / EMPLOYER / EMPLOYMENT INFORMATION

This section is to be completed by the applicant's previous or current employer and sent directly to the Professional Licensing Agency at the address listed on the bottom of this form.

Total number of months the above-named applicant served in the practice of mental health counseling		
Total number of hours served at the address below	State average number of hours worked per week	
Address(es) of where the above-named applicant provided the majority of his / her mental health counseling services		
Printed name of employer and title		
Cellular telephone number	Work telephone number	Email address
Signature of employer	Date (<i>month, day, year</i>)	

RETURN THIS FORM TO:
Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, IN 46204

FORM E2

VERIFICATION OF EXPERIENCE FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC) (continued)

Part of State Form 50319 (R9 / 9-21)

SECTION C / AFFIRMATION OF EXPERIENCE

To be completed by applicant if the applicant's previous employer is no longer able to complete **SECTION B** (on reverse side of this form). Please indicate below the reason why your previous employer is no longer able to complete **SECTION B** (on the reverse side of this form). **If you are affirming experience acquired through more than one previous employer this form may be duplicated but you must submit one AFFIRMATION OF EXPERIENCE for each previous employer that is no longer able to complete SECTION B (on the reverse of this form).**

I am unable to have my previous employer(s) complete SECTION B for the following reason:

- Deceased Unable to be located Other reason

If you have checked "Other reason", please briefly explain:

Total number of months that you have been providing mental health counseling services directly to clients on an average of at least _____ hours per week, at the address below: _____

Total number of hours served at the address below: _____

Period of time in which you provided these services: _____ to _____
(month / year) (month / year)

Name of facility and address where mental health counseling services were provided:

Provide the name of a professional colleague who can attest to the validity of the above statements:

Name of colleague (last, first, middle, maiden) ()
Daytime telephone number of colleague

Address of colleague (number and street, city, state, and ZIP code)

List all graduate degrees, credentials and / or state board issued licenses / certifications held by this colleague

APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties perjury that the above statements are true, complete and correct.

Signature of applicant

Date (month, day, year)

FORM S-2**VERIFICATION OF SUPERVISION FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC)**

Part of State Form 50319 (R9 / 9-21)

Complete **SECTION A** and then forward this form to your previous or current supervisor(s) for completion of **SECTION B**. You must submit proof that you have received at least one hundred (100) hours of face to face supervision acquired during your 3,000 hours of post-graduate clinical experience. **This form may be duplicated if your one hundred (100) hours of face to face supervision have been completed through multiple supervisors.** If you are no longer able to contact your previous supervisor(s), you may complete **SECTION C** (on the reverse side of this form) for each previous supervisor. Sign the form(s) and return the form to the Professional Licensing Agency at the address listed on the bottom of this form.

SECTION A / APPLICANT INFORMATION

Name of applicant (<i>last, first, middle, maiden</i>)	Social Security number *
Name of supervisor	Dates of supervision (<i>month/year to month/year</i>)

SECTION B / SUPERVISOR INFORMATION

This section is to be completed by the applicant's previous or current supervisor and sent directly from the applicant's previous or current supervisor to the Professional Licensing Agency at the address listed on the bottom of this form.

Total number of hours of face to face supervision you provided to the above-named applicant: _____

Total number of months above supervision was completed: _____

The above-named applicant was providing mental health counseling services directly to clients at the time of my supervision?

 Yes No

If No, please explain: _____

I hold the following graduate degree(s), credential(s), and / or state board issued license(s) / certification(s) that qualify me to serve as a mental health counselor supervisor: _____

Printed name of supervisor

Cellular telephone number

Work telephone number

Email address

Signature of supervisor

Date (*month, day, year*)

FORM S-2**VERIFICATION OF SUPERVISION FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC) (continued)**

Part of State Form 50319 (R9 / 9-21)

SECTION C / AFFIRMATION OF SUPERVISION

To be completed by applicant if your previous supervisor is no longer able to complete **SECTION B** (on reverse side of this form). Please indicate below the reason why your previous supervisor is no longer able to complete **SECTION B** (on the reverse side of this form). If you are affirming supervision received from more than one previous supervisor, this form may be duplicated but you must submit one **AFFIRMATION OF SUPERVISION** for each previous supervisor that is no longer able to complete **SECTION B** (on the reverse side of this form).

Please indicate below the reason why your previous supervisor is no longer able to complete **SECTION B**.

My previous supervisor named below is:

Deceased

Unable to be located

Other reason

If you have checked "Other reason", please briefly explain:

Supervision was provided by: _____
(Name of supervisor / last, first, middle, maiden)

Total number of hours of face-to-face supervision you have received from this supervisor while providing mental health counseling services directly to clients: _____

Date of Supervision: _____ to _____
(month / year) (month / year)

List all graduate degrees, credentials and / or state board issued licenses / certifications that qualified this individual to serve as a mental health counselor supervisor: _____

APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties perjury that the above statements are true, complete and correct.

Signature of applicant

Date (month, day, year)