

**TEXAS STATE BOARD OF EXAMINERS OF
PROFESSIONAL COUNSELORS**
VERIFICATION OF LICENSURE IN OTHER JURISDICTION

DIRECTIONS TO APPLICANT: Complete Part I and forward to the state where you hold a license to practice Professional Counseling.

PART I-TO BE COMPLETED BY THE APPLICANT

Name of Applicant	State from which Verification Requested	License No.	Date Issued
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I was granted a license as a Licensed Professional Counselor. You are hereby authorized to release any information in your files, favorable or otherwise, directly to this state's Professional Counselor Board.

Your early attention is appreciated. _____
Signature Date

PART II-TO BE COMPLETED BY THE STATE BOARD VERIFYING LICENSURE (Please complete this form and return it to the address indicated below. Attach copies of any verification of supervision or supervised experience toward LPC licensure.

Name of Licensee	Licensure Level	License No.	Date Issued
Hours of supervision and direct supervised clinical experience required for licensure held: Total hours of practice: _____ Number of hours of direct clinical services: _____ Other requirements: _____			
Please Verify Supervision Requirements Met in Your Jurisdiction Supervision dates: From _____ to _____ Number of months credited _____ Employer name: _____ Employer address: _____ Clinical Supervisor: _____ License # _____ phone number: _____ Type of license held: _____ LPC _____ PSY _____ LCSW _____ LMFT _____ Total hours of practice: _____ Number of hours of direct clinical services: _____			
Please Verify Supervision Requirements Met in Your Jurisdiction Supervision dates: From _____ to _____ Number of months credited _____ Employer name: _____ Employer address: _____ Clinical Supervisor: _____ License # _____ phone number: _____ Type of license held: _____ LPC _____ PSY _____ LCSW _____ LMFT _____ Total hours of practice: _____ Number of hours of direct clinical services: _____			
Exam Taken _____ NBCC (NCE) Other _____	Date Exam Passed	Exam Score	
License Current? _____ Yes _____ No	Expiration Date _____	Complaints and/or Disciplinary Action _____ Yes _____ No	

*Explain Complaints or Disciplinary Actions:

Board Seal

Print Name of person completing this form. _____ Date _____

Signature _____ Title _____ Telephone # _____

Mail To:
 Texas State Board of Examiners of Professional Counselors
 Mail Code 1982
 P.O. Box 149347
 Austin, TX 78714-9347
 512-834-6658 Fax 512-834-6677



PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us/> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004) DSHS Publication #: F75-13407 6/10/2010