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

Applicant: Your supervisor must complete this form (unless experience is verified by an out-of-state licensing agency). Use a separate form for each person verifying hours of supervised experience toward licensure as a professional clinical counselor and for each employment setting. Submit this form with your application for examination eligibility.

Supervisor: You must complete this form. **Make certain that this form is complete and correct prior to signing. Any change should be initialed by you and is subject to verification.** Return the completed form to the applicant.

(*Please type or print clearly in ink*)

Applicant: Last	First	Middle	Social Security Number

SUPERVISOR: (*Please type or print clearly in ink*)

1. Supervisor: Last	First	Middle	2. Business Phone:
3. Address: Number and Street	City	State	Zip Code
4. Name of Applicant's Employer:			5. Business Phone:
6. Employer's Address: Number and Street	City	State	Zip Code

7. a. Was this experience gained in a setting that lawfully and regularly provides mental health counseling or psychotherapy? Yes ☐ No ☐

   b. Was this experience gained in a private practice setting? Yes ☐ No ☐

   c. Was this experience gained in a hospital or community mental health setting, as defined under California Code of Regulations section 1820(d) as a setting that: lawfully and regularly provides mental health counseling or psychotherapy; where clients who routinely receive psychopharmacological interventions in conjunction with psychotherapy, counseling, or psycho-social interventions; where clients receive coordinated care that includes the collaboration of mental health providers; and is not a private practice owned by a licensed professional clinical counselor, marriage and family therapist, a licensed psychologist, a licensed clinical social worker, a licensed physician or surgeon, a professional corporation of any of these licensed professions or unlicensed individuals? Yes ☐ No ☐

8. 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 for the profession? Yes ☐ No ☐

9. Was the applicant either an employee or a volunteer during the dates of experience claimed? Yes ☐ No ☐
   If the applicant was an employee and receiving pay, attach a copy of the applicant's W-2 statement for each year experience is claimed. For the current year in which a W-2 has not been issued, submit a copy of a current paystub.
   If applicant volunteered, a letter from the employer verifying volunteer status is required.

10. Dates of the experience being claimed From: ____________ (mm/dd/yyyy) To: ____________ (mm/dd/yyyy)

11. How many weeks of supervised experience are being claimed? ____________

12. Show only those hours of experience as logged on the weekly summary of hours form.	Total Logged Hours
a. Direct Psychotherapy (performed by the applicant; minimum 1,750 hours)	
b. Group Therapy or Group Counseling (maximum 500 hours)	
c. Telephone Counseling (maximum 250 hours)	
d. Administering and evaluating psychological tests of counselees, writing clinical reports and progress or process notes (maximum 250 hours)*	
e. Workshops, seminars, training sessions, or conferences directly related to professional clinical counseling (maximum 250 hours)*	
f. Client Centered Advocacy (CCA)*	

Applicant: Last	First	Middle

13. Face-to-face supervision*:	Hours per week (Range)	Total Logged Hours
a. Individual		
b. Group (Group supervision contained no more than eight (8) persons)		

14. Supervisor License Information:

Type of License	License Number	State of Licensure	Date Originally Licensed

If M.D., were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision? Yes ☐ No ☐

Date Board certified: ______________________

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct

Signature of Supervisor: ______________________________ Date: ____________________

***When combined, these categories shall not exceed 1,250 hours of experience (BPC Section 4999.46(b)(6)).**

 This form may be reproduced