



Mental Health Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Practicum Exemption Verification for Mental Health Counselor or Associate

1. Applicant

To be considered for the exemption from the graduate level counseling practicum requirement, please complete section one and forward this form to your supervisor(s) for completion. Only clinical experience as an agency affiliated counselor credentialed in Washington State will be considered. Use a separate form for each supervisor verifying your clinical experience. This form may be duplicated.

| | | |
|--------------|---------------|--------|
| Last Name | First | Middle |
| Credential # | Date of Birth | |

2. Supervisor

Please review and complete sections two and three and return this form to the department.

| | | |
|--------------|---------------|--------|
| Last Name | First | Middle |
| Credential # | Date of Birth | |

3. Clinical Experience Verification [WAC 246-809-221](#)

The above individual seeks verification of clinical experience in lieu of completing a graduate level counseling practicum as required in [WAC 246-809-221](#).

An applicant for Mental Health Counselor or Associate is considered to have met the clinical practicum component of the educational requirements if they:

- a) Have held an agency affiliated counselor credential for the past year in good standing; and
- b) Demonstrate 600 hours of clinical experience under the supervision of a mental health professional as defined in [RCW 71.05.020](#). Experience must include demonstrated competence in the principles of human development, learning theory, psychotherapy, group dynamics, or dysfunctional behavior in the delivery of direct clinical care.

| | | |
|------------------------------------|------------------|----------------|
| Dates of Clinical Experience | From: mm/dd/yyyy | To: mm/dd/yyyy |
| Total Hours of Clinical Experience | | |

I certify that the above information is, to the best of my knowledge, accurate and complete. I understand that the Department may request additional information if it is needed to evaluate the application of the individual named on this document.

Supervisor's Signature: _____ Date: _____