Washington State Department of HEALTH

Mental Health Counselor Associate Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360.236.4700

Mental Health Counselor Associate Supervision and Experience Verification

Applicant:

Use a separate form for each supervisor verifying your postgraduate supervision and professional experience for each practice setting. This form may be duplicated. Fill out Section 1 and forward to the supervisor for completion.

1. Print or Type Clearly:

Name Last	First	Middle	Birth Date (mm/dd/yyyy)
Address			
City	State		Zip Code

2. Approved Supervisor: (an approved licensed mental health practitioner or equally qualified licensed mental health practitioner)

The above individual seeks verification of supervised mental health counselor postgraduate experience for license as a mental health counselor. Please complete the following:

Supervisor Name		Current Phone
Credential State		First Issuance Date
Current Street Address		
City	State	Zip Code

3. Supervised Postgraduate Experience:

Applicants must have a minimum of **thirty-six months** of full time counseling or **3,000 hours** of supervised postgraduate experience under the supervision of an approved licensed mental health practitioner or equally qualified licensed mental health practitioner. Please complete the actual months under your supervision.

Dates applicant was supervised from: _____ To: _____
Month Day Year Month Day Year

Supervised Work Experience—Supervised postgraduate experience consists of a minimum of 3,000 hours; at least 1,200 of the total hours must be direct client counseling with individuals, couples, families or groups. 100 hours must be immediate supervision. Please complete the actual number of hours under your supervision.

Supervision	Total Hours
Number of hours in immediate supervision (**100 hours required)**	
Number of hours of direct counseling **(1200 hours required)**	
Number of all other supervised hours	
Number of total supervised experience hours **(3000 hours required)**	

Supervisor

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. I also attest I meet or exceed the educational and supervision requirements to be an approved supervisor.

Signature: _____ Date: _____

Return this form to the address above.