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

Verification of Mental Health Counselor Supervised Postgraduate Experience

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 one and forward to the supervisor for completion.

1. Print Clearly:

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

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

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

Supervisor Name	Current Phone
Credential Number	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 counselor or equally qualified licensed mental health practitioner. Please complete the actual months in the space provided below.

Months of Supervision	From: mm	dd	yyyy	To: mm	dd	yyyy

	Hours Required	**Total Hours Verified**
A. **Immediate Supervision,** means a meeting with an approved supervisor, involving one supervisor and no more than two licensing consultants.	At least 100	
B. **Direct Counseling,** with individual couples, families, or groups.	At least 1,200	
C. **All other hours,** hours not listed in section A or B may be listed here	Unlimited	
D. **Total Hours required**	**A+B+C = D Total of 3,000**	

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: _____

Please provide a separate form for each supervisor.