Professional Experience Verification Form

The Board of Professional Counselors and Therapists
4201 Patterson Avenue – Room 316
Baltimore, MD 21215
www.dhmh.state.md.us/bopc
(410) 764-4735

The person named below has applied to the Board of Professional Counselors and Therapists to become a Licensed Clinical Professional Counselor, LCPC. Your documentation of the applicant's professional counselor experience will enable the Board to evaluate whether this applicant meets the requirements for licensure. **Please attest to the following statement, and return the form to the applicant in the sealed envelope with the sealed flap signed.**

(Print name of applicant)_____ has

☐ A master's degree with **less than 60 graduate credits or less than 90 graduate quarter credits!** and at least 3 years licensed as an LCPC with 3,000 hours of clinical professional counseling experience.

Are you a licensed Professional Counselor? Yes ☐ No ☐

License Number: _____ State: _____ Expiration Date: _____

Are you licensed as another mental health care provider? Yes ☐ No ☐

If yes, where are you licensed? State: _____ License Number: _____ Expiration Date: _____

I HEREBY AFFIRM UNDER THE PENALITIES OF PERJURY THAT THE FOREGOING INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE INFORMATION AND BELIEF.

Check one: ___ Applicant's supervisor ___ Applicant's employer ___ Applicant's colleague
(In the case of colleague, provide documentation of colleague's mental health credentials)

Your Name:_____

Signature:_____

Date:_____

Your Business Address:_____

_____ **Zip Code:** _____

Daytime Contact: _____