Professional Experience Verification Form

Maryland Board of Professional Counselors and Therapists
4201 Patterson Avenue – Suite 316
Baltimore, MD 21215
www.dhmh.maryland.gov/bopc
(410) 764-4735

The person named below has applied to the Maryland 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 a sealed envelope with the sealed flap signed.**

(Print name of applicant)_____has

- A **doctoral degree** with at least of two years licensed as a clinical professional counselor and doctoral degree with a minimum of 2,000 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 PENALTIES 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 credential)

Your Name: _____

Signature: _____

Date: _____

Your Business Address:_____

_____Zip Code: _____

Daytime Contact: _____