Reset Form

APPLICATION FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC) OR A MENTAL HEALTH COUNSELOR ASSOCIATE (LMHCA)

State Form 50319 (R12 / 3-25)
Approved by State Board of Accounts, 2017

BEHAVIORAL HEALTH AND HUMAN SERVICES LICENSING BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2054
E-mail: pla8@pla.IN.gov
www.pla.in.gov

INSTRUCTIONS:

1. *The fee for this application is $50.00, payable to the Indiana Professional Licensing Agency, in accordance with 839 IAC 1-2-5.*
2. *If applying for a temporary permit, please include your fee of $25.00 in accordance with 839 IAC 1-2-5.*
3. *Completed application and fees should be mailed to the address listed in the upper right-hand corner of this form.*
4. *All fees are non-refundable and non-transferable.*
5. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

FOR OFFICE USE ONLY

Application Fee	Permit fee
Date fee paid *(month, day, year)*	Date fee paid *(month, day, year)*
Receipt number	Receipt number
License number issued	Permit number issued
License issuance date *(month, day, year)*	Permit issuance date *(month, day, year)*

DO NOT WRITE ABOVE THIS LINE

BASIS FOR LICENSURE

License Type *(select one)*
☐ Mental Health Counselor ☐ Mental Health Counselor Associate

Obtained by method (*Associate applicants must apply by examination)*
☐ Examination ☐ Reciprocity

Do you wish to apply for a temporary permit?*
**One permit allowed per applicant. Temporary permit applicants are required to meet and are subject to the requirements provided under:*
(1) IC 25-23.6-8.5-1.5, for mental health counselor associate (LMHCA) license applicants.
(2) IC 25-23.6-8.5-10 and 839 IAC 1-5-3, for mental health counselor (LMHC) license applicants.

__ Yes No

APPLICANT INFORMATION

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory, and this record cannot be processed without it.
** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

Name of applicant (*last, first, middle*)			Social Security Number*
Date of birth (*month, day, year*)	Gender** Male Female	Telephone number (*daytime*) ( )	E-mail address
Address of applicant (*number and street or rural route*)		City, state, and ZIP code	

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that (select one of the following):

☐ I am a United States Citizen
☐ I am a qualified alien (as defined under 8 U.S.C. § 1641)
☐ I am authorized by the federal government to work in the United States

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)*
☐ Yes ☐ No

Are you an active-duty member of the military? *(Optional)*
☐ Yes ☐ No

ORGAN & TISSUE DONOR

In 2022, the Indiana State Legislature passed a law (SEA 260) allowing Indiana residents to sign up as organ donors when seeking or renewing professional licenses via the Indiana Professional Licensing Agency. More than 100,000 people are awaiting a lifesaving transplant, and more than 1,000 of those waiting are Hoosiers, so your decision to say "yes" can truly help save lives.

By selecting "yes", I affirm that I wish to be an organ donor upon my death. I would like to donate all organs for transplant, research, and education. At the time of my death, I understand that my family cannot override my decision. I understand this online sign-up is binding and is a legal document of gift. I do solemnly swear, affirm or certify that I am the applicant described in this application and that the information entered herein is true and correct.

Do you want to sign up to be an organ and tissue donor? ☐ Yes ☐ Not Today

EXAMINATION INFORMATION

ELIGIBILITY FOR EXAMINATION PRIOR TO GRADUATION [MENTAL HEALTH COUNSELOR ASSOCIATE (LMHCA) APPLICANTS ONLY]

Pursuant to IC 25-23.6-8.5-5, mental health counselor associate (LMHCA) applicants who are:

(1) Enrolled in the last "term" of the last year of their program leading to their degree that meets the requirements of IC 25-23.6-8.5-1.5; and
(2) provide a "Letter of Good Standing" from the director of the mental health counselor department or the director's designee;

may take the examination provided by the Behavioral Health and Human Services Board (the NCE) prior to graduation.

The "Letter of Good Standing" provided by the director or the director's design must include the follow information:

(1) The applicant's first and last name.
(2) The type of degree and program in which the applicant is enrolled.
(3) A statement confirming that the applicant is currently in the final term of the program.
(4) The anticipated date of completion of the program.
(5) A statement confirming that the applicant is in good academic standing.

LMHCA applicants who meet these eligibility requirements and are interested in being approved to register and take the NCE during their last "term" prior graduation should indicate their interest by "checking" (✓) the box below and supply their "Letter of Good Standing" with this application.

☐ I affirm that I meet the eligibility requirements provided above, and I would like to be approved to register and take the Behavioral Health and Human Services Board's examination (the NCE), towards my LMCHA license. I affirm that I am including my "Letter of Good Standing" with this application.

If you have already passed a mental health counseling examination, provide the following information for the most recent examination passed:

** LMHC applicants who have only taken the NCE exam will not qualify for reciprocity. They must show they have passed the NCMHCE exam or an equivalent exam.*

Date *(month, day, year)*	State	Level of examination *(select one)*
		☐ NCE* ☐ NCMHCE ☐ Other *(Specify)*:

GRADUATE EDUCATION (MASTER'S OR DOCTORAL)

Name of academic institution	Department	Program title
Location (*city and state*)	Dates attended (*mm/yy - mm/yy*)	Degree earned
Name of academic institution	Department	Program title
Location (*city and state*)	Dates attended (*mm/yy - mm/yy*)	Degree earned
Name of academic institution	Department	Program title
Location (*city and state*)	Dates attended (*mm/yy - mm/yy*)	Degree earned

EMPLOYMENT HISTORY FOR THE PAST FIVE (5) YEARS

Please list all places of professional employment, including self-employment.

Name of employer	Position or title	Name of supervisor
Location (*city and state*)	Dates employed (*mm/yy - mm/yy*)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location (*city and state*)	Dates employed (*mm/yy - mm/yy*)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location (*city and state*)	Dates employed (*mm/yy - mm/yy*)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location (*city and state*)	Dates employed (*mm/yy - mm/yy*)	Average hours per week

Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location (*city and state*)	Dates employed (*mm/yy - mm/yy*)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location (*city and state*)	Dates employed (*mm/yy - mm/yy*)	Average hours per week
Duties or responsibilities		

STATES LICENSED

List all states and territories, ***including Indiana,*** in which you have been licensed to practice any regulated health occupation. Verification of all listed licenses must be submitted directly to the board from the state/territory that issued each license. *Licenses issued by the Indiana Professional Licensing Agency will not need verifications.*

Type of License / Certificate / Registration / Permit	State	Number	Date Issued *(month, day, year)*	Status

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No

2. Have you ever been denied license, certificate, registration or permit to practice any regulated health occupation in any state (*including Indiana*), country or U.S. Territory? ☐ Yes ☐ No

3. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice in a competent, ethical, and professional manner? ☐ Yes ☐ No

4. *Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*
   - (1) have you ever been arrested; Yes No
   - (2) have you ever entered int a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; Yes No
   - (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; Yes No
   - (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or Yes No
   - (5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state? Yes No

5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline of limitations? ☐ Yes ☐ No

6. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No

7. Have you ever had a malpractice judgement against you or settled any malpractice action? ☐ Yes ☐ No

AUTHORIZATION FOR RELEASE OF INFORMAITON

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency or any of its authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency, and the Board from any and all liability in connection
with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I affirm, under penalties for perjury, that the foregoing representations are true.

Signature	Date *(month, day, year)*

FORM C

VERIFICATION OF GRADUATE COURSEWORK FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC) OR A MENTAL HEALTH COUNSELOR ASSOCIATE (LMHCA)

Part of State Form 50319 (R11 / 8-24)

COURSEWORK INFORMATION

Please list the course titles in the areas indicated below, or courses, as they appear on your transcript, that in your opinion, meet the following requirements. If two or more courses combine meet the criteria, list all courses that may apply. Once complete, you will submit the form to the PLA for processing. Please use FORM C-1 to assist you in determining which courses to list in each content area. Only graduate level courses are acceptable. The board will not accept coursework counted or credited toward an undergraduate degree.

HUMAN GROWTH AND DEVELOPMENT

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____ Year _____

SOCIAL AND CULTURAL FOUNDATIONS

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____ Year _____

HELPING RELATIONSHIPS

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____ Year _____

GROUP WORK

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____ Year _____

CAREER AND LIFESTYLE DEVELOPMENT

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____ Year _____

APPRAISAL

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____ Year _____

RESEARCH AND PROGRAM EVALUATION

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____ Year _____

PROFESSIONAL ORIENTATION

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____ Year _____

FOUNDATIONS OF MENTAL HEALTH COUNSELING

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____ Year _____

CONTEXTUAL DIMENSIONS

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester/ Quarter _____ Year _____

KNOWLEDGE AND SKILLS FOR THE PRACTICE OF MENTAL HEALTH COUNSELING				
Name of Educational Institution	**Course Number**	**Course Title**	**Credit Hours**	**Semester/ Quarter** _____ **Year** _____
Applicants for licensure as a mental health counselor must also show successful completion of a one hundred (100) hour practicum, and a six hundred (600) hour internship with a minimum of sixty-six (66) hours of face-to-face supervision combined between your practicum and internship. Please list these requirements below.				
PRACTICUM				
Name of Educational Institution	**Course Number**	**Course Title**	**Credit Hours**	**Semester/ Quarter** _____ **Year** _____
INTERNSHIP				
Name of Educational Institution	**Course Number**	**Course Title**	**Credit Hours**	**Semester/ Quarter** _____ **Year** _____
Printed name of applicant			Date of birth *(month, day, year)*	
Signature of applicant			Date (*month, day, year*)	

FORM C-1

GRADUATE COURSEWORK CONTENT AREAS

Part of State Form 50319 (R11 / 8-24)

HUMAN GROWTH AND DEVELOPMENT

Studies that provide an understanding of the nature and needs of individuals at all developmental levels.

A. Theories of individual and family development and transitions across the life-span;

B. Theories of learning and personality development;

C. Human behavior including an understanding of developmental crises, disability, addictive behavior, psychopathology, and environmental factors as they affect both normal and abnormal behavior; **D.** Strategies for facilitating development over the life span.

SOCIAL AND CULTURAL FOUNDATIONS

Studies that provide an understanding of issues and trends in a multicultural and diverse society.

A. Multicultural and pluralistic trends including characteristics and concerns of diverse groups;

B. Attitudes and behavior based on such factors as age, race, religious preference, physical disability, sexual orientation, ethnicity and culture, family patterns, gender, socioeconomic status, and intellectual ability; **C.** Individual, family, and group strategies with diverse populations.

HELPING RELATIONSHIPS

Studies that provide an understanding of counseling and consultation processes.

A. Counseling and consultation theories including both individual and systems perspectives as well as coverage of relevant research and factors considered in applications;

B. Basic interviewing, assessment, and counseling skills;

C. Counselor or consultant characteristics and behaviors that influence helping processes including age, gender and ethnic differences, verbal and nonverbal behaviors and personal characteristics, orientations, and skills;

D. Client or consultee characteristics and behaviors that influence helping processes including age, gender and ethnic differences, verbal and nonverbal behaviors and persona characteristics, traits, capabilities, and life circumstances.

GROUP WORK

Studies that provide an understanding of group development, dynamics, counseling theories, group counseling methods and skills, and other group work approaches.

A. Principles of group dynamics including group process components, developmental stage theories, and group members' roles and behaviors;

B. Group leadership styles and approaches including characteristics of various types of group leaders and leadership styles;

C. Theories of group counseling including commonalities, distinguishing characteristics, and pertinent research and literature;

D. Group counseling methods including group counselor orientations and behaviors, ethical standards, appropriate selection criteria and methods, and methods of evaluation of effectiveness;

E. Approaches used for other types of group work, including task groups, prevention groups, support groups, and therapy groups.

CAREER AND LIFESTYLE DEVELOPMENT

Studies that provide an understanding of career development and related life factors.

A. Career development theories and decision-making models;

B. Career, avocational, educational, and labor market information resources, visual and print media, and computer-based career information systems;

C. Career development program planning, organization, implementation, administration, and evaluation;

D. Interrelationships among work, family, and other life roles and factors including multicultural and gender issues as related to career development;

E. Career and educational placement, follow-up and evaluation;

F. Assessment instruments and techniques relevant to career planning and decision-making;

G. Computer based career development applications and strategies, including computer-assisted career guidance systems;

H. Career counseling processes, techniques and resources including those applicable to specific populations.

APPRAISAL

Studies that provide an understanding of individual and group approaches to assessment and evaluation.

A. Theoretical and historical bases for assessment techniques;
B. Validity including evidence for establishing content, construct, and empirical validity;
C. Reliability including methods of establishing stability, internal and equivalence reliability;
D. Appraisal methods including environmental assessment, performance assessment, individual and group test and inventory methods, behavioral observations, and computer-managed and computer-assisted methods;
E. Psychometric statistics including types of assessment scores, measures of central tendency, indices of variability, standard errors, and correlations;
F. Age, gender, ethnicity, language, disability, and culture factors related to the assessment and evaluation of individuals and groups;
G. Strategies for selecting, administering, interpreting, and using assessment and evaluation instruments and techniques in counseling.

RESEARCH AND PROGRAM EVALUATION

Studies that provide an understanding of types of research methods, basic statistics, and ethical and legal considerations in research. **A.** Basic types or research methods to include qualitative and quantitative research designs;
B. Basic parametric and non parametric statistics;
C. Principles, practices, and applications of need assessment and program evaluation;
D. Uses of computers for data management and analysis.

PROFESSIONAL ORIENTATION

Studies that provide an understanding of all aspects of professional functioning including history, roles, organizational structures, ethics, standards, and credentialing.

A. History of the helping professions including significant factors and events;
B. Professional roles and functions including similarities and differences with other types of professionals;
C. Professional organizations, primarily ACA, its divisions, branches, and affiliates, including membership benefits, activities, services to members, and current emphases;
D. Ethical standards of the ACA and related entities, ethical and legal issues, and their applications to various professional activities (*e.g., appraisal, group work*);
E. Professional preparation standards, their evolution, and current applications;
F. Professional credentialing including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues; and
G. Public policy processes including the role of the professional counselor in advocating on behalf of the profession and its clientele.

FOUNDATIONS OF MENTAL HEALTH COUNSELING

Studies in this area include, but are not limited to, the following:

A. Historical, philosophical, societal, cultural, economic, and political dimensions of mental health counseling;
B. Roles, functions, and professional identity of mental health counselors;
C. Structures and operations of professional organizations, training standards credentialing bodies, and ethical codes pertaining to the practice of mental health counseling;
D. Implications of professional issues unique to mental health counseling including, but not limited to, recognition, reimbursement, right to practice, core provider status, access to and practice privileges within managed care systems, and expert witness status; and **E.** Implications of sociocultural, demographic, and lifestyle diversity relevant to mental health counseling.

CONTEXTUAL DIMENSIONS: MENTAL HEALTH COUNSELING

Studies in this area include, but are not limited to, the following:

A. Assumptions and roles of mental health counseling within the context of the health and human services systems, including functions and relationships among interdisciplinary treatment teams, and the historical, organizational, legal, and fiscal dimensions of the public and private mental health care systems;
B. Theories and techniques of community needs assessment to design, implement, and evaluate mental health care programs and systems;
C. Principles, theories, and practices of community intervention, including programs and facilities for inpatient, outpatient, partial treatment, and aftercare, and the human services network in local communities; and
D. Theoretical and applied approaches to administration, finance and budgeting; management of mental health services and programs in the public and private sectors; principles and practices for establishing and maintaining both solo and group private practice; and concepts and procedures for determining accountability and cost containment.

KNOWLEDGE AND SKILLS FOR THE PRACTICE OF MENTAL HEALTH COUNSELING

Studies in this area include, but are not limited to, the following:

- **A.** General principles of etiology, diagnosis, treatment, and prevention of mental and emotional disorders and dysfunctional behavior, and general principles and practices of the promotion of optimal mental health;
- **B.** Specific models and methods for assessing mental status; identification of abnormal, deviant, or psychopathological behavior, and the interpretation of findings in current diagnostic categories [*e.g., Diagnostic and Statistical Manual (DSM)*];
- **C.** Application of modalities for maintaining and terminating counseling and psychotherapy with mentally and emotionally impaired clients, including crisis intervention, brief, intermediate, and long-term approaches;
- **D.** Basic classifications, indications, and contraindications of commonly prescribed psychopharmacological medications for the purpose of identifying effects and side effects of such medications;
- **E.** Principles of conducting an intake interview and mental health history for planning and managing of client caseload;
- **F.** Specialized consultation skills for effecting living and work environments to improve relationships, communications and productivity, and for working with counselors of different specializations and with other mental health professionals in areas related to collaborative treatment strategies;
- **G.** The application of concepts of mental health education, consultation, outreach and prevention strategies, and of community health promotion and advocacy; and
- **H.** Effective strategies for influencing public policy and government relations on local, state, and national levels to enhance funding and programs affecting mental health services in general and the practice of mental health counseling in particular.

FORM P

VERIFICATION OF PRACTICUM FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC) OR A MENTAL HEALTH COUNSELOR ASSOCIATE (LMHCA)

Part of State Form 50319 (R11 / 8-24)

*Complete **SECTION A** and then forward this form to the educational institution at which you have completed your practicum.*

SECTION A / APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Date of birth *(month, day, year)*

My minimum one hundred (100) hour practicum was completed under the auspices of the following educational institution

_____ located at _____

(Name of institution) *(City and State)*

I completed the practicum between the following dates ***I completed the practicum at the following location***

_____ _____ _____

Date began *(Month/Year)* Date completed *(Month/Year)* *(Specific location of practicum)*

SECTION B / VERIFICATION OF COMPLETION OF THE ONE HUNDRED (100) HOUR PRACTICUM

***SECTION B** must be completed by an official of the institution that has granted you the academic credit for this supervised clinical experience.*

As an official of the school named above. I certify, that the above-named applicant has completed at least the following experience during the completion of the practicum:

(1) Applicant has completed at least a one hundred (100) hour practicum that enabled the applicant to develop basic counseling skills and to integrate professional knowledge and skills appropriate to the applicant's program emphasis.

(2) Applicant has completed a minimum of forty (40) hours of direct service with clients during this practicum and at least one fourth (1/4) of the hours were completed in group work.

As an official of the school named above, I certify that the above-named applicant did receive the following supervision during the completion of the practicum: Applicant received a minimum of one (1) hour per week of individual supervision and a minimum of one and one-half (1 1/2) hours per week of group supervision with other students over a minimum of one (1) academic term. For the purposes of this certification, individual supervision is defined as supervision rendered to one (1) person at a time, and group supervision is supervision rendered to at least two (2) and not more than twelve (12) individuals at one (1) time.

During the completion of this practicum, the applicant did receive the following total number of hours of face-to-face supervision: _____

I further certify that the supervision for this practicum was conducted by either a program faculty member or a supervisor working under the supervision of a program faculty member using audiotape, videotape and / or direct observation. The applicant's supervisor(s) held the following position(s), degree(s), license(s), and / or certification(s) - [*Provide name(s) and qualification(s) below*]:

Program faculty member

Site supervisor

Additionally, I certify the applicant's performance was evaluated throughout the practicum and a formal evaluation was performed at the conclusion of the practicum by the program faculty supervisor, in consultation with the site supervisor, if applicable.

Position held at the institution	Name of institution

Name (*last, first, middle, maiden or previous name*)

Work telephone number	Cellular telephone number	E-mail address
( )	( )	

Signature	Date *(month, day, year)*

RETURN THIS FORM TO:
Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, IN 46204

FORM I
VERIFICATION OF INTERNSHIP FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC) OR A MENTAL HEALTH COUNSELOR ASSOCIATE (LMHCA)

Part of State Form 50319 (R11 / 8-24)

*Complete **SECTION A** and then forward this form to the educational institution at which you have completed your internship.*
***SECTION B** must be completed by an official of the institution that has granted you the academic credit for this supervised clinical experience*

SECTION A / APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Date of birth

My minimum six hundred (600) hour internship was completed under the auspices of the following educational institution:

(*Name of Institution*) located at (*City and State*)

I completed the internship between the following dates:

Date began (*Month/Year*) _____ Date completed (*Month/Year*) _____

I completed the internship at the following location:

(*Specific location of practicum*) _____

SECTION B / VERIFICATION OF COMPLETION OF THE SIX HUNDRED (600) HOUR INTERNSHIP

As an official of the school named above. I certify, that the above-named applicant has completed at least the following experience during the completion of the internship:

(1) Applicant has completed at least a six hundred (600) hour internship that enabled the applicant to refine and enhance basic counseling skills, to develop more advanced counseling skills and to integrate professional knowledge and skills appropriate to the student's initial post graduation professional placement.

(2) Applicant has completed a minimum of two hundred forty (240) hours of direct service with clients appropriate to the program of study.

(3) Additionally, the applicant was provided with the following opportunities:
- (a) for the student to become familiar with a variety of professional activities other than direct service.
- (b) for the student to develop audiotapes and/or videotapes of the student's interactions with clients appropriate for use in supervision.
- (c) for the student to gain supervised experience in the use of a variety of professional resources, such as, assessment instruments; computers; print and nonprint media; professional literature; research; and information and referral to appropriate providers.

As an official of the school named above, I certify that the above-named applicant did receive the following supervision during the completion of the internship: Applicant received a minimum of one (1) hour per week of individual supervision and a minimum of one and one-half (1 1/2) hours per week of group supervision, throughout the internship. For the purposes of this certification, individual supervision is defined as supervision rendered to one (1) person at a time, and group supervision is supervision rendered to at least two (2) and not more than twelve (12) individuals at one (1) time.

During the completion of this internship, the applicant did receive the following total number of hours of face-to-face supervision: _____

I further certify that the supervision for this internship was conducted by either a program faculty member or a supervisor working under the supervision of a program faculty member using audiotape, videotape and/or direct observation. The applicant's supervisor(s) held the following position(s), degree(s), license(s), and/or certification(s) - [*Provide name(s) and qualification(s) below*]:

Program faculty member

Site supervisor

Additionally, I certify the applicant's performance was evaluated throughout the internship and a formal evaluation was performed at the conclusion of the internship by the program faculty supervisor, in consultation with the site supervisor, if applicable.

Position held at the institution	Name of institution

Name (*last, first, middle, maiden or previous name*)

Work telephone number	Cellular telephone number	E-mail address
( )	( )	
Signature		Date *(month, day, year)*

RETURN THIS FORM TO:
Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, IN 46204

VERIFICATION OF EXPERIENCE AND SUPERVISION FORM FOR MENTAL HEALTH COUNSELOR (LMHC) LICENSE APPLICANTS

Part of State Form 50319 (R11 / 8-24)

INSTRUCTIONS: *Applicants must have at least three thousand (3,000) hours of post-graduate clinical experience and have acquired at least one hundred (100) hours of face-to-face supervision over a two (2) year period. This two (2) year period means experience under an approved supervisor, acquired over no less than twenty-one (21) months and over no more than forty-eight (48) months. A doctoral internship may be applied toward the supervised work experience requirement. This supervision must be completed and signed by your previous or current supervisor(s). All supervision may be completed either in person or virtual. However, any completed virtual supervision is required to meet the definition of "virtual supervision" provided under IC-25-23.6-8.5-4.The clinical work requirement may not be performed away from the supervising mental health counselor's premises if the work: Is the independent private practice of mental health counseling; and is not performed at a place that has the supervision of a licensed mental health counselor, clinical social worker, marriage & family therapist, physician psychiatrist, psychologist, nurse specializing in psychiatric or mental health nursing, or mental health professional from another state. Disclaimer: Max of five (5) employers and five (5) supervisors allowed per form. Additional Verification of Employer and Supervision forms may be submitted to help applicants establish the total required months and hours.*

SECTION A: APPLICANT INFORMATION & AFFIRMATION				
Last Name:	First Name:	Date of Birth	I hereby certify under the penalty of perjury that the following information is true and accurate:	Date:

SECTION B: EMPLOYMENT HISTORY

INSTRUCTIONS: *In this section, enter information related to your qualifying employment. Applicants should only be counting clinical experience as defined by IC 25- 23.6-1-7.5. Applicants should complete the "Employment Information" section for each employer. If time at any employers overlap with one another (i.e. you worked two jobs at once), you can only count the months for one of your employers. This is to prevent duplicate counting of months earned. Each entry must be verified by your employer. If employer is not available (business closure, death, incapacity, etc.) to verify the employment information, write "unavailable" in the employer signature line and a member of staff will follow up with you. Please be advised that if you cannot substantially verify your employment within 5 years, the Board may require you to complete additional experience hours. At the end of this section, add the "Months Worked" column to get your "Total Months of Employment" and the "Hours Worked" column to get your "Total Hours of Employment." You cannot count any employment that was not supervised.*

B(1)	**Employment Information**						
	Employer Name:	Employer Address:	Start Date:	End Date:	Avg. Weekly Hours:	Employed Month(s):	Employed Hour(s):
	Employer Verification						
	I hereby certify that the information entered in Section B(1) of this form is true and accurate.						
	Employer Signature:	Date:	Employer Printed Name:	Employer Position/Title:	Employer Email:		
B(2)	**Employment Information**						
	Employer Name:	Employer Address:	Start Date:	End Date:	Avg. Weekly Hours:	Employed Month(s):	Employed Hour(s):
	Employer Verification						
	I hereby certify that the information entered in Section B(2) of this form is true and accurate.						
	Employer Signature:	Date:	Employer Printed Name:	Employer Position/Title:	Employer Email:		

B(3)	**Employment Information**						
	Employer Name:	Employer Address:		Start Date:	End Date:	Avg. Weekly Hours:	Employed Month(s):	Employed Hour(s):
	Employer Verification						
	I hereby certify that the information entered in Section B(3) of this form is true and accurate.						
	Employer Signature:	Date:	Employer Printed Name:	Employer Position/Title:		Employer Email:	
B(4)	**Employment Information**						
	Employer Name:	Employer Address:		Start Date:	End Date:	Avg. Weekly Hours:	Employed Month(s):	Employed Hour(s):
	Employer Verification						
	I hereby certify that the information entered in Section B(4) of this form is true and accurate.						
	Employer Signature:	Date:	Employer Printed Name:	Employer Position/Title:		Employer Email:	
B(5)	**Employment Information**						
	Employer Name:	Employer Address:		Start Date:	End Date:	Avg. Weekly Hours:	Employed Month(s):	Employed Hour(s):
	Employer Verification						
	I hereby certify that the information entered in Section B(5) of this form is true and accurate.						
	Employer Signature:	Date:	Employer Printed Name:	Employer Position/Title:		Employer Email:	
				Total Months of Employment			
				Total Hours of Employment			

SECTION C: SUPERVISION

***INSTRUCTIONS**: In this section, enter information related to your qualifying supervision under an approved supervisor. Applicants should complete the "Supervisor Information" section for each supervisor(s). Each supervisor must verify the total hours you have completed under their supervision. If a supervisor is not available (death, incapacity, maternity leave, etc.) to verify the supervision information, write "unavailable" in the supervisor signature line and a member of staff will follow up with you. Please be advised that if you cannot substantially verify your supervision within 5 years, the Board may require you to complete additional supervision hours. At the end of this section, add the "Month(s) Worked" column to get your "Total Months of Supervision" and the "Hours Worked" column to get your "Total Hours of Supervision." You cannot count any supervision where you were not employed.*

C(1)	**Supervision Information**						
	Applicant Employer Section(s) from Section B:	Supervision Start Date:		Supervision End Date:		Supervised Month(s):	Supervised Hour(s):
	Supervision Verification						
	I hereby certify that the information entered in Section C(1) of this form is true and accurate.						
	Supervisor Signature:	Printed Name:	Date:	License Number:	State:		
C(2)	**Supervision Information**						
	Applicant Employer Section(s) from Section B:	Supervision Start Date:		Supervision End Date:		Supervised Month(s):	Supervised Hour(s):
	Supervision Verification						
	I hereby certify that the information entered in Section C(2) of this form is true and accurate.						
	Supervisor Signature:	Printed Name:	Date:	License Number:	State:		
C(3)	**Supervision Information**						
	Applicant Employer Section(s) from Section B:	Supervision Start Date:		Supervision End Date:		Supervised Month(s):	Supervised Hour(s):
	Supervision Verification						
	I hereby certify that the information entered in Section C(3) of this form is true and accurate.						
	Supervisor Signature:	Printed Name:	Date:	License Number:	State:		

C(4)	**Supervision Information**						
	Applicant Employer Section(s) from Section B	Supervision Start Date		Supervision End Date		Supervised Month(s):	Supervised Hour(s):
	Supervision Verification						
	I hereby certify that the information entered in Section C(4) of this form is true and accurate.						
	Supervisor Signature:	Printed Name:	Date:	License Number:	State:		
C(5)	**Supervision Information**						
	Applicant Employer Section(s) from Section B	Supervision Start Date		Supervision End Date		Supervised Month(s):	Supervised Hour(s):
	Supervision Verification						
	I hereby certify that the information entered in Section C(5) of this form is true and accurate.						
	Supervisor Signature:	Printed Name:	Date:	License Number:	State:		
				Supervision Total Months			
				Supervision Total Hours			

SECTION D: TOTALS

***Instructions**: In this section, enter the total months and hours you obtained for your post-degree experience and supervision based upon the above-entered information. This total should only reflect the total among of post-degree experience and supervision obtained under an approved supervisor.*

		Total Month(s)	Total Hour(s)
For Section B Employment, Total Months must be between 21 and 48 AND Total Hours must be at least 3,000	**B**		
For Section C Supervision, Total Months must be between 21 and 48 AND Total Hours must be at least 100	**C**		