Reset Form

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

State Form 50319 (R10 / 8-22)
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.*

* 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.
*** 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

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? ***Only Examination applicants who have not taken the national exam are eligible to request the temporary permit. One permit allowed per applicant.***
☐ Yes ☐ No

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

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

APPLICANT INFORMATION

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

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. Do you have any condition or impairment *(including a history of alcohol or substance abuse)* that currently interferes, or if left untreated may interfere, with your ability to practice in a competent 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 (R10 / 8-22)

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 _____

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 (R10 / 8-22)

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 (R10 / 8-22)

*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 (R10 / 8-22)

*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:

_____ located at _____
(*Name of Institution*) (*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

FORM E2

VERIFICATION OF EXPERIENCE FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC)

Part of State Form 50319 (R10 / 8-22)

*Complete **SECTION A** and then forward this form to your previous or current employer(s) for completion of **SECTION B**. You must submit proof that you have acquired at least 3,000 hours of post-graduate clinical experience completed in no less than 21 months and no more than 48 months. **This form may be duplicated if your 3,000 hours of experience have been completed at more than one place of employment.** If you are no longer able to contact your previous employer(s), you may complete **SECTION C** (on the reverse side of this form) for each previous place of employment. Sign the form(s) and return the form to the Professional Licensing Agency.*

SECTION A / APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)		Date of birth *(month, day, year)*
Name of employer	Dates of employment began *(month, day, year)*	Dates of employment end *(month, day, year)*
Location of place of employment or place of practice		

SECTION B / EMPLOYER / EMPLOYMENT INFORMATION

This section is to be completed by the applicant's previous or current employer and sent directly to the Professional Licensing Agency at the address listed on the bottom of this form.

Applicant employer name	Applicant Employer business address (*street address, city, State, and Zip code)*
Total number of months the applicant worked	Average number of client contact hours worked per week
Total number of hours served at employer	Average number of hours worked per week
Provide a brief description of duties	
Printed name of employer and title	

Cellular telephone number	Work telephone number	Email address
Signature of employer	Date *(month, day, year)*	

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

FORM E2

VERIFICATION OF EXPERIENCE FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC) *(continued)*

Part of State Form 50319 (R10 / 8-22)

SECTION C / AFFIRMATION OF EXPERIENCE

*To be completed by applicant if the applicant's previous employer is no longer able to complete **SECTION B** (on reverse side of this form). Please indicate below the reason why your previous employer is no longer able to complete **SECTION B** (on the reverse side of this form). **If you are affirming experience acquired through more than one previous employer this form may be duplicated but you must submit one AFFIRMATION OF EXPERIENCE for each previous employer that is no longer able to complete SECTION B (on the reverse of this form).***

I am unable to have my previous employer(s) complete SECTION B for the following reason:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have selected "Other reason", please briefly explain:

Total number of months that you have been providing mental health counseling services directly to clients on an average of at least _____ hours per week, at the address below:_____

Total number of hours served at the address below:_____

Period of time which you provided these services: _____ to _____
(month/year) *(month/year)*

Name of facility address where mental health counseling services were provided: _____
(Name of facility)

_____
(Address of facility)

Provide name of a professional colleague who can attest to the vality of the above statements:

_____ _____
Name of colleague *(last, first, middle, maiden* Daytime telephone number of colleague

_____
Address of colleague *(number and street, city, state, and ZIP code)*

List all graduate degrees, credentials and / or board issued licenses / certifications held by this colleague:

APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties perjury that the above statements are true, complete and correct.

Signature of applicant	Date (*month, day, year*)

FORM S-2

VERIFICATION OF SUPERVISION FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC)

Part of State Form 50319 (R10 / 8-22)

*Complete **SECTION A** and then forward this form to your previous or current supervisor(s) for completion of **SECTION B**. You must submit proof that you have received at least one hundred (100) hours of face to face supervision while employed for no less than 21 months and no more than 48 months. **This form may be duplicated if your one hundred (100) hours of face to face supervision have been completed through multiple supervisors.** If you are no longer able to contact your previous supervisor(s), you may complete **SECTION C** (on the reverse side of this form) for each previous supervisor. Sign the form(s) and return the form to the Professional Licensing Agency.*

SECTION A / APPLICANT INFORMATION

Name of applicant (*last, first, middle,maiden*)	Social Security number *	
Name of supervisor	Supervision begin date *(month, day, year)*	Supervision end date *(month, day, year)*

SECTION B / SUPERVISOR INFORMATION

This section is to be completed by the applicant's previous or current supervisor and sent directly from the applicant's previous or current supervisor to the Professional Licensing Agency at the address listed on the bottom of this form.

Total number of hours of face-to-face supervision you provided to the above-named applicant: _____

Total number of months above supervision was completed: _____

The above-named applicant was providing mental health counseling services directly to clients at the time of my supervision?

☐ Yes ☐ No ☐ If No, please explain: _____

The applicant's virtual supervision was no more than fifty percent (50%) of the total supervision: ☐ True ☐ False

Printed name of supervisor		
Cellular telephone number	Work telephone number	Email address
Signature of supervisor	Date *(month, day, year)*	

FORM S-2

VERIFICATION OF SUPERVISION FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC) *(continued)*

Part of State Form 50319 (R10 / 8-22)

SECTION C / AFFIRMATION OF SUPERVISION

To be completed by applicant if your previous supervisor is no longer able to complete ***SECTION B*** *(on reverse side of this form). Please indicate below the reason why your previous supervisor is no longer able to complete* ***SECTION B*** *(on the reverse side of this form).* ***If you are affirming supervision received from more than one previous supervisor, this form may be duplicated but you must submit one AFFIRMATION OF SUPERVISION for each previous supervisor that is no longer able to complete SECTION B (on the reverse side of this form).***

Please indicate below the reason why your previous supervisor is no longer able to complete SECTION B.

My previous supervisor named below is:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you selected "Other reason", please briefly explain:

Supervision was provided by: _____

Name of supervisor *(last, first, maiden)*

Total number of hours of face-to-face supervision you have received from this supervisor while providing mental health counseling services directly to clients: _____

Date of supervision: _____ to _____

(month/year *(month/year)*

List all graduate degrees, credentials and / or state board issued licenses / certifications that qualified this individual to serve as a mental health counselor supervisor: _____

APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties perjury that the above statements are true, complete and correct.

Signature of applicant	Date (*month, day, year*)