Board of Behavioral Sciences
1625 North Market Blvd., Suite S200, Sacramento, CA 95834
Telephone: (916) 574-7830
www.bbs.ca.gov

LICENSED PROFESSIONAL CLINICAL COUNSELOR

IN-STATE EXPERIENCE VERIFICATION

This form is to be completed by the applicant's California supervisor and submitted by the applicant with their *Application for Licensure*. All information on this form is subject to verification.

- Use separate forms for each supervisor and each employment setting.
- Ensure that your form is complete and correct prior to signing. Have your supervisor initial any changes.
- Do not submit your *Weekly Summary* forms unless specifically requested by the Board.

APPLICANT NAME:

Last	First	Middle	Associate Number APC

Dates of experience being claimed:	From: _____ mm/dd/yyyy	To: _____ mm/dd/yyyy

SUPERVISOR INFORMATION:

Supervisor's Name		Telephone	
License Type	License Number	State	Date First Licensed*

- Physicians: Were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision?
  ☐ No ☐ Yes: Date Board Certified: _____ Certification Number: _____
- LPCCs: If the applicant is reporting experience with couples or families, did you meet the qualifications to treat couples and families, as specified in California law?
  ☐ N/A ☐ No ☐ Yes: Date you met the qualifications: _____

**If licensed in California for less than two years on the first date of experience claimed, attach out-of-state license information*

APPLICANT'S EMPLOYER INFORMATION:

Name of Applicant's Employer			Business Phone	
Address: Number and Street		City	State	Zip Code

Applicant: Last	First	Middle

APPLICANT'S EMPLOYER INFORMATION *(continued)*:

1. Was this experience gained in a setting that lawfully and regularly provides mental health counseling or psychotherapy? ☐ Yes ☐ No
2. Was this experience gained in a private practice setting? ☐ Yes ☐ No
3. Was this experience gained in a hospital or community mental health setting? *(Minimum 150 hours required overall)* ☐ Yes ☐ No
4. Was this experience gained in a setting that provided oversight to ensure that the applicant's work meets the experience and supervision requirements and is within the scope of practice? ☐ Yes ☐ No
5. Was the applicant receiving pay? *If YES, attach a copy of the applicant's W-2 statement for each year experience is claimed. If a W-2 has not yet issued for this year, attach a copy of the current paystub. If applicant volunteered, submit a letter from the employer verifying volunteer status for these dates.* ☐ Yes ☐ No

EXPERIENCE INFORMATION:

1. How many weeks of supervised experience are being claimed? _____ Weeks		
2. Hours of Experience:		**Logged Hours**
a. Total Direct Counseling Experience *(Minimum 1,750 hours overall)*		
• Of the above hours, how many were gained while working with Couples, Families or Children?		
b. Total Non-Clinical Experience *(Maximum 1,250 hours overall)*		
• Of the above hours, how many were Face-to-Face Supervision?	**Hours Per Week**	**Logged Hours**
☐ Individual or Triadic		
☐ Group (group contained no more than **8** persons)		

NOTE: Knowingly providing false information or omitting pertinent information may be grounds for denial of the application. The Board may take disciplinary action on a licensee who helps an applicant obtain a license by fraud, deceit or misrepresentation. All information on this form is subject to verification.

Signature of Supervisor: _____ Date: _____

ORIGINAL SIGNATURE REQUIRED