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STATE OF DELAWARE

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

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COUNSELING EXPERIENCE VERIFICATION – EMPLOYMENT
PROFESSIONAL COUNSELOR OF MENTAL HEALTH

INSTRUCTIONS

This form is ***not*** required for applicants applying by reciprocity. **Upload this document when you submit your application.**

The purpose of this form is to verify the hours of post-Masters mental health counseling that an employed applicant provided ***in addition to*** the mandatory minimum 1600 hours under direct clinical supervision of an *approved* or *acceptable* supervisor. ***If you obtained at least 3200 direct supervision hours, you DO NOT need to complete this form.***

Please follow these instructions for completing this form. ***Incomplete or incorrectly completed forms delay processing of the application.*** The clinical or administrative supervisor must complete the entire form, sign it and return it to the applicant to upload it with their application in DELPROS.

An administrative supervisor completes the **COUNSELING EXPERIENCE VERIFICATION - EMPLOYMENT** form to document estimated additional hours of professional counseling experience that the applicant will accrue while ***not*** under the direct supervision of an approved clinical supervisor.

Remember that these *additional* experience hours, when added to the 1,600 or more hours of *direct* supervised hours verified by the approved clinical supervisor(s), must total *at least* 3,200 hours. *All applicants must complete all the required hours in a period of not less than two but no more than four consecutive years.*

Section 2.4 of the Board's Rules and Regulations explains the supervision requirements.

APPLICANT – UPLOAD THIS DOCUMENT WITH YOUR APPLICATION IN DELPROS.

1. Applicant Name: _____ _____ _____
   Last First Middle

INFORMATION ABOUT SUPERVISOR

2. Supervisor Name: _____ _____ _____
   Last First Middle

3. Supervisor's Practice Name (if applicable): _____

4. Practice Address: _____

   _____ _____ _____
   City State Zip

5. Phone: _____ Email: _____

VERFICATION OF COUNSELING HOURS

6. Enter the period when you supervised the applicant:

   From _____ To _____
   Month/Year Month/Year

   This period must not span more than four years and not less than two years.

7. In addition to the mandatory minimum 1600 hours working under a Board-approved clinical supervisor, how many hours of administrative mental health counseling services did the applicant complete? _____

   Calculate and enter a total number of hours. Answers such as "40 hours/week" will not be accepted.

8. Describe the practice, agency, or setting where the applicant worked during the period above. (Examples include group practice, community mental health agency, etc.)

   _____

   _____

   _____

CERTIFICATION

I certify that I have personally completed all sections of this form and that the information provided herein is accurate and complete to the best of my knowledge.

Supervisor Signature: _____ Date: _____