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STATE OF DELAWARE

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

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COUNSELING EXPERIENCE VERIFICATION FORM – SELF-EMPLOYMENT
PROFESSIONAL COUNSELOR OF MENTAL HEALTH

INSTRUCTIONS

This form is ***not*** required for applicants applying by reciprocity.

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.

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 mail it *directly* to the Board office at the address above. Forms not received *directly* from the supervisor will not be accepted.

In completing this form, the following applies:

- Applicants ***must*** complete *at least* 3,200 hours of mental health counseling services over a period of *at least two but not more than four* consecutive years.
- Of the required 3,200 hours of total experience, *at least* 1,600 hours **must** be completed under the direct clinical supervision of an *approved* or *acceptable* supervisor.
  - An approved supervisor is a Licensed Professional Counselor of Mental Health
  - An acceptable supervisor **must** be Board-approved, which could be a Licensed Behavioral Health Professional (Marriage and Family Therapist, Clinical Social Worker, Clinical Psychologist, Advanced Practice Nurse or Physician) ***with*** a specialty or expertise in a clinical competency essential to the applicant's training.
  - ***Certified school counselors and certified school psychologists are not approved clinical supervisors.***
- Hours of direct clinical supervision are verified on the *Direct Supervision Reference* form. Do **not** enter direct clinical supervision hours on *Counseling Experience Verification* forms.
- For hours provided while the applicant was employed, use the *Counseling Experience Verification Form- Employment*.
- The person completing this form to attest to the applicant's experience **must** be a professional colleague, supervisor or other individual who has personal knowledge of the applicant's professional practice while self-employed. This person **cannot** be the applicant's spouse, former spouse, parent, step-parent, grand-parent, child, step-child, sibling, aunt, uncle, cousin or in-law.
- All 3,200 hours, including the mandatory minimum 1,600 hours of direct clinical supervision, **must** be provided over a period of ***at least two but not more than four consecutive years***.

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

MAIL THIS DOCUMENT DIRECTLY TO THE BOARD OFFICE. ENTER YOUR APPLICATION ID:_____

INFORMATION ABOUT PERSON ATTESTING TO EXPERIENCE

1. Applicant Name: _____ _____ _____
   Last First Middle

2. Your Name: _____ _____ _____
   Last First Middle

3. Do you have personal knowledge of the extent of the applicant's professional practice while he or she was self-employed? Yes ☐ No ☐ If yes, explain your professional relationship to the applicant: _____

   _____

   _____

4. Are you related to the applicant as a spouse, former spouse, parent, step-parent, grand-parent, child, step-child, sibling, aunt, uncle, cousin or in-law? Yes ☐ No ☐ If yes, specify relationship: _____

5. Your Address: _____

_____ _____ _____
City State Zip

6. Phone: _____ Email: _____

EXPERIENCE HOURS

7. Enter the period of the applicant's experience of which you have personal knowledge:

From _____ To _____
Month/Year Month/Year

This period must not span more than four years.

8. During this period, how many total hours of mental health counseling did the applicant provide while *not* under direct supervision of an approved supervisor?

_____

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

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.

Signature: _____ Date: _____