Verification of State Professional License/Certification

This completed form must be mailed by the State Board that regulates the Applicants current out-of-state license/ certificate to:

Arkansas Board of Examiners in Counseling
101 East Capitol Suite 202
Little Rock, AR 72201

Applicant Name:_____ Date of Birth:_____
(Please Print Legibly)

License Number: _____ Issuing State:_____ Social Security No.:_____

1. Does the applicant hold a current state license/ certificate? Yes: No:

   Date of Original Licensure:_____

   Expiration Date:_____

2. Is the Licensure status provisional? Yes: No:

   If yes, when will the applicant have full status:_____

3. Was the applicant licensed by passing the NCE or AMFT exam? Yes: No:

   Applicant Score:_____ Passing Score:_____ Date of Exam:_____

   Was this applicant licensed through a 'grandparenting' clause exempting examination? Yes: _____ No: _____

4. Has the applicant's license/ certificate ever been suspended or revoked? Yes:_____ No:

   If yes, please provide details.

5. Has the applicant's license/ certificate ever been voluntarily relinquished? Yes: No:

   If yes, please provide details.

6. Are there any valid complaints pending or ever filed against the applicant? Yes: _____ No:

   If yes, please provide details.

7. If currently licensed, is the applicant in good standing? Yes: No:

   If no, please provide details.

Verification of Supervision Requirements

Total Hours of Clinical Practice: _____ From:_____ To:_____

Individual Client Contact Hours:_____

Couples & Family Contact Hours:_____

Indirect Clinical Service Hours: _____

Total Hours of Supervision: _____ From:_____ To:_____

Number of hours of Individual Supervision: _____

Number of hours of Group Supervision: _____

Other comments----------

State Seal:

Signature:----------

Title: ----------

Date: _____