



APPLICATION FOR LICENSURE AS A PROFESSIONAL COUNSELOR

GEORGIA STATE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS, AND MARRIAGE & FAMILY THERAPISTS

237 Coliseum Drive, Macon, Georgia 31217-3858

Phone (478) 207-2440

Please read the instructions carefully and be familiar with the laws and rules governing the practice of Professional Counseling in the State of Georgia. Visit the following web site for information: <http://www.sos.state.ga.us/plb/counselors>

****Important****

The Board cannot process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board. Please review this application before you submit it to ensure that all information and documentation is complete and correct. Incomplete applications result in delayed processing. Incomplete applications are void after one year and you must reapply.

Application Checklist

The following checklist is an important part of your application. Please use this checklist to ensure that you submit a **COMPLETE** application.

The **NON-REFUNDABLE APPLICATION FEE** made payable to Georgia Professional Counselors, Social Workers, and Marriage & Family Therapists must be included with the application. (Please see Fee Schedule at the Board's website)

PLEASE ACCESS THE BOARD RULES WHICH INCLUDES LICENSURE REQUIREMENTS FROM OUR WEBSITE AT WWW.SOS.STATE.GA.US/PLB/COUNSELORS

- NOTARIZED APPLICATION:** The five-page application must be mailed to the Board's office at the address listed above, along with your **FEE**. All questions must be answered. Any question answered "yes", requires further documentation to be submitted. Request official court documents be submitted to the Board and provide an explanation if you have had any criminal convictions or charges, or sanctions by another state licensing board. The Board will review a complete application with all required documentation at their next scheduled meeting. Approval of licensure is at the Board's discretion.
- NATIONAL BOARD SCORES:** All applicants are required to pass the **either** the National Counselor Examination (NCE) **OR** the National Clinical Mental Health Counseling Examination (NCMHCE) offered by the National Board for Certified Counselors (NBCC). If you have taken one of these exams, please contact the National Board's administrative offices at (336) 547-0607 and have them certify your scores to Georgia. **You must submit the exam fee directly to NBCC, do not include fee with your application. If you have an Associate Professional Counselor license in Georgia, your LPC application will be combined with the APC application and you will not need to resubmit another NCE exam score.**
- DEGREE TRANSCRIPT:** All applicants for licensure must have graduated with a master's degree primarily counseling in content from an institution accredited by a regional body recognized by the Council on Higher Education Accreditation. An **official** college transcript certifying the grades, degree conferred and the date awarded must be received in this office directly from the Registrar of the college/school. If you have an Associate Professional Counselor license in Georgia, your LPC application will be combined with the APC application and you will not need to resubmit another transcript unless you have obtained a higher degree.
- FORM A/INTERNSHIP SUPERVISION VERIFICATION:** The instructor of record at the college or university or the Site Supervisor may provide verification of the Internship which was part of your graduate degree program. If you have an Associate Professional License with Georgia, your APC file will be combined with the LPC application and you will not need to submit another Form A/Internship Verification.

- OTHER STATE LICENSURE CERTIFICATION:** If you are or have ever been licensed in another State(s), please have that/those State(s) officially certify that license directly to the Board's office.
- FORM C- POSTMASTER'S DIRECTED EXPERIENCE SUPERVISION:** This form must be completed by the employer/director and document the hours required to meet minimum licensure requirements.
- FORM E – SUPERVISION VERIFICATION:** This form must be completed by an eligible supervisor that has provided supervision which means the direct clinical review, for the purpose of teaching or training, of a professional counselor's interaction with client(s) and document the hours required to meet minimum licensure requirements.
- REFERENCES:** Please submit references from two (2) teachers or supervisors who are familiar with their experience in Professional Counseling.
- If your name has changed since you attended school, please make a note on the application advising of your former name(s) so we can match-up the documents with your application.
- IMPORTANT:** Applicants, please note when accessing your application status on our website under the *Online Services* category *Check the Status of an Application* that checklist items that have been moved over to the completed column only means that those documents have been received. This tool is to be used as an option for you to monitor your application for items received as you are going through the licensure process.
- Only the Georgia Composite Board of Professional Counselors, Social Workers and Marriage & Family Therapists has the authority to approve or deny an application for licensure. Every application file must be submitted to the Board for review. The Board meets monthly to review applications and conduct other Board business. Once your application file has been reviewed by the Board, you will receive written communication of the Board's decision within five to seven working days after the Board meeting.

**PLEASE DO NOT SUBMIT THESE INSTRUCTION PAGES WITH YOUR
APPLICATION AND SUPPORTING DOCUMENTS**

FOR BOARD USE ONLY
 Amount Submitted _____
 Date _____
 Receipt # _____



FOR BOARD USE ONLY
 Certificate Number _____
 Date Issued _____
 Applicant No. _____

GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS AND MARRIAGE & FAMILY THERAPISTS

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APPLICATION FOR LICENSURE AS A PROFESSIONAL COUNSELOR

Application Fee \$100 (non-refundable)

Checks returned for insufficient funds will be assessed a \$40.00 service charge pursuant to O.C.G.A. §16-9-20.

Applications are valid for (1) one year ONLY

Additional License Types (currently or previously issued by the Georgia Professional Licensing Boards): _____

Method Obtained by:

Applicant is applying for above referenced license by:

- Examination
- Examination Waiver (only if you have already taken the NCE or NCMHCE exam thru NBCC)
- Endorsement (Considered on a State by State basis – the Board will determine if the licensure requirements of the issuing state meet or exceed those of Georgia-provide a copy of the issuing states licensure requirements. Currently, the only approved states are AL, AR, KY, LA, ME, MD, NE, OH, OK and PA)

Name _____
 Last First Middle

Name as shown on exam records or transcripts

(if different) _____
 Last First Middle

***Social Security Number**

Date of Birth

*(This information is authorized to be obtained & disclosed to State & Federal agencies pursuant to O.C.G.A. §19-11-1 & O.C.G.A. §20-3-295,42 U.S.C.A. §551 & 20 U.S.C.A. § 1001).

Physical Address

 **Number and Street Apt. No City/State Zip

*** (P.O. Box not acceptable – If you are granted a license, your name, mailing address and license number are public information and your mailing address will appear on the internet. Your physical address is required, if different than the mailing address. You must immediately notify the Board in writing of an address change).*

Mailing Address

(if different) _____
 Number and Street Apt. No City/State Zip

 Telephone Number Day

 Telephone Number Evening

 ***Email Address

***Acknowledgement of your application will be sent by e-mail. Also, if any additional information is needed, e-mail is the most efficient way for the Board staff to contact you so that your application can be processed in the most efficient manner. Please notify the Board of any e-mail address change. YOUR E-MAIL ADDRESS WILL NOT BE SHARED WITH ANY THIRD PARTY.

- Yes No 4. Have you been subject to disciplinary action or had your membership revoked by any professional organization?
- Yes No 5. Have you knowingly failed to renew a license during an investigation of a disciplinary matter against you?
- Yes No 6. To the best of your knowledge, is there any disciplinary action or investigation pending against you by any licensing board, agency, or professional organization?
- Yes No 7. Have you ever been convicted of any criminal offense?
- Yes No 8. Have you ever been arrested, charged or sentenced for the commission of a felony, misdemeanor (other than minor traffic or parking violations) or any crime of moral turpitude, including the entry of a plea of nolo contendere or a plea entered pursuant to the provisions of the "Georgia First Offenders Act? You must respond, "yes" if you plead and completed probation as a First Offender. If yes, provide certified copies of the court disposition.
- Yes No 9. Have you been the defendant in a malpractice suit and either entered into a settlement agreement or paid court awarded expenses?
- Yes No 10. Do you now hold or have you ever held a license as a licensed professional counselor in any jurisdiction? If "yes" complete the following:
Jurisdiction _____ License No. _____
Date Issued _____ Expiration _____
Please request each licensing board submit verification of license to Georgia
- Yes No 11. Have you previously applied for the same license for which you are currently applying? If "yes" name under which application was submitted: _____
- Yes No 12. Have you ever served on active duty in the Armed Forces, the Reserves or the National Guard during wartime or during any conflict when military personnel were committed by the President? If "Yes," you may be eligible for Veterans' Preference Points to be added to your examination score. Submit your DD214 Form to the Board office.

PART III - GRADUATE EDUCATION

- INSTRUCTIONS:**
- Complete this part for the graduate degree that you want the Board to consider as part of this application.
 - List any additional courses you want considered as part of this Application.
 - Direct the Registrar of your institution(s) to send an official copy of your transcript directly to the Board office.

DEGREE

Master's Master's - Specialist Master's - Rehabilitation Counseling Ph.D.

Date Awarded:

Program/Major:

Name of Institution:

Street Address:

City/State/Zip:

ADDITIONAL COURSEWORK

COURSE TITLE AND NUMBER	INSTITUTION

REQUIRED COURSEWORK

INSTRUCTIONS:

- List the titles and numbers of courses from your transcript(s) which satisfy the professional counseling content area requirements.
- This must be graduate level coursework from an accredited institution, **either as part of the degree program, or** as additional coursework completed **prior to, during or after the degree program** to demonstrate that the degree is **primarily counseling in content or a program in applied psychology.**
- Have the Instructor of Record/Supervisor of your Practicum/Internship course complete Form A.
- See Board Rule Chapter 135-5-.02(b)

COUNSELING PSYCHOTHERAPY THEORY

INSTITUTION	COURSE #	COURSE TITLE

COUNSELING OR APPLIED PSYCHOLOGY PRACTICUM OR INTERNSHIP

SIX (6) OF THE FOLLOWING NINE (9) CONTENT AREAS

I - HUMAN GROWTH AND DEVELOPMENT

II - SOCIAL AND CULTURAL FOUNDATIONS OR CORE FOUNDATIONS

III - THE HELPING RELATIONSHIP OR ADVANCED PSYCHOTHERAPY/INTERVENTION THEORY

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IV - GROUP DYNAMICS AND GROUP COUNSELING/PSYCHOTHERAPY

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V - LIFESTYLE AND CAREER DEVELOPMENT

VI - APPRAISAL/ASSESSMENT OF INDIVIDUALS

VII - RESEARCH METHODS AND EVALUATION OR RESEARCH STATISTICS

VIII - PROFESSIONAL ORIENTATION

IX PSYCHOPATHOLOGY

PART IV – PRACTICUM/INTERNSHIP and POST-MASTER’S DIRECTED EXPERIENCE UNDER SUPERVISION

Practicum/Internship

*The applicant must present evidence of a supervised practicum or internship of at least 300 hours which were part of the graduate degree program.

___ Not Applicable – **Did not complete a practicum/internship**

Must be a minimum of 300 hours and may qualify as one (1) year of the required four (4) years.

Institution /Date of Degree/Course #	Location of Internship/Practicum	Dates of Internship/Practicum

___ Check here if the director/supervisor is Missing or Deceased. **Complete Form B.**

Post-Master's Directed Experience Under Supervision

- *The number of years of Post-Master's Directed Experience in professional counseling under Supervision required **depends on the graduate degree you hold.** Board Rule 135-5-.02(b)(2)
- *Professional Counseling means work that uses "counseling and psychotherapy to evaluate and treat emotional and mental problems and conditions."
- *Directed Experience means the employment /practice relationship for the purpose of obtaining post-master experience under supervision
- *Supervision means clinical review, for the purpose of training or teaching, of an applicant's interaction with clients.

- Director is the person who is the employer or the supervisor in the employment chain and
 - is located at the same site where the applicant provided the work
 - provides ongoing administrative oversight of work
 - assures quality of work
 - assures applicant is adequately supervised
- Supervisor is a LPC, CSW, LMFT, Psychologist, or Psychiatrist who meets Board requirements for supervision
- Refer to Board Rule 135-5-.02(a)(5) for experience after licensure for qualified supervisors
- The applicant's degree determines the minimum amount of supervision that must be provided by a qualified LPC, Refer to Board Rule 135-5-.02(b)(2).
- A Supervisor is the person who provides:
 - The clinical review of applicant's interaction with clients for the purpose of the development of the applicant's clinical skill;
 - Activities that may include, but not limited to, review of case presentations, audio/videotapes of client interactions, direct observations of applicant's clinical skills; and,
 - Maintains a contemporaneous record of dates, duration, type of supervision including brief summary of activities.

Summary of Directed Experience and Supervision

Complete this information to provide a clear record of how you have completed the required directed experience and supervision required for licensure. Directed experience and supervision **MUST** be documented on the appropriate forms. If your director or supervisor is deceased or you are unable to contact them complete Form D and Form F and provide evidence of due diligence in trying to contact them.

Post Master's Directed Experience – Complete form C

Degree Held: ___ Master's ___ Master's Specialist ___ Master's Rehab ___ PhD

*Directed experience must be a minimum of 600 per year. Number of years required depends on your degree.

Years are defined as follows:

- One Year = not less than 12 months or more than 20 months (600 hours)
- Two Years = not less than 24 months or more than 60 months (1200 hours)
- Three Years = not less than 36 months or more than 60 months (1800 hours)
- Four Years = not less than 48 months or more than 60 months (2400 hours)

_____ Check here if the director/supervisor is Missing or Deceased. Complete Form D

Director	Location	Dates of Experience	Hours	Deceased or Missing?

Post Master’s Supervision – Complete Form E

Dates of Supervision and Directed Experience must be concurrent. A minimum of 30 hours of supervision must be obtained each year. A minimum number of hours must be provided by an LPC.

Years are defined as follows:

One Year = not less than 12 months or more than 20 months (30 hours)

Two Years = not less than 24 months or more than 60 months (60 hours)

Three Years = not less than 36 months or more than 60 months (90 hours)

Four Years = not less than 48 months or more than 60 months (120 hours)

_____ Check here if the supervisor is Missing or Deceased. Complete Form F.

Supervisor	Degree	License Type	Dates of Supervision	Total Hours	Deceased or Missing?

**APPLICANT: PLEASE CHECK THE FORM OF IDENTIFICATION BELOW THAT YOU POSSESS.
RETURN THIS FORM ALONG WITH A COPY OF YOUR APPROPRIATE DOCUMENTATION.**

Printed Name

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2

Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 (“IIREA”) provides that “not later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law’s website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General.” O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

_____ A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____ A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____ A driver’s license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____ An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____ A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at:

<http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm> [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____ A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____ An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____ A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

_____A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

_____A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. §50-36-2(b)(3); 22 CFR § 41.2]

_____A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]



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PROFESSIONAL COUNSELOR
 PRACTICUM/INTERNSHIP SUPERVISION VERIFICATION — FORM A

INSTRUCTIONS: Please type or print clearly.

APPLICANTS:

- Complete Part I and submit to your Practicum/Internship Supervisor. See Board Rule Chapter 135-5-.02(a)5.
- If you have more than one practicum or internship, submit a form for each. You may photocopy this form.

PRACTICUM/INTERNSHIP SUPERVISOR:

Complete Part II, noting requirements. Please enclose this form in a sealed envelope. Sign your name over the flap and then either mail it to the applicant or send it directly to the Board office. Fax copies are not acceptable.

The Practicum/Internship must:

- Be part of the master's degree program.
- Be in Professional Counseling or in applied psychology before January 1, 2004
- Include a minimum of 300 hours in the practice of Professional Counseling under supervision.

The Practicum/Internship Supervisor must:

- **Be the Instructor of Record at the college or university or the Site Supervisor; and**
- Be licensed — as a Professional Counselor, Clinical Social Worker, Marriage and Family Therapist, Psychologist, Psychiatrist — or be a Certified Rehabilitation Counselor. See Board Rule Chapter 135-5-1(a) 5 for further details.

PART I - APPLICANT

NAME: _____ SOCIAL SECURITY NUMBER: _____

PART II — SUPERVISOR

NAME: _____

ADDRESS: _____
 Street City State Zip Code

TELEPHONE: () FAX: ()

TYPE OF LICENSE: Professional Counselor Clinical Social Worker Marriage and Family Therapist
 Psychologist Psychiatrist Certified Rehabilitation Counselor

LICENSE #: _____ STATE: _____ DATE ISSUED: _____ EXP. DATE: _____

CERTIFICATION OF SUPERVISION:

I hereby certify that I supervised the Internship/Practicum of the above-named applicant who practiced Professional Counseling work at:
 NAME OF PRACTICUM/INTERNSHIP SITE: _____

FROM: _____ TO _____ FOR A TOTAL OF _____ HOURS.
 MONTH/YEAR MONTH/YEAR # HOURS

DESCRIBE THE PRACTICE SUPERVISED: _____

VERIFICATION: I attest that I provided the supervision described above and that this is a true and accurate representation of this supervision.

 Date Signature of Supervisor/Instructor of Record

Sworn to and subscribed before me this
 _____ day of _____, _____.

Notary Public

My Commission Expires:

NOTARY SEAL



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PROFESSIONAL COUNSELOR POST-MASTER'S DIRECTED EXPERIENCE
 MISSING OR DECEASED DIRECTOR AFFIDAVIT - FORM D

INSTRUCTIONS:

- Please type or print clearly.
- Post-Master's directed experience may have been obtained at any time during your professional career. The directed experience documented for your licensure application need not necessarily be from the Director(s) who provided your original experience. Recent directed experience may be used, as long as it meets the standards set out in the Rules for Professional Counselors. See Board Rule Chapter 135-5-.02 (a).

The Director must be:

- Either the employer or the supervisor in the employment chain of command.
- Located at the same site where the experience is being acquired.

APPLICANTS:

- Make every effort to locate the as many of the directors of Directed Experience as necessary to document the required Directed Experience.
- You may show your diligence with returned mail, copies of letters, verifications from your academic institution, etc.
- If, however, you have obtained sufficient directed experience to meet licensure requirements, but after a diligent search you are unable to locate enough Directors to document the required time, you may attest to undocumented Directed Experience by taking the Oath below.
- The Board may require additional information upon review.

OATH

Under penalty of perjury, as provided in the Official Code of Georgia Annotated, I hereby aver and swear that I was unsuccessful, after I made a diligent effort, to locate:

Name of Director: _____

who served as my Director of directed experience in the practice of Professional Counseling at:

 Name and Address of Agency or Organization

from : _____ to _____ totaling _____ years/s on the time basis of _____ hours/week.
 Month/Year Month/Year

I have attached copies of letters and/or returned mail that demonstrates my attempt/s to reach this individual.

 Date
 Sworn to and subscribed before me this

 Signature of Applicant

_____ day of _____, _____.

NOTARY SEAL

 Notary Public

My Commission Expires:



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APPLICATION FOR CLINICAL PROFESSIONAL COUNSELOR LICENSE BY EXAMINATION
PROFESSIONAL COUNSELING SUPERVISION VERIFICATION FORM
FORM E

INSTRUCTIONS: Please print or type.

APPLICANT

■ **Complete Part I** and forward this form to each supervisor from the organization or agency in which you completed your directed experience practicing Professional Counseling. Complete a separate form for each Directed Experience Supervisor listed in your application. Use this form to only verify Professional Counseling supervision.

■ If you need additional forms, you may photocopy this form.

DIRECTED EXPERIENCE SUPERVISOR

■ The Directed Experience Supervisor must Complete Part II and return it to the Applicant for inclusion with the Application for licensure.

■ "Supervision" means the direct clinical review by a Supervisor for the purpose of training or teaching of a Professional Counselor's interaction with a client.

PART I - APPLICANT

NAME OF APPLICANT: _____
First Middle Last Maiden

SOCIAL SECURITY NUMBER: _____

PART II - DIRECTED EXPERIENCE SUPERVISOR

I HEREBY CERTIFY THAT I SUPERVISED THE ABOVE-NAMED INDIVIDUAL IN THE PRACTICE OF PROFESSIONAL COUNSELING AS FOLLOWS:

SUPERVISION:

Supervision Provided:	From: (Month/Year)	To: (Month/Year)	Total Number of Hours:
Description of Practice Supervised:			

I attest that I served as this Applicant's Directed Experience Supervisor, as defined above, that this description is a true and accurate representation of my supervision of this Applicant, and I:

Recommend Do Not Recommend this Applicant for licensure.

_____ Date _____ Signature of Directed Experience Supervisor

Highest Level of Education Completed Master's EdD PhD Other

Years of Experience After License Issued: _____ Printed Name: _____

Address: _____
Street City State Zip Code

Telephone #: (____) _____ Fax #: (____) _____

License Type: _____ License #: _____ State: _____ Date Originally Issued: _____ Exp. Date: _____

Sworn to and subscribed before me this
_____ day of _____, _____.

NOTARY SEAL

Notary Public

My Commission Expires: _____



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**PROFESSIONAL COUNSELOR
 POST-MASTER'S DIRECTED EXPERIENCE - MISSING OR DECEASED SUPERVISOR AFFIDAVIT
 FORM F**

INSTRUCTIONS:

- Please type or print clearly.
- Supervision may have been obtained at any time while you engaged in post-master's directed experience. The supervision documented for your licensure application need not necessarily be from the supervisors who provided your original training. Supervision must meet the standards set out in the Rules for Professional Counselors. You must have received a minimum of 30 hours of supervision during each 12-month period of directed experience.

The Directed Experience Supervisor must be:

Either be licensed — as a Professional Counselor, Clinical Social Worker, Marriage and Family Therapist, Psychologist, Psychiatrist — or a Certified Rehabilitation Counselor.

- Meet the post-licensure experience requirements for the degree held.
- See Board Rule Chapter 135-5-.02(a) 5.

APPLICANT:

- Make every effort to locate the as many of the directors of Directed Experience as necessary to document the required Directed Experience.
- You may show your diligence with returned mail, copies of letters, verifications from your academic institution, etc.
- If, however, you have obtained sufficient directed experience to meet licensure requirements, but after a diligent search you are unable to locate enough Directors to document the required time, you may attest to undocumented Directed Experience by taking the Oath below.
- The Board may require additional information upon review.

PART I - APPLICANT

NAME: _____ SOCIAL SECURITY NUMBER: _____

I hold a: Master's Degree Specialist Degree Doctorate Degree

OATH

Under penalty of perjury, as provided in the Official Code of Georgia Annotated, I hereby aver and swear that I was unsuccessful, after I made a diligent effort, to locate:

Name of Supervisor: _____
 who served as my supervisor while I worked under the direction of: _____

Name of Director: _____

at: _____

Name of Agency or Organization Address City State Zip

and that this supervisor has the following credentials:

License Type: Professional Counselor Clinical Social Worker Marriage and Family Therapists
 Psychologist Psychiatrist Certified Rehabilitation Counselor

License #: _____ State: _____ Date Issued: _____ Expir. Date: _____ Years of Practice After Licensed: _____

SUPERVISION:

Supervision Provided:	From: (Month/Year)	To: (Month/Year)	Total Number of Hours:
Description of Practice Supervised:			

_____ Date
 Sworn to and subscribed before me this
 _____ day of _____, _____.

Notary Public
 My Commission Expires: _____

 Signature of Applicant

NOTARY SEAL



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VERIFICATION OF LICENSURE - FORM N

INSTRUCTIONS

- Please type or print legibly.
- **Applicant** - Complete Part I. Mail a form to the Board or Agency of each state or jurisdiction by which you are currently licensed or certified as a Professional Counselor, Social Worker (any level) or Marriage and Family Therapist. Request the Licensure Board or Regulatory Agency to send the Georgia Board a copy of its current licensure laws and rules. Refer to List of Approved/Disapproved States for Endorsement.
- **State Licensure Board or Regulatory Agency** - Complete Part II.

PART I - APPLICANT

Full Name:

Address:

Date of Birth:

Social Security #:

GEORGIA LICENSE APPLIED FOR - CHECK ONLY ONE: Marriage and Family Therapist
 Professional Counselor Clinical Social Worker Master Social Worker

Jurisdiction:

License Number:

Title of License:

Date Issued:

Expiration Date:

TO WHOM IT MAY CONCERN

I, the undersigned applicant, am applying for a license with the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists. I hereby consent to the release of any information, favorable or otherwise, which you may have concerning my license or practice. Please return the completed form directly to the Georgia Board at the above address.

Date

Signature of Applicant

PART II - LICENSURE BOARD OR REGULATORY AGENCY CERTIFICATION

I, _____, Board Chair or Designated Official
of the _____
(Name of Board or Regulatory Agency)

certify that the information provided above by this applicant does does not conform with that in our record.

If "does not", please explain: _____

According to our record, the applicant has has not been disciplined by this or any other Board, state agency, or professional organization. **If the applicant has been disciplined, please explain and attach a copy of the Order or Decree:**

Date

Signature of Board Chair/Designated Official

Title of Board

Street Address

BOARD SEAL

City/State/Zip Code