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: _____