Post-graduate Verification - MENTAL HEALTH COUNSELOR

Access this form via website at: hawaii.gov/dcca/pvl

Instructions to the Applicant: Complete Section 1, **have your supervisor complete Section 2 to verify your post-graduate experience,** then attach the completed form to your application before submitting it to the department. Please note that your supervisor must sign the form before a notary public. **You must complete at least 3000 hours of post-graduate experience in the practice of mental health counseling with 100 hours of face-to-face clinical supervision in no less than two years and in no more than four years.**

Section 1: APPLICANT

Name (First, Middle)	(Last)	Date of Birth
Address (Include Apt. No., City, State and Zip Code)		Social Security No.
		Phone No.
SIGN HERE:	Date:	Date of Graduation

Section 2: SUPERVISOR ONLY

TO THE SUPERVISOR:

*The person named above is applying for a mental health counselor license in Hawaii. Please complete Section 2 to verify the applicant completed the post-graduate experience **under your supervision**, sign the form before a notary public, then return the completed form to the applicant. To correct an error in Section 2, please draw a single line through the incorrect information and initial. DO NOT use correction fluid or write over incorrect information.*

Post-graduate Experience Dates (mo/day/yr)		Total Hours Post-graduate Experience in Mental Health Counseling	Total hours of Face-to-Face Supervision	Name of Post-graduate Firm including Address, City, State	Description of Counseling Setting and Mental Health Services Provided
From	To				
		hrs.	hrs.		

Please attach a brief summary of the duties that the applicant performed during the post-graduate period listed.

Affidavit of Supervisor:

I hereby attest that I supervised the post-graduate experience of the individual listed above and that the information in Section 2 is accurate. I further certify that during the post-graduate dates above, I was: (check one)

☐ A licensed mental health counselor.

☐ A licensed psychologist, licensed clinical social worker, advanced practice registered nurse with a specialty in mental health, a physician with a specialty in psychiatry, or a licensed marriage and family therapist.

____
Signature of Supervisor

Print name of Supervisor: ______________

Address: ______________

____

Phone No.: (____) ______________

State of Licensure: ________ Type of Lic.: ________

License No.: ______________

Initial date of License: ________ Expiration date: ________

Subscribed and sworn to before me this
________ *day of* ______________ *A.D. 20*____ .

Notary Signature: ______________

Notary Public, State of: ______________

My commission expires: ______________

Print Name: ______________

Doc. Date: ________ *No. of Pages:* ________

Notary Name: ________ *Circuit Court:* ________

Doc. Description ______________

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Notary Signature: ______________

Date: ______________

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.