Practicum Verification - MENTAL HEALTH COUNSELOR

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

Instructions to the Applicant: Complete Section 1, **have your supervisor complete Section 2 to verify your practicum 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 2 academic terms of supervised mental health practicum intern experience of a total of at least 6 graduate semester hours or 10 graduate quarter hours in a mental health counseling setting, with a minimum total of 300 hours of supervised client contact.**

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:	

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 practicum 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.*

Practicum Terms	Total number of semester or quarter hours in practicum	Total hours of supervised client contact	Name of Practicum Facility including Address, City, State	Description of Mental Health Counseling Setting and Mental Health Services Provided
	sem/qtr hrs.	hrs.		

Please attach a brief summary of the duties that the applicant performed during the practicum.

Affidavit of Supervisor:

I hereby attest that I supervised the **mental health** practicum experience of the individual listed above and that the information in Section 2 is accurate. I further certify that during the practicum 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* ____ .

Signature of Notary: _____

Notary Public, State of: _____

My commission expires: _____

Print Name: _____

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

Notary Name: _____ *Circuit Court:* _____

Doc. Description _____

_____

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.

Print Form