

## Practicum Verification - MENTAL HEALTH COUNSELOR

Access this form via website at: [cca.hawaii.gov/pvl](http://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:

### 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, signed in ink by the supervisor.**

### 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: _____	