Mississippi Board of Examiners for Licensed Professional Counselors

APPLICATION PACKET

APPLICATION FOR LICENSED PROFESSIONAL COUNSELOR
*** * * GENERAL INSTRUCTIONS * * ***

GENERAL INSTRUCTIONS:

- **Application should be completed by the applicant using the online process. Paper version is for reference.**
- Refer to the Rules & Regulations when completing the Application and Forms.
- All items in Part I, II, III, IV, V, & VI of Application must be completed and submitted via the online process to the MS Board of Examiners for Licensed Professional Counselors (Rule 9). Every blank should have a response; even if it is N/A.
- Forms must be filled out completely and submitted together in one packet to complete the online application.
- Note: Form A, B, and/or C, must be properly notarized and signed, placed in a sealed envelope with the supervisor's signature over the envelope flap and returned to you for inclusion with your application materials.
- Faxed documents are not acceptable.
- Applicants must meet all applicable requirements before being considered for licensure.
- All forms/documents submitted in support of the application must bear original signatures.
- NAME(S): If some of your records are in different names, please indicate in Part I of application.
- Provide only requested information. If the Board requires additional information, you will be notified in writing.
- Applicants are encouraged to make a copy of application materials for their personal records.
- The Board must receive all the supporting documents required, e.g. color passport style photo, supervision verification form(s) (Form A, B, and/or C), transcript(s), and background check from the Department of Public Safety (Form E).
- You are responsible for ensuring that your file is complete. There are no exceptions!
- The Board **only** reviews **complete** applications with all required information and application materials received by the deadline date. Incomplete applications **will not** be reviewed by the Board.

CHECKLIST FOR COMPLETE APPLICATION MATERIALS:

- ☐ Online Application for Licensed Professional Counselor (Parts I, II, III, IV, & V, VI)
- ☐ Notarized Supervision Verification Forms
  - o Practicum/Internship Supervision Verification – Form A (If applicable)
  - o Post-Master's Supervision Verification - Form B (This form has 2 pages.)
  - o Post-Master's Supervision Verification - Missing or Deceased Supervisor Affidavit - Form C (if applicable)
- ☐ Official Transcript(s) from an approved educational institution verifying educational qualifications are to be included with application materials. Only the graduate-level transcripts are required. The official transcript(s) should be sealed in an envelope and signed or stamped across the envelope's seal by the transcript clerk issuing the document to the applicant. If the approved educational institution will not issue an official transcript to the applicant, the approved educational institution may submit the official transcript directly to the Board. If transcript(s) are sent directly to the Board office from the school/university, ask the Registrar to provide you with a verification that the transcript has been sent and include this with your application.
- ☐ Fee Schedule. New Applications: A non-refundable Application Fee of $100.
- ☐ Official NCE or NCMHCE score report, if applicable. The official score report must be submitted directly to the Mississippi LPC Board from the National Board for Certified Counselors, Inc. (NBCC).★
- ☐ Completed background check release (Form E) and fee sent directly to Department of Public Safety.
- ☐ Color passport style photo uploaded.
- ☐ Verification of Licensure in Other Jurisdiction (Form D): 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 office

APPLICANT FILE:

- A file is "open" **one year** from the date application is received; the applicant must pay a reapplication fee in order to reactivate their file for one (1) additional year. After two (2) years, incomplete applications will be destroyed.

APPLICATIONS REVIEW:

- The Board reviews only applications received by the deadline that corresponds to the regularly scheduled meetings (10 days prior to regularly scheduled meeting).
- Only **complete** applications received by the corresponding deadline will be reviewed.
- Individuals approved by the Board as candidates will receive a letter from the Board notifying them of their Candidacy to sit for the licensure exam, and it is the candidate's responsibility to schedule licensure exam.
- Individuals approved for licensure will be awarded a license as a professional counselor.
- The Board meeting dates are posted on the website. www.lpc.state.ms.us

DENIED APPLICATIONS (Board Rule 5.1(D)):

- If your application is denied, you will receive a reason for the denial. Within sixty (60) days of the date of that letter, you may request an administrative hearing at the next regularly scheduled Board meeting. You should enclose additional evidence [documentation] to support your qualifications, if you wish the Board to reconsider the denial of your application. You may request, in writing, to meet with the Board. If you do, an appointment will be scheduled.
- If the Board reviews your application again and denies it, an individual can appeal the decision of the Board to the circuit court of the county of the applicant's residence.
- If you do not petition the Board to re-evaluate your application within the 60-day period, your application file will be closed. Any subsequent request for licensure will require submission of a new application, documents, and the required fee.

REINSTATEMENT (LICENSE LAPSED GREATER THAN THREE (3) YEARS) (Rule 5.3)

- You must meet the current licensure requirements, submit a new application, and pay all application and renewal fees.

YOUR COPY:

- Keep a complete copy of your application materials, except those under seal.

SUBMIT PACKET VIA RETURN RECEIPT TO:

MISSISSIPPI BOARD OF EXAMINERS
FOR LICENSED PROFESSIONAL COUNSELORS
239 N. Lamar Street
Suite 402
Jackson, MS 39201
601-359-1010

(Return Receipt will provide you with assurance/proof materials are received by Board office.)

★ *Although the Mississippi LPC Board's licensure process requires that an applicant receive Mississippi LPC Board approval to sit for the National Counselor Examination (NCE) or the National Clinical Mental Health Counselor Exam (NCMHCE), there are two specific situations in which an applicant may have already taken the NCE or the NCMHCE outside of the Mississippi LPC Board licensure process: Individuals holding the National Certified Counselor (NCC) credential may have already taken the NCE or those licensed in another jurisdiction may have already taken the NCE or the NCMHCE. If you have already taken the NCE or the NCMHCE in either of these two situations, you have one additional requirement. IN ADDITION TO THE MATERIALS LISTED ABOVE, YOU MUST ALSO SUBMIT:*

- An official copy of your passing scores. (Your licensure application is considered incomplete without submission of the test scores and will not be forwarded to the Mississippi LPC Board for review until an official copy of your passing scores is received by the Board Office. Therefore, if you have already taken the NCE or the NCMHCE, you should contact the National Board for Certified Counselors, Inc., (NBCC) and request that your test scores be submitted directly to the Mississippi LPC Board. It is your responsibility to ensure that the Mississippi LPC Board receives an official copy of your passing test scores.)

	APPLICATION FOR MISSISSIPPI LICENSED PROFESSIONAL COUNSELOR	ATTACH PHOTO HERE

I hereby make application for Licensed Professional Counselor pursuant with the laws of the State of Mississippi and the Rules and Regulations for The Mississippi State Board of Examiners for Licensed Professional Counselors.

NO FAXED FORMS ACCEPTED

(check one)

☐ **APPLY FOR LICENSURE:** If you meet all licensure requirements and have taken and passed the NBCC Examination and completed your Supervised Experience in accordance with the Rules and Regulations, complete Parts I, II, III, IV, V, and VI of the Application, request an official passing grade letter from NBCC to the Board office, if it is not already on file, and submit all required supporting documents as detailed in General Instructions.

☐ **APPLY FOR LICENSURE CANDIDACY:** If you meet licensure requirements in effect at the time the application is received by the Board office and intend to take the license examination, if approved, complete Parts I, II, III, IV, V, and VI of the Application and submit all required supporting documents as detailed in General Instructions.

Do you require special accommodations for License exam? ☐No ☐Yes (Please provide documentation with application.)

☐ **REINSTATEMENT:** If your LICENSE LAPSED UP TO A PERIOD OF 3 YEARS (36 MONTHS), you must reapply for licensure, meet the current licensure requirements, and pay all application and renewal fees.

☐ Are you a member of the military, veteran, or spouse of active duty military? ☐No ☐Yes (Please provide documentation.)

PART I - PERSONAL INFORMATION

Please type or print clearly.

Name ☐Mr. ☐Ms. ☐Dr. _____

(Type or Print legal name as it should appear on certificate)

Name(s) as shown on transcripts and/or exam records if different from above:

_____

If granted a license, your name, preferred address, preferred phone number, email address, and license number will appear on the internet. You must immediately notify the Board in writing of any changes of information.

PREFERRED ADDRESS: ☐HOME ☐BUSINESS

HOME ADDRESS: _____

Street (**P.O. Box not acceptable) City State Zip Code

BUSINESS ADDRESS: _____

Street City State Zip Code

PREFERRED PHONE NUMBER: ☐HOME ☐BUSINESS ☐CELL

HOME PHONE: (___)_____ BUSINESS PHONE: (___)_____ CELL: (___)_____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER _____

Month/Day/Year

NATIONAL COUNSELOR EXAMINATION (NCE) TAKEN: ☐Yes ☐No If "Yes," Date Taken _____

Indicate Pass/Fail ☐Pass ☐Fail If "Pass," Score _____/_____ (your score / minimum score)

NATIONAL CLINICAL MENTAL HEALTH COUNSELOR EXAM (NCMHCE) TAKEN: ☐Yes ☐No

If "Yes," Date Taken _____ Indicate Pass/Fail ☐Pass ☐Fail If "Pass," Score _____

Have you requested passing scores be forwarded to the Board ☐Yes ☐No

Board Office Use Only
Date Received _____
Fee Paid _____

PART I cont'd

INSTRUCTIONS:

- Complete this part for the graduate degree that you want the Board to consider as part of this application.
- The official transcript(s) should be sealed in an envelope and signed or stamped across the envelope's seal by the transcript clerk issuing the document to the applicant. If the approved educational institution will not issue an official transcript to the applicant, the approved educational institution may submit the official transcript directly to the Board. If transcript(s) are sent directly to the Board office from the school/university, ask the Registrar to provide you with a verification that the transcript has been sent and include this with your application.

DEGREE: ❒Doctoral (specify _____) ❒Specialist ❒Master's ❒Other _____
Date Awarded:
Program/Major:
Name of Institution:
Street Address:
City/State/Zip:

DEGREE: ❒Doctoral (specify _____) ❒Specialist ❒Master's ❒Other _____
Date Awarded:
Program/Major:
Name of Institution:
Street Address:
City/State/Zip:

PART II - SUPERVISED EXPERIENCE

INSTRUCTIONS:

- List only the name(s) and address(es) of the Supervisor(s) whose time you will use to fill the Supervision requirement for licensure and will complete Supervision Verification Forms on your behalf.
- Have each Supervisor complete a separate "Supervisor Verification Form." (Form A or Form B)
- If your Supervisor is missing or deceased, complete Form C.
- Effective July 1, 2015, Applicants shall present supervised experience obtained within the last (7) years.

SUPERVISORS

NAME: _____

ADDRESS: _____
Street City State Zip

Place of employment where Supervisory Hours were obtained _____

Date of Supervised experience: FROM _____ TO _____
BQS: ☐ NO ☐ YES, DATE BQS APPROVED: _____

TOTAL HOURS: _____ DIRECT CONTACT: _____ INDIVIDUAL SUPERVISION: _____ GROUP SUPERVISION: _____

Did you receive at least 1 hour of direct face-to-face supervision for every twenty-five (25) hours of direct service to clients? _____
At the time of supervision my experience/employment was (check only one)
☐ PRACTICUM ☐ INTERNSHIP ☐ POST DEGREE ___ FULL TIME ___ PART TIME AT _____ %

NAME: _____

ADDRESS: _____
Street City State Zip

Place of employment where Supervisory Hours were obtained _____

Date of Supervised experience: FROM _____ TO _____
BQS: ☐ NO ☐ YES, DATE BQS APPROVED: _____

TOTAL HOURS: _____ DIRECT CONTACT: _____ INDIVIDUAL SUPERVISION: _____ GROUP SUPERVISION: _____

Did you receive at least 1 hour of direct face-to-face supervision for every twenty-five (25) hours of direct service to clients? _____
At the time of supervision my experience/employment was (check only one)
☐ PRACTICUM ☐ INTERNSHIP ☐ POST DEGREE ___ FULL TIME ___ PART TIME AT _____ %

NAME: _____

ADDRESS: _____
Street City State Zip

Place of employment where Supervisory Hours were obtained _____

Date of Supervised experience: FROM _____ TO _____
BQS: ☐ NO ☐ YES, DATE BQS APPROVED: _____

TOTAL HOURS: _____ DIRECT CONTACT: _____ INDIVIDUAL SUPERVISION: _____ GROUP SUPERVISION: _____

Did you receive at least 1 hour of direct face-to-face supervision for every twenty-five (25) hours of direct service to clients? _____
At the time of supervision my experience/employment was (check only one)
☐ PRACTICUM ☐ INTERNSHIP ☐ POST DEGREE ___ FULL TIME ___ PART TIME AT _____ %

NAME: _____

ADDRESS: _____
Street City State Zip

Place of employment where Supervisory Hours were obtained _____

Date of Supervised experience: FROM _____ TO _____
BQS: ☐ NO ☐ YES, DATE BQS APPROVED: _____

TOTAL HOURS: _____ DIRECT CONTACT: _____ INDIVIDUAL SUPERVISION: _____ GROUP SUPERVISION: _____

Did you receive at least 1 hour of direct face-to-face supervision for every twenty-five (25) hours of direct service to clients?
At the time of supervision my experience/employment was (check only one)
☐ PRACTICUM ☐ INTERNSHIP ☐ POST DEGREE ___ FULL TIME ___ PART TIME AT _____ %

PART II - SUPERVISED EXPERIENCE

INSTRUCTIONS:

- List only the name(s) and address(es) of the Supervisor(s) whose time you will use to fill the Supervision requirement for licensure and will complete Supervision Verification Forms on your behalf.
- Have each Supervisor complete a separate "Supervisor Verification Form." (Form A or Form B)
- If your Supervisor is missing or deceased, complete Form C.

SUPERVISORS

NAME: _____

ADDRESS: _____
Street City State Zip

Place of employment where Supervisory Hours were obtained _____

Date of Supervised experience: FROM _____ TO _____
BQS: ☐ NO ☐ YES, DATE BQS APPROVED: _____

TOTAL HOURS: _____ DIRECT CONTACT: _____ INDIVIDUAL SUPERVISION: _____ GROUP SUPERVISION: _____

Did you receive at least 1 hour of direct face-to-face supervision for every twenty-five (25) hours of direct service to clients? _____
At the time of supervision my experience/employment was (check only one)
☐ PRACTICUM ☐ INTERNSHIP ☐ POST DEGREE ☐ FULL TIME ☐ PART TIME AT _____ %

NAME: _____

ADDRESS: _____
Street City State Zip

Place of employment where Supervisory Hours were obtained _____

Date of Supervised experience: FROM _____ TO _____
BQS: ☐ NO ☐ YES, DATE BQS APPROVED: _____

TOTAL HOURS: _____ DIRECT CONTACT: _____ INDIVIDUAL SUPERVISION: _____ GROUP SUPERVISION: _____

Did you receive at least 1 hour of direct face-to-face supervision for every twenty-five (25) hours of direct service to clients? _____
At the time of supervision my experience/employment was (check only one)
☐ PRACTICUM ☐ INTERNSHIP ☐ POST DEGREE ☐ FULL TIME ☐ PART TIME AT _____ %

NAME: _____

ADDRESS: _____
Street City State Zip

Place of employment where Supervisory Hours were obtained _____

Date of Supervised experience: FROM _____ TO _____
BQS: ☐ NO ☐ YES, DATE BQS APPROVED: _____

TOTAL HOURS: _____ DIRECT CONTACT: _____ INDIVIDUAL SUPERVISION: _____ GROUP SUPERVISION: _____

Did you receive at least 1 hour of direct face-to-face supervision for every twenty-five (25) hours of direct service to clients? _____
At the time of supervision my experience/employment was (check only one)
☐ PRACTICUM ☐ INTERNSHIP ☐ POST DEGREE ☐ FULL TIME ☐ PART TIME AT _____ %

NAME: _____

ADDRESS: _____
Street City State Zip

Place of employment where Supervisory Hours were obtained _____

Date of Supervised experience: FROM _____ TO _____
BQS: ☐ NO ☐ YES, DATE BQS APPROVED: _____

TOTAL HOURS: _____ DIRECT CONTACT: _____ INDIVIDUAL SUPERVISION: _____ GROUP SUPERVISION: _____

Did you receive at least 1 hour of direct face-to-face supervision for every twenty-five (25) hours of direct service to clients?
At the time of supervision my experience/employment was (check only one)
☐ PRACTICUM ☐ INTERNSHIP ☐ POST DEGREE ☐ FULL TIME ☐ PART TIME AT _____ %

PART III - PERSONAL AND LICENSURE HISTORY

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED.
If you answer "Yes" to ANY of the following questions, explain in full by addendum to the application. You must make a statement that includes, but is not limited to, the date(s) location(s), specific circumstances, practitioners and/or treatment involved, and must be substantiated by official documents sent directly to the board office from the respective state licensing board or official copies of court records. A "yes" answer is NOT an automatic cause for denial of licensure. The failure to accurately disclose information will result in immediate denial of licensure.

☐ Yes ☐ No 1. Do you currently have a medical condition which in any way impairs or limits your ability to practice professional counseling with reasonable skill and safety?
☐ Yes ☐ No a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?

☐ Yes ☐ No 2. Do you currently use chemical substances?
☐ Yes ☐ No a. If yes, do they in any way impair or limit your ability to practice professional counseling with reasonable skill and safety?

☐ Yes ☐ No 3. Are you currently engaged in the illegal use of controlled substances?

☐ Yes ☐ No 4. Have you ever had an application for a license to practice professional counseling in any state, country, or province, denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?

☐ Yes ☐ No 5. Have you ever had a license or certificate in any mental/health care profession, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or that You voluntarily surrendered under threat of investigation or disciplinary action?

6. In relation to the performance of your professional services in counseling or any profession:
☐ Yes ☐ No a. Have you ever had a final judgment rendered against you;
☐ Yes ☐ No b. Have you ever had settlement of any legal action rendered against you; or
☐ Yes ☐ No c. Are there any legal actions pending against you or to which you are a party?

☐ Yes ☐ No 7. Have you ever been rejected or censured by a professional association?

☐ Yes ☐ No 8. Is there currently pending, in any jurisdiction, a complaint against your professional conduct of competency in counseling or any profession?

☐ Yes ☐ No 9. Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was alleged negligence, malpractice or lack of professional competence?

☐ Yes ☐ No 10. 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 contender. You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question.

☐ Yes ☐ No 11. Have you ever been convicted of any criminal offense?

☐ Yes ☐ No 12. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?

PART IV – OATH

I, the undersigned Applicant, do hereby affirm under penalty of perjury that all statements made and information contained in this Application are true and correct to the best of my knowledge and belief. I acknowledge that I may be required to furnish additional information promptly in order for this Application to be processed.

_____ _____

Date Signature of Applicant

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

_____

Notary Public

My Commission Expires: _____ Notary Seal

PART V - AFFIDAVIT AND RELEASE

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

I,_____ , of_____ _____
(*Applicant's Name)* *(City)* *(State)*
being duly sworn and identified as the person referred to in this application attests to the truth of each statement made in said application. I further swear that I have read and understand the statute Mississippi Code of 1972, Annotated Section 73-30-1 et seq and the Rules and Regulations and Application Guidelines of the Mississippi State Board of Examiners for Licensed Professional Counselors, which are a part of the application information and agree to abide by them in the practice of professional counseling in the State of Mississippi.

I HEREBY:
SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice professional counseling.

AUTHORIZE release, use of disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations that provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

Sworn to before me this_____ day of _____, _____.

Notary Seal _____
NOTARY PUBLIC

_____
My commission expires

PART VI – COURSE VERIFICATION FORM

Applicant's Name_____

- Complete the following according to your graduate work.
- A graduate program related to counselor education is defined as one that contains course work in all of the following areas. Each applicant must have completed a three (3) hour semester course or its equivalent in each of the following areas.
- Please note that all references to hours of college credit are for semester hours. Quarter hours may be converted to semester using the standard formula (Number of quarter hours X .66 = Semester hour equivalent). Semester hours must total sixty (60) hours.

	Area	Course Number	Course Title	University/College
1	**Human Growth and Development**			
2	**Social and Cultural Foundations**			
3	**Counseling and Psychotherapy Skills**			
4	**Group Counseling**			
5	**Lifestyle and Career Development**			
6	**Testing and Appraisal**			
7	**Research and Evaluation**			
8	**Professional Orientation to Counseling or Ethics**			
9	**Theories of Counseling Psychotherapy and Personality**			
10	**Marriage and/or Family Counseling/Therapy**			
11	**Abnormal Psychology and Psychopathology**			
12	**Internship**			

FORM A
PRACTICUM-INTERNSHIP SUPERVISION VERIFICATION

Please type or print clearly.

APPLICANT:

- Complete Applicant section and submit to your Practicum/Internship Supervisor.
- If you have more than one practicum or internship, submit a form for each.

PRACTICUM/INTERNSHIP SUPERVISOR:

- Complete Supervisor section, noting requirements.
- Please enclose this form in a sealed envelope.
- Sign your name over the flap and then mail it to the applicant.
- No faxed forms accepted.

Do not forget to complete these steps.

The Practicum/Internship must:

- Be part of the master's educational specialists or doctoral degree program.
- Be in Counselor Education or a related counseling program.

The Practicum/Internship Supervisor must:

- Be the Instructor of Record at the college or university or the site supervisor at the time of the experiene;
- Be a licensed professional, where possible the Board would prefer an LPC.

APPLICANT

NAME: _____ SOCIAL SECURITY NUMBER: _____

SUPERVISOR

NAME: _____

ADDRESS: _____
Street City State Zip Code

TELEPHONE: (____)_____FAX: (____)_____E-mail _____

TYPE OF LICENSE: _____

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 _____ . THE TIME SPENT IN THE EXPERIENCE CONSISTED OF:

TOTAL HOURS: _____ DIRECT CONTACT: _____ INDIVIDUAL SUPERVISION:_____ GROUP SUPERVISION:_____

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

Board Office Use Only
☐ Envelope Sealed & Signed
☐ Signature Matches Form

FORM B
POST-MASTER'S SUPERVISION VERIFICATION

NO FAXED FORMS ACCEPTED • Please type or print clearly.

APPLICANT:

- Complete **Applicant** section and submit to your employer or supervisor in the employment chain of command where you have done your post-master's supervised experience. If you have more than one work setting under which you completed your supervised experience, submit additional forms. This form may be photocopied.

SUPERVISOR:

- Complete **Supervisor** section, noting requirements. (2 pages)
- Please enclose this form in a sealed envelope.
- Sign your name over the flap and then mail it to the Applicant.
- The supervisor must not be a member of the applicant's immediate family.
- The supervisor must have assumed full responsibility for the clinical activities of the applicant for the duration of the supervised experience.

Do not forget to complete these steps.

Supervision Must Be:

- "Supervision" — the direct clinical review, for the purpose of teaching or training, of a professional counselor's interaction with client(s). The ongoing process performed by a BQS/LPC-S in assisting the counselor in developing expertise in methods of the professional mental health counseling practice and in developing self-appraisal and professional development strategies.
- One hour of supervision for every 25 hours direct client contact.
- In the practice of Professional Counseling.
- May be provided pro bono or for a fee.
- May be individual (one-on-one) or group (two to six supervisees).

Two group hours equals one individual. Report the TOTAL group hours and the Board will divide the total group hours by two.

APPLICANT

NAME: _____ SOCIAL SECURITY NUMBER: _____

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

SUPERVISOR

NAME: _____ YEARS OF PRACTICE AFTER LICENSED: _____

TYPE OF LICENSE: ☐ Licensed Professional Counselor ☐ Other _____ BQS CERT # _____

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

ADDRESS: _____
Street City State Zip

EMAIL:_____TELEPHONE: (_____)_____FAX: (_____) _____

CERTIFICATION OF SUPERVISION:

I hereby certify that I supervised the Professional Counseling practice of the above-named Applicant during the following period(s):

FROM _____ TO _____ LOCATION _____

TOTAL HOURS*: _____ DIRECT CONTACT: _____ INDIVIDUAL SUPERVISION: _____ GROUP SUPERVISION: _____

*Total Hours = sum of direct hours, indirect hours, individual supervision, and group supervision.

At the time of supervision the applicant's employment was (check only one)

☐ FULL TIME ☐ PART TIME AT _____ %

Board Office Use Only
☐ Envelope Sealed & Signed
☐ Signature Matches Form

DESCRIPTION OF PRACTICE SUPERVISED: (Please provide detailed description.)

RECOMMENDATION AND VERIFICATION:

I, the undersigned Supervisor or authorized representative, attest that I provided the supervision described above- that this is a true and accurate representation of that supervision and that I:

☐ Recommend, without reservation, that the applicant be considered for licensure.

☐ Recommend with some reservations, that the applicant be considered for licensure. ☐ Explanation attached.

☐ Do Not Recommend that the applicant be considered for licensure. ☐ Explanation attached.

_____ _____

Date Signature of Supervisor

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

_____

Notary Public

_____

My Commission Expires:_____

NOTARY SEAL

FORM C - PROFESSIONAL COUNSELOR
POST-MASTER'S SUPERVISION VERIFICATION - MISSING OR DECEASED SUPERVISOR AFFIDAVIT

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print clearly.
- Supervision may have been obtained at any time while you engaged either in practicum, internship or 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 Licensed Professional Counselors. You must have received a minimum of 1 hour of supervision for every 25 direct contact hours of service.

The Directed Experience Supervisor must be:

- Supervision received after July 1, 2001, must be from a Licensed Professional Counselor. Before July 1, 2001, a supervisor who is satisfactory to the Board must have been licensed in Mississippi as a professional counselor, psychologist, Department of Mental Health clinical mental health therapist, clinical social worker, psychiatrist, or must have been licensed in Mississippi by another mental health profession. Supervision after July 1, 2008, must be from a Board Qualified Supervisor.
- Meet the post-licensure experience requirements for the degree held.

APPLICANT:

- Make every effort to locate as many of the directors of Directed Experience as necessary to document the required Directed Experience.
- You must show your diligence with returned mail, copies of letters, and 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 supervisors to document the required time, you may attest to undocumented Supervised Experience by taking the Oath below.
- The Board may require additional information upon review.

APPLICANT

NAME: _____ SOCIAL SECURITY NUMBER: _____

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

OATH

Under penalty of perjury, as provided in the Mississippi Code of 1972, 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 either in a work or educational setting.

Name of Agency, Organization, or University: _____

Address: _____
Street City State Zip

and that this supervisor has/had the following credentials:

License Type: ☐ Licensed Professional Counselor ☐ Psychologist ☐ Clinical Social Worker ☐ Psychiatrist
☐ Department of Mental Health clinical mental health therapist ☐ Other Mississippi Licensed mental health professional
License #: _____ State: _____ Date Issued: _____ Exp. Date: _____ Yrs. of Practice After Licensed: _____

The supervision of my Professional Counseling Practice was provided during the following period(s):

FROM: _____ TO _____ TOTAL HOURS: _____ DIRECT HOURS: _____ INDIVIDUAL & GROUP: _____

Date _____ Signature of Applicant _____

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

_____
Notary Public
My Commission Expires: _____ NOTARY SEAL

MISSISSIPPI STATE BOARD OF EXAMINERS FOR LICENSED PROFESSIONAL COUNSELORS

VERIFICATION OF LICENSURE IN OTHER JURISDICTION – FORM D

DIRECTIONS TO APPLICANT: Complete Part I and forward to the state where you hold a license to practice Professional Counseling.

PART I-TO BE COMPLETED BY THE APPLICANT

Name of Applicant	Date of Birth	State Verifying license	License No.	Date issued

I was granted a license as a Licensed Professional Counselor. You are hereby authorized to release any information in your files, favorable or otherwise, directly to this state's Professional Counselor Board.

Your early attention is appreciated. _____

Signature **Date**

PART II-TO BE COMPLETED BY THE STATE BOARD VERIFYING LICENSURE (Please complete this form and return it to the address indicated below. Attach copies of any verification of supervision or supervised experience toward LPC licensure.

Name of Licensee	Licensure Level	License No.	Date Issued

Hours of supervision and direct supervised clinical experience required for licensure held:

Supervision dates: From _____ to _____

Total hours of practice: _____ Number of hours of direct clinical services: _____

Number of individual supervision hours: _____ Number group supervision hours: _____

Other requirements:

_____

_____

Exam Taken	Date Exam Passed	Exam Score
_____ NBCC (NCE) Other_____		

License Current?	Expiration Date	Complaints and/or Disciplinary Action
____ Yes ____ No	_____	____ Yes _____ No

***Explain Complaints or Disciplinary Actions:**

_____

_____

Board Seal

I certify that the information provided on this form is true and correct to the best of my knowledge.

Print Name of person completing this form. _____ Date_____

_____

Signature Title Telephone #

Send To:
Mississippi State Board of Examiners for Licensed Professional Counselors
239 N. Lamar Street • Suite 402
Jackson, MS 39201
601-359-1010 or Fax 601-359-1030

FORM E

MISSISSIPPI DEPARTMENT OF PUBLIC SAFETY
AUTHORIZATION TO RELEASE INFORMATION

MCIC POLICY: 9.006

THIS FORM MUST BE **COMPLETED** AND **SIGNED.** (MUST BE PRINTED AND LEGIBLE)

IF THE CRIMINAL BACKGROUND CHECK RESULTS ARE TO BE RELEASED TO A **THIRD PARTY**, YOU **MUST** PROVIDE THE THIRD PARTY NAME AND MAILING ADDRESS IN **BLOCKS 11, 12, 13, 14 & 15.**

IF THE CRIMINAL BACKGROUND CHECK RESULTS ARE TO BE FAXED, YOU **MUST** PROVIDE A FAX NUMBER IN **BLOCK 16**.

SUBMIT THIS FORM WITH A $32.00 MONEY ORDER TO: MONEY ORDER #	**MS DEPARTMENT OF PUBLIC SAFETY** **ATTN: CIC/BACKGROUND CHECKS** **3891 HIGHWAY 468WEST** **PEARL, MISSISSIPPI 39208**

REASON FOR CRIMINAL BACKGROUND CHECK: ☐ ADOPTION ☐ IMMIGRATION ☐ OTHER

1. NAME (LAST,FIRST & MIDDLE INITIAL)		**2. ADDRESS**		
3. CITY		**4. STATE**		**5. ZIP CODE**
6. SOCIAL SECURITY NO.	**7. DOB** (YYYYMMDD)	**8. RACE**	**9. SEX**	**10. PHONE NO.**

I AUTHORIZE AND CONSENT TO RELEASE A (FINGERPRINT) OR (NAME) BASED BACKGROUND CHECK TO:

11. NAME (LAST,FIRST & MIDDLE INITIAL)	**12. ADDRESS**		
MS Board of Examiners for Licensed Professional Counselors	239 North Lamar Street; Suite 402		
13. CITY	**14. STATE**	**15. ZIP CODE**	**16. FAX NO.**
Jackson	MS	39201	

AND, REQUEST THE INSPECTION OF **ANY AND ALL CRIMINAL RECORDS INFORMATION** IN THE POSSESSION OF OR ACCESSIBLE BY THE MISSISSIPPI JUSTICE INFORMATION CENTER, INCLUDING, BUT NOT LIMITED TO, ANY PAST HISTORY OF A CRIMINAL OFFENSE(S) FOR WHICH I MAY HAVE BEEN CHARGED OR CONVICTED.

BY GIVING THE ABOVE-DESCRIBED RELEASE, I HEREBY WAIVE ANY AND ALL CLAIMS OR LIABILITY FOR COMPLIANCE WHICH I MAY NOW HAVE OR MAY HAVE IN THE FUTURE AGAINST THE STATE OF MISSISSIPPI, THE MISSISSIPPI DEPARTMENT OF PUBLIC SAFETY AND THE MISSISSIPPI JUSTICE INFORMATION CENTER, IT'S EMPLOYEES AND AGENTS, CONCERNING SAID INFORMATION, AND DO HEREBY INDEMNIFY THE STATE OF MISSISSIPPI, THE MISSISSIPPI DEPARTMENT OF PUBLIC SAFETY AND THE MISSISSIPPI JUSTICE INFORMATION CENTER, IT'S EMPLOYEES AND AGENTS, AGAINST ANY AND ALL FUTURE ACTIONS WITH REFERENCE TO THE RELEASE OF THE ABOVE-DESCRIBED INFORMATION AND THE CIRCUMSTANCES SURROUNDING THE SAME.

SIGNATURE	**DATE**
WITNESS TO SIGNATURE	**DATE**

RESULTS OF INQUIRY (MDPS/CIC USE ONLY):

FORM CIC/SPU 2.0 (8/2011)