FORM E2

VERIFICATION OF EXPERIENCE FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC)

Part of State Form 50319 (R10 / 8-22)

*Complete **SECTION A** and then forward this form to your previous or current employer(s) for completion of **SECTION B**. You must submit proof that you have acquired at least 3,000 hours of post-graduate clinical experience completed in no less than 21 months and no more than 48 months. **This form may be duplicated if your 3,000 hours of experience have been completed at more than one place of employment.** If you are no longer able to contact your previous employer(s), you may complete **SECTION C** (on the reverse side of this form) for each previous place of employment. Sign the form(s) and return the form to the Professional Licensing Agency.*

SECTION A / APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)		Date of birth *(month, day, year)*
Name of employer	Dates of employment began *(month, day, year)*	Dates of employment end *(month, day, year)*
Location of place of employment or place of practice		

SECTION B / EMPLOYER / EMPLOYMENT INFORMATION

This section is to be completed by the applicant's previous or current employer and sent directly to the Professional Licensing Agency at the address listed on the bottom of this form.

Applicant employer name	Applicant Employer business address (*street address, city, State, and Zip code*)	
Total number of months the applicant worked	Average number of client contact hours worked per week	
Total number of hours served at employer	Average number of hours worked per week	
Provide a brief description of duties		
Printed name of employer and title		
Cellular telephone number	Work telephone number	Email address
Signature of employer	Date *(month, day, year)*	

RETURN THIS FORM TO:
Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, IN 46204

FORM E2

VERIFICATION OF EXPERIENCE FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC) *(continued)*

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SECTION C / AFFIRMATION OF EXPERIENCE

*To be completed by applicant if the applicant's previous employer is no longer able to complete **SECTION B** (on reverse side of this form). Please indicate below the reason why your previous employer is no longer able to complete **SECTION B** (on the reverse side of this form). **If you are affirming experience acquired through more than one previous employer this form may be duplicated but you must submit one AFFIRMATION OF EXPERIENCE for each previous employer that is no longer able to complete SECTION B (on the reverse of this form).***

I am unable to have my previous employer(s) complete SECTION B for the following reason:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have selected "Other reason", please briefly explain:

Total number of months that you have been providing mental health counseling services directly to clients on an average of at least __________ hours per week, at the address below:____________

Total number of hours served at the address below:______________

Period of time which you provided these services: ____________________ *(month/year)* to ____________________ *(month/year)*

Name of facility address where mental health counseling services were provided:

____________________ *(Name of facility)*

____________________ *(Address of facility)*

Provide name of a professional colleague who can attest to the vality of the above statements:

____________________ Name of colleague *(last, first, middle, maiden*

____________________ Daytime telephone number of colleague

____________________ Address of colleague *(number and street, city, state, and ZIP code)*

List all graduate degrees, credentials and / or board issued licenses / certifications held by this colleague:

APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties perjury that the above statements are true, complete and correct.

Signature of applicant	Date (*month, day, year*)