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) From	To	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
		hrs.	hrs.		

Please attach a brief summary of the duties that the applicant performed during the post-graduate period listed, signed in ink by the supervisor.

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 _____

_____

Notary Signature: _____

Date: _____

MHC-04 0723R

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