



APPLICATION FOR LICENSURE AS A PROFESSIONAL COUNSELOR

GEORGIA STATE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS, AND MARRIAGE & FAMILY THERAPISTS

237 Coliseum Drive, Macon, Georgia 31217-3858

Phone (478) 207-2440

Please read the instructions carefully and be familiar with the laws and rules governing the practice of Professional Counseling in the State of Georgia. Visit the following web site for information: <http://www.sos.state.ga.us/plb/counselors>

****Important****

The Board cannot process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board. Please review this application before you submit it to ensure that all information and documentation is complete and correct. Incomplete applications result in delayed processing. Incomplete applications are void after one year and you must reapply.

Application Checklist

The following checklist is an important part of your application. Please use this checklist to ensure that you submit a COMPLETE application.

The NON-REFUNDABLE APPLICATION FEE made payable to Georgia Professional Counselors, Social Workers, and Marriage & Family Therapists must be included with the application. (Please see Fee Schedule at the Board's website)

PLEASE ACCESS BOARD RULE 135-5-.02 PROFESSIONAL COUNSELOR LICENSURE REQUIREMENTS FROM OUR WEBSITE AT WWW.SOS.STATE.GA.US/PLB/COUNSELORS

- ☐ APPLICATION: The application must be mailed to the Board's office at the address listed above, along with your FEE. All questions must be answered. Any question answered "yes", requires further documentation to be submitted. Request official court documents be submitted to the Board and provide an explanation if you have had any criminal convictions or charges, or sanctions by another state licensing board. The Board will review a complete application with all required documentation during their next available meeting. Approval of licensure is at the Board's discretion.
- ☐ EDUCATION/COURSEWORK SECTION—PART III: ALL applicants are required to complete the education/coursework section of this application.
- ☐ NATIONAL BOARD SCORES: All applicants are required to take and pass either the National Counselor Examination (NCE) OR the National Clinical Mental Health Counseling Examination (NCMHCE) offered by the National Board for Certified Counselors (NBCC). If you have taken and passed one of these exams, please contact the National Board's administrative offices at (336) 482-2856 or visit www.nbcc.org to request certification of your exam score report to Georgia. If not, you will be required to take and pass one of these exams before a license can be issued. You must submit the exam fee directly to NBCC once you obtain exam approval, do not include the examination fee with your application. If you hold an APC license in Georgia and your exam score report is already on file, you are not required to resubmit it.
- ☐ DEGREE TRANSCRIPT: All applicants for licensure must have graduated with a master's degree primarily counseling in content from an institution accredited by a regional body recognized by the Council on Higher Education Accreditation. An official college transcript certifying the grades, degree conferred and the date awarded must be received in this office directly from the Registrar of the college/school. If you have an Associate Professional Counselor license in Georgia and your official transcript is already on file, you will not need to resubmit another transcript unless you have obtained a higher degree. NOTE: IF YOUR NAME HAS CHANGED SINCE YOU

ATTENDED SCHOOL, please make a note on the application advising of your former name(s) so we can match the documents with your application. If you hold an APC license in Georgia and your official transcript is already on file, you are not required to resubmit it.

- ☐ **FORM A/INTERNSHIP SUPERVISION VERIFICATION:** The instructor of record at the college or university or the Site Supervisor may provide verification of the Internship which was part of your graduate degree program. To obtain credit for your internship either Form A or Form B is required.
- ☐ **OTHER STATE LICENSURE CERTIFICATION:** If you are currently licensed, or have ever been licensed, in another state(s), please have that state(s) officially verify the license directly to the Board's office either by fax to 866-888-7127, e-mail to verifications@sos.ga.gov or by USPS mail service.
- ☐ **FORM C- POSTMASTER'S DIRECTED WORK EXPERIENCE:** This form must be completed by the employer/director and document the hours required to meet minimum licensure requirements. For a missing or deceased employer/director, Form D may be submitted. Documentation of attempts to contact employer/director is required. This form is required from all exam and exam waiver applicants. Page 8 of this application is required to be completed to summarize the Forms C submitted. Note: The total hours are required to be listed on the form for the reported time period. The dates (month, day, year) are required to be listed on the forms. The Board will not accept hours per week in lieu of total hours and will not accept "to present/current" in lieu of the month, day, year.
- ☐ **FORM E -POSTMASTER'S CLINICAL SUPERVISION VERIFICATION:** This form must be completed by an eligible supervisor that has provided clinical supervision which means the direct clinical review, for the purpose of teaching or training, of a professional counselor's interaction with client(s) and document the hours required to meet minimum licensure requirements. For a missing or deceased supervisor, Form F may be submitted. Documentation of attempts to contact employer/director is required. This form is required from all exam and exam waiver applicants. Page 8 of this application is required to be completed to summarize the Forms E submitted. Note: The total hours is required to be listed on the form for the reported time period. The dates (month, day and year) are required to be listed on the forms. The Board will not accept "to present/current" in lieu of the month, day, year.
- ☐ **FORM G - REFERENCES:** Please submit references from two (2) teachers or supervisors who are familiar with your experience in Professional Counseling. Current references are required from all exam and exam waiver applicants. ALL applicants are required to submit two current LPC Form G references.
- ☐ **IMPORTANT:** Applicants, please note when accessing your application status on our website under the Online Services category Check the Status of an Application that checklist items that have been moved over to the completed column only means that those documents have been received and is not an indication of approval. This tool is to be used as an option for you to monitor your application for items received as you are going through the licensure process.
- ☐ **A SECURE & VERIFIABLE DOCUMENT & AFFIDAVIT OF CITIZENSHIP (See page 9 of this application) MUST BE INCLUDED WITH APPLICATION.** See list of secure & verifiable documents acceptable to the Board on the list provided on the website http://sos.ga.gov/index.php/licensing/secure_and_verifiable_documents - FAILURE TO PROVIDE BOTH OF THESE DOCUMENTS WILL RESULT IN PROCESSING DELAYS OF YOUR APPLICATION.
- ☐ Only the Georgia Composite Board of Professional Counselors, Social Workers and Marriage & Family Therapists has the authority to approve or deny an application for licensure. Every complete application file must be submitted to the Board for review. The Board meets monthly to review complete applications and conduct other Board business. Once your application file is complete and has been reviewed by the Board, you will receive written communication of the Board's decision within five to ten working days following the Board meeting date.

PLEASE DO NOT SUBMIT THESE INSTRUCTION PAGES WITH YOUR
APPLICATION AND SUPPORTING DOCUMENTS

FOR BOARD USE ONLY
Amount Submitted _____
Date _____
Receipt # _____



FOR BOARD USE ONLY
Certificate Number _____
Date Issued _____
Applicant No. _____

GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS AND
MARRIAGE & FAMILY THERAPISTS

237 Coliseum Drive • Macon, Georgia 31217 • (478) 207-2440

www.sos.state.ga.us/plb/counselors

APPLICATION FOR LICENSURE AS A PROFESSIONAL COUNSELOR

Application Fee \$100 (non-refundable)

Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A. §16-9-20.

Applications are valid for (1) one year ONLY

Additional License Types (currently or previously issued by any Georgia Professional Licensing Board): _____

Method Obtained by: Please check one

() Examination (Check ONLY if you have NEVER taken OR passed the NCE or NCMHCE thru NBCC)

() Examination Waiver (Check ONLY if you have taken and passed the NCE or NCMHCE thru NBCC)

Name _____
Last First Middle

Name as shown on exam records or transcripts

(If different) _____
Last First Middle

*Social Security Number

Date of Birth

*(This information is authorized to be obtained & disclosed to State & Federal agencies pursuant to O.C.G.A. §19-11-1 & O.C.G.A. §20-3-295,42 U.S.C.A. §551 & 20 U.S.C.A. § 1001).

Physical Address _____
**Number and Street Apt. No City/State Zip

**(P.O. Box not acceptable – If you are granted a license, your name, mailing address and license number are public information and your mailing address will appear on the internet. Your physical address is required, if different than the mailing address. You must immediately notify the Board in writing of an address change).

Mailing Address _____
(If different) Number and Street Apt. No City/State Zip

Telephone Number Day Telephone Number Evening ***Email Address (Please print clearly)

***Acknowledgement of your application will be sent by e-mail. Also, if any additional information is needed, e-mail is the most efficient way for the Board staff to contact you so that your application can be processed in the most efficient manner. Please notify the Board of any e-mail address change. YOUR E-MAIL ADDRESS WILL NOT BE SHARED WITH ANY THIRD PARTY.

☐ Please check this box if you are a military spouse or a transitioning service member of the United States armed forces (including the National Guard).

PART I

APPLICATION FOR PROFESSIONAL COUNSELOR LICENSURE
BY EXAMINATION OR EXAMINATION WAIVER

- ☐ Please type or print clearly.
- ☐ Refer to Application Checklist for additional information.
- ☐ Rules available @ www.sos.ga.gov/plb/counselors
- ☐ Attach Fee. Refer to Fee Schedule. Application fee is non-refundable.

☐ I currently hold License # _____ from the State of _____
which was issued on _____ and expires on _____.

- ☐ I have provided verification of this license to the Board by completing Form N and requesting that the above-referenced state return that Form, or their own verification form/document, to the GA Board office.

PART II - PROFESSIONAL BACKGROUND

ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS. IF "YES," TO 1 THROUGH 9, ATTACH A DETAILED LETTER OF EXPLANATION AND SUPPORTING COURT OR RELATED DOCUMENTS OF THE DISPOSITION OF THE ISSUE.

- ☐ Yes ☐ No 1. Are you unable to practice safely as a result of use of alcohol or other drugs?
- ☐ Yes ☐ No 2. Have you been denied professional licensure or renewal because of a license disciplinary proceeding?
- ☐ Yes ☐ No 3. Have you ever had a license to practice social work, counseling, marriage and family therapy, or any other profession revoked, suspended or annulled or otherwise sanctioned, including by private order, by any board or agency in Georgia or any other state, territory, or country?
- ☐ Yes ☐ No 4. Have you been subject to disciplinary action or had your membership revoked by any professional organization?
- ☐ Yes ☐ No 5. Have you knowingly failed to renew a license during an investigation of a disciplinary matter against you?
- ☐ Yes ☐ No 6. To the best of your knowledge, is there any disciplinary action or investigation pending against you by any licensing board, agency, or professional organization?
- ☐ Yes ☐ No 7. Have you ever been convicted of any criminal offense? If yes, provide certified copies of the court disposition.
- ☐ Yes ☐ No 8. Have you ever been arrested or convicted of a felony, misdemeanor (other than a minor traffic violation), crime involving moral turpitude, or a crime violating federal or state law relating to controlled substances or dangerous drugs? (DWI and DUI are not minor traffic violations.) For purposes of this question, a "conviction" includes a finding of verdict of guilty, plea of guilty, a plea of nolo contendere, or first offender treatment, and also includes adjudication of guilt or sentence withheld or not entered on the charge (s). NOTE: The answer to this question is "YES" if an arrest or conviction has been pardoned, expunged, dismissed or deferred, you pled & completed probation under First offender and/or your civil rights have been restored and/or you have received legal advice that the offense will not appear on your criminal record.

If you answered "yes," to # 8 above, you must include a certified copy of the court records and final disposition from the court with your application. In the event the file no longer exists, you must submit documentation from the court stating that fact. Also include a personal letter of explanation regarding each incident, and the Consent Form for Background Check (found on the same webpage as this application). Failure to submit all required supporting documentation may result in processing delays.

- ☐ Yes ☐ No 9. Have you been the defendant in a malpractice suit and either entered into a settlement agreement or paid court awarded expenses?
- ☐ Yes ☐ No 10. Do you now hold, or have you ever held, a license as a licensed professional counselor (or equivalent) in any other state or jurisdiction? If "yes" complete the following:
- Jurisdiction _____ License No. _____
- Date Issued _____ Expiration _____
- Please request each licensing board submit verification of license to Georgia-Form N or on their own form/document
- ☐ Yes ☐ No 11. Have you previously applied for the same license for which you are currently applying? If "yes" name under which application was submitted: _____
- ☐ Yes ☐ No 12. Have you ever served on active duty in the Armed Forces, the Reserves or the National Guard during wartime or during any conflict when military personnel were committed by the President? If "Yes," you may be eligible for Veterans' Preference Points to be added to your examination score. Submit your DD214 Form to the Board office.

PART III - GRADUATE EDUCATION

INSTRUCTIONS:

- ☐ Complete this part for the graduate degree that you want the Board to consider as part of this application.
- ☐ List any additional courses you want considered as part of this Application.
- ☐ Direct the Registrar of your institution(s) to send an official copy of your transcript directly to the Board office.
- ☐ Descriptions of the Content Areas can be found in Board Rule 135-5-.02.

DEGREE

☐ Master's ☐ Master's - Specialist (Ed.S.) ☐ Master's - Rehabilitation Counseling/CRC* ☐ Ph.D./Ed.D.

*If you are applying as a Rehabilitation Counseling/CRC applicant, please include verification of your CRC certification.

(Official transcript **MUST** indicate degree awarded and checked above)

Date Awarded:

Program/Major:

Name of Institution:

Street Address:

City/State/Zip:

ADDITIONAL COURSEWORK

COURSE TITLE AND NUMBER	INSTITUTION

REQUIRED COURSEWORK

- ☐ List the titles and numbers of courses from your transcript(s) which satisfy the professional counseling content area requirements.
- ☐ This must be graduate level coursework from an accredited institution to demonstrate that the degree is primarily counseling in content or a program in applied psychology.
- ☐ See Board Rule 135-5-.02 for descriptions of each content area
- ☐ Please note: A course may only be documented one time in one content area.
- ☐ This section is required to be completed by ALL applicants

COUNSELING/PSYCHOTHERAPY THEORY (required course)

INSTITUTION	COURSE #	COURSE TITLE

COUNSELING OR APPLIED PSYCHOLOGY PRACTICUM OR INTERNSHIP

A MINIMUM OF SIX (6) OF THE FOLLOWING NINE (9) CONTENT AREAS ARE REQUIRED

I - HUMAN GROWTH AND DEVELOPMENT

II - MULTICULTURAL COUNSELING OR DIVERSITY TRAINING

III – COUNSELING TECHNIQUES OR SKILLS, OR ADVANCED PSYCHOTHERAPY/INTERVENTION THEORY

IV - GROUP DYNAMICS AND GROUP COUNSELING/PSYCHOTHERAPY

V - LIFESTYLE AND CAREER DEVELOPMENT

VI - APPRAISAL/ASSESSMENT OF INDIVIDUALS

VII - RESEARCH METHODS AND EVALUATION OR RESEARCH STATISTICS

VIII - PROFESSIONAL ORIENTATION & ETHICS

IX PSYCHOPATHOLOGY

PART IV – PRACTICUM/INTERNSHIP and POST-MASTER'S DIRECTED EXPERIENCE UNDER SUPERVISION

Practicum/Internship – Complete Form A

*The applicant may present evidence of a supervised practicum or internship completed as part of the graduate degree program.

____ **Did not complete a practicum/internship**

Institution /Date of Degree/Course #	Location of Internship/Practicum	Dates of Internship/Practicum

____ Check here if the director/supervisor is Missing or Deceased. Must **Complete Form B.**

****THIS PAGE IS REQUIRED TO BE COMPLETED****

Post-Master's Directed Experience Under Supervision

*The number of years of Post-Master's Directed Experience in professional counseling under Supervision required depends on the graduate degree you hold. Please review Board Rule 135-5-.02 for the requirements. The Board rules can be found on the Board's website <http://www.sos.ga.gov/plb/counselors> under the "Laws, Policies & Rules" heading.

Summary of Directed Experience and Supervision

Complete this information to provide a clear record of how you have completed the required directed experience under supervision required for licensure. Directed experience and supervision **MUST** be documented on the appropriate forms. If your director or supervisor is deceased or you are unable to contact them, complete Form D and Form F and provide evidence of due diligence in trying to contact them. Please note that post-master's directed work experience and supervision must be obtained concurrently and should not be reported for more than a 5 year/60 month period.

Post Master's Directed Work Experience – Complete form C and provide a summary of the Forms C below.

_____ Check here if the director/supervisor is Missing or Deceased. Complete Form D

Director	Location	Dates of Experience	Hours	Deceased - Missing?

Post Master's Clinical Supervision – Complete Form E and provide a summary of the Forms E below:

Dates of Supervision and Directed Experience must be concurrent.

_____ Check here if the supervisor is Missing or Deceased. Complete Form E.

Supervisor	Degree	License Type	Dates of Supervision	Total Hours	Deceased or Missing?

Affidavit Regarding Citizenship

Please submit this document along with a copy of your Secure and Verifiable document to the Board office as indicated on the application.

Print Name: _____

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Board for which I am applying for licensure and I agree to abide by these laws and rules.

By executing this affidavit under oath, as an applicant for a professional license, as referenced in O.C.G.A. § 50-36-1, administered by the Professional Licensing Boards Division, the undersigned applicant also verifies one of the following with respect to his/her application for a public benefit (check one):

1) _____ I am a United States citizen. You **MUST** submit a copy of your current **Secure and Verifiable Document(s)** such as driver's license, passport, or other document. A listing of acceptable documents can be found on the PLB website, www.sos.ga.gov/plb.

2) _____ I am **not** a United States citizen, but I am either a legal permanent resident of the United States or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency. You **MUST** submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number. A listing of acceptable documents can be found on the PLB website, www.sos.ga.gov/plb.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit.

In making the above representations under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute. I also understand that any failure to make full and accurate disclosures may result in disciplinary action by the Board for which I am applying for licensure.

Executed in _____ (City), _____ (State)

Signature of Applicant _____

Printed Name of Applicant _____

SUBSCRIBED AND SWORN BEFORE ME ON THIS THE

DAY OF _____, 20_____

Notary Seal

Notary Public

My Commission Expires _____



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PROFESSIONAL COUNSELOR
PRACTICUM/INTERNSHIP SUPERVISION VERIFICATION — FORM A

Please type or print clearly.

APPLICANTS:

- ☐ Complete Part I and submit to your Practicum/Internship Supervisor. See Board Rule 135-5-.02
☐ If you have more than one practicum or internship, submit a form for each. You may photocopy this form.

PRACTICUM/INTERNSHIP SUPERVISOR:

Complete Part II, noting requirements.

The Practicum/Internship must:

- ☐ Be part of the master's degree program for master's level applicants or doctoral degree program for doctoral level applicants.

The Practicum/Internship Supervisor must:

- ☐ Be the Instructor of Record at the college or university or the Site Supervisor; and
☐ Be licensed — as a Professional Counselor, Clinical Social Worker, Marriage and Family Therapist, Psychologist, Psychiatrist — or be a Certified Rehabilitation Counselor. See Board Rule Chapter 135-5-.02 for further details.

PART I - APPLICANT

FULL NAME:

PART II — SUPERVISOR

NAME:

ADDRESS:

Street

City

State

Zip Code

TELEPHONE: ()

FAX: ()

TYPE OF LICENSE: ☐ Professional Counselor ☐ Clinical Social Worker ☐ Marriage and Family Therapist
☐ Psychologist ☐ Psychiatrist ☐ Certified Rehabilitation Counselor

LICENSE #:

STATE:

ORIGINAL DATE ISSUED:

EXP. DATE:

Highest Level of Education Completed Master's _____ Master's Specialist _____ EdD _____ PhD _____ Other _____

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 _____ FOR A TOTAL OF _____ HOURS.
MONTH/YEAR MONTH/YEAR # HOURS

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
Sworn to and subscribed before me this

_____ day of _____, _____.

Notary Public

My Commission Expires:

Signature of Supervisor/Instructor of Record

NOTARY SEAL



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PROFESSIONAL COUNSELOR
PRACTICUM/INTERNSHIP - MISSING OR DECEASED SUPERVISOR AFFIDAVIT
FORM B

INSTRUCTIONS: Please type or print clearly.

APPLICANTS:

- ☐ Make every effort to locate the supervisor(s)/instructor of record as necessary to document the required Practicum/Internship Experience.
- ☐ If, however, after a diligent search you are unable to locate the supervisor(s), you may attest to undocumented supervision of practicum/internship by taking the Oath below.
- ☐ Please include documentation to show your diligence. Examples include: returned mail, copies of letters, and verifications from your academic institution, etc.
- ☐ The licensure information of the supervisor is required.
- ☐ The Board may require additional information upon review.

OATH

Under penalty of perjury, as provided in the Official Code of Georgia 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 Practicum/Internship Supervisor in the practice of Professional Counseling

during the period of : _____ to _____
Month/Year Month/Year

and during that period he/she was licensed as a:

- ☐ Professional Counselor
- ☐ Clinical Social Worker
- ☐ Marriage and Family Therapist
- ☐ Psychologist
- ☐ Psychiatrist
- ☐ Certified Rehabilitation Counselor

License Number: _____ In the State of : _____

I have attached copies of letters and/or returned mail that demonstrates my attempt/s to reach this supervisor.

_____ Date

_____ Signature of Applicant

Sworn to and subscribed before me this

_____ day of _____, _____.

NOTARY SEAL

Notary Public

My Commission Expires: _____



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APPLICATION FOR PROFESSIONAL COUNSELOR LICENSE
POST-MASTER'S DIRECTED WORK EXPERIENCE VERIFICATION FORM
FORM C

INSTRUCTIONS:

- ☐ Please print or type.
- ☐ APPLICANT – Complete Part I and forward this form to the agency or organization in which you completed your directed experience practicing Professional Counseling.
- ☐ AGENCY OR ORGANIZATION - The Director MUST Complete Part II in its entirety and return it to the Applicant for inclusion with the Application for licensure. Failure to complete all requested information WILL delay the processing of the application.
- ☐ The dates must be noted on the form. “Present” or “Current” is not acceptable in lieu of an actual date.

PART I – APPLICANT

NAME OF APPLICANT: _____
Last Middle First Maiden

PART II – AGENCY OR ORGANIZATION

INSTRUCTIONS:

- ☐ “Direction” means the on-going administrative oversight of an employer or superior of a practitioner’s work in the practice of professional counseling as defined in Board Rule 135-5-.02.

CERTIFICATION

I CERTIFY THAT THE ABOVE-NAMED INDIVIDUAL PRACTICED PROFESSIONAL COUNSELING UNDER THE OFFICIAL JOB TITLE OF: _____ (MUST be provided or processing of application will be delayed).

At _____
(Name of Agency)

Address: _____
Street City State Zip Code

Start Date: ____/____/____ End Date ____/____/____ For ____ Total # of Hours

Date _____ Signature of Director or Authorized Person _____

Printed Name _____

Title/Position _____

Sworn to and subscribed before me this

_____ day of _____, _____.

Notary Public _____

My Commission Expires: _____.

NOTARY SEAL



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PROFESSIONAL COUNSELOR POST-MASTER'S DIRECTED WORK EXPERIENCE
MISSING OR DECEASED DIRECTOR AFFIDAVIT - FORM D

- ☐ Please type or print clearly.
☐ See Board Rule Chapter 135-5-.02 for Post Masters Directed Work Experience requirements.
The Director must be:
☐ Either the employer or the superior in the administrative chain of command.
APPLICANTS:
☐ Make every effort to locate the as many of the directors of Directed Experience as necessary to document the required Directed Experience.
☐ If, however, you have obtained sufficient directed experience to meet licensure requirements, but after a diligent search you are unable to locate enough Directors to document the required time, you may attest to undocumented Directed Experience by taking the Oath below.
☐ Please include documentation to show your diligence. Examples include: returned mail, copies of letters, and verifications from your employer, etc.
☐ The Board may require additional information upon review.

OATH

Under penalty of perjury, as provided in the Official Code of Georgia Annotated, I hereby affirm and swear that I was unsuccessful, after I made a diligent effort, to locate:

Name of Director: _____

who served as my Director of directed experience in the practice of Professional Counseling at:

_____ as a _____
Name of Agency Official Job Title

Agency Address _____

from: _____ to _____,
(month/day/year) (month/day/year)

Totaling _____ years/s on the time basis of _____ hours/week for \$ _____ wages/salary.

I have attached copies of letters and/or returned mail that demonstrates my attempts to reach this individual.

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

Signature of Applicant

Notary Public

My Commission Expires: _____

NOTARY SEAL



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APPLICATION FOR PROFESSIONAL COUNSELOR LICENSE
POST-MASTER'S CLINICAL SUPERVISION VERIFICATION FORM
FORM E

APPLICANT

- ☐ Complete Part I and forward this form to each supervisor from whom you obtained direct, clinical supervision as defined in Board Rule 135-5-.02. Complete a separate form for each Supervisor listed in your application. Use this form to only verify Professional Counseling CLINICAL supervision.
☐ If you need additional forms, you may photocopy this form.

DIRECTED EXPERIENCE SUPERVISOR

- ☐ The Supervisor must Complete Part II and return form to the Applicant for inclusion with the application for licensure OR submit directly to the Board office.
☐ "Supervision" means the direct clinical review by an eligible Supervisor for the purpose of training or teaching of a Professional Counselor's interaction with a client.
☐ The dates must be noted on the form. "Present" or "Current" is not acceptable in lieu of an actual date.

PART I - APPLICANT

NAME OF APPLICANT: _____
First Middle Last Maiden

PART II - CLINICAL SUPERVISOR

I HEREBY CERTIFY THAT I PROVIDED DIRECT CLINICAL SUPERVISION OF THE ABOVE-NAMED INDIVIDUAL AS DEFINED IN BOARD RULE 135-5-.02 FOR THE PERIOD INDICATED BELOW

SUPERVISION:

Supervision Provided: *Dates Required	From: (Month/Day/Year)	To: (Month/Day/Year)	Total Number of Hours:
Description of Practice Supervised:			

I attest that I served as this Applicant's Clinical Supervisor, as defined in Board Rule 135-5-.02 and that this description is a true and accurate representation of my clinical supervision of this Applicant.

I ☐ Recommend ☐ Do Not Recommend this Applicant for licensure.

Date

Signature of Clinical Supervisor

Highest Level of Education Completed Master's _ Master's Specialist _ EdD _ PhD _ Other _

Printed Name: _____

Address: _____
Street City State Zip Code

Telephone #: (____) _____ Fax #: (____) _____

License Type:	License #:	State:	Date Originally Issued:	Current Exp. Date:
---------------	------------	--------	-------------------------	--------------------

Sworn to and subscribed before me this

_____ day of _____, _____.

Notary Public

My Commission Expires: _____

NOTARY SEAL



GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS,
SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS
237 Coliseum Drive, Macon, Georgia 31217-3858
(478) 207-2440 (Telephone)
www.sos.state.ga.us/plb/counselors

PROFESSIONAL COUNSELOR
POST-MASTER'S MISSING OR DECEASED SUPERVISOR AFFIDAVIT
FORM F

INSTRUCTIONS:

- ☐ Please type or print clearly.
- ☐ Supervision must have been obtained while you engaged in post-master's directed experience. Supervision must meet the standards set out in the Rules for Professional Counselors. The Clinical Supervisor must be: Either be licensed as a: Professional Counselor, Clinical Social Worker, Marriage and Family Therapist, Psychologist, Psychiatrist — or a Certified Rehabilitation Counselor based on the criteria specified in Board rule 135-5-.02.
- ☐ Meet the post-licensure experience requirements for the degree held.
See Board Rule Chapter 135-5-.02

APPLICANT:

- ☐ Make every effort to locate the as many of the Supervisors as necessary to document the required supervision.
- ☐ If, however, you have obtained sufficient supervision 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 supervision by taking the Oath below.
- ☐ You must provide documentation to show your diligence. Examples include: returned mail, copies of letters etc.
- ☐ The Board may require additional information upon review.

PART I - APPLICANT

FULL NAME:

OATH

Under penalty of perjury, as provided in the Official Code of Georgia Annotated, I hereby affirm and swear that I was unsuccessful, after I made a diligent effort, to locate:

Name of Supervisor: _____

who served as my clinical supervisor while I worked under the direction of:

Name of Director: _____

at: _____
Name of Agency or Organization Address City State Zip Code

and that this supervisor has the following credentials:

License Type: ☐ Professional Counselor ☐ Clinical Social Worker ☐ Marriage and Family Therapists
☐ Psychologist ☐ Psychiatrist ☐ Certified Rehabilitation

Counselor License #: _____ State: _____ Date Issued: _____ Expiration Date: _____

SUPERVISION:

Supervision Provided:	From: (Month/Year)	To: (Month/Year)	Total Number of Hours:
Description of Practice Supervised:			

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

Notary Public
My Commission Expires: _____

Signature of Applicant

NOTARY SEAL



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PROFESSIONAL COUNSELOR
PERSONAL REFERENCE FORM
FORM G

INSTRUCTIONS:

- ☐ Please type or print legibly.
- ☐ Applicants must have references from two (2) teachers or supervisors who are familiar with their experience in Professional Counseling.
- ☐ APPLICANT - Complete Part I, give this form to your references with an envelope addressed to yourself. Retrieve the completed form from your reference for inclusion with your application.
- ☐ REFERENCE - Complete Part II, enclose this form in the envelope provided to you by the applicant, seal the envelope, sign your name across the envelope flap and return it to the applicant. The Board assumes that in recommending this applicant, references will interpret or substantiate to the Board your recommendation if the Board needs to contact you at a later date.

PART I - APPLICANT

Applicant's Name:

PART II - REFERENCE

Name:

Address: _____

Day Phone: ()

Other Phone: ()

Relationship to Applicant: ☐ Teacher ☐ Supervisor

Dates of Teaching/Supervisory Relationship: FROM: TO:
Month/Day/Year Month/Day/Year

PROFESSIONAL POSITION WHEN TEACHING OR SUPERVISING APPLICANT:

Title: _____

Agency/Institution: _____

Address: _____

RECOMMENDATION: I ☐ Recommend ☐ Do Not Recommend the Applicant for licensure.

ADDITIONAL COMMENTS:

[Please write any comments that would assist the Board in making a decision on this Applicant for licensure.]

Date

Signature of Reference



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PART I - APPLICANT

Applicant's Name: _____

PART II - REFERENCE

Name: _____

Address: _____

Day Phone: () _____

Other Phone: () _____

Relationship to Applicant: ☐ Teacher ☐ Supervisor

Dates of Teaching/Supervisory Relationship: FROM: _____ TO: _____
Month/Day/Year Month/Day/Year

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Title: _____

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Address: _____

RECOMMENDATION: I ☐ Recommend ☐ Do Not Recommend the Applicant for licensure.

ADDITIONAL COMMENTS:

[Please write any comments that would assist the Board in making a decision on this Applicant for licensure.]

Date

Signature of Reference



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VERIFICATION OF LICENSURE FROM ANOTHER STATE/JURISDICTION - FORM N

- ☐ Please type or print legibly. NOTE: The GA Board will also accept this verification of licensure on any form or format the issuing state(s) may utilize or prefer.
- ☐ Applicant - Complete Part I. Mail, fax or e-mail this form to each Board or Agency of each state or jurisdiction which you are currently licensed, or have ever been licensed, or certified as a Professional Counselor.
- ☐ State Licensure Board or Regulatory Agency - Complete Part II. Then mail, fax (to 866-888-7127) or e-mail to ExamBoards-Healthcare@sos.state.ga.us. You may also submit your own state or regulatory agency form or document in lieu of this form.

PART I - APPLICANT

Full Name:

Address:

Date of Birth:

Social Security #:

GEORGIA LICENSE APPLIED FOR - CHECK ONLY ONE: ☐ Marriage and Family Therapist

☐ Professional Counselor

☐ Clinical Social Worker

☐ Master Social Worker

Jurisdiction:

License Number:

Title of License:

Original Date Issued:

Expiration Date:

TO WHOM IT MAY CONCERN

I, the undersigned applicant, am applying for a license with the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists. I hereby consent to the release of any information, favorable or otherwise, which you may have concerning my license or practice. Please return the completed form directly to the Georgia Board at the above address.

Date

Signature of Applicant

PART II - LICENSURE BOARD OR REGULATORY AGENCY CERTIFICATION

I, _____, Board Chair or Designated Official
of the _____

(Name of Board or Regulatory Agency)

certify that the information provided above by this applicant ☐ does ☐ does not conform with that in our record.

If "does not", please explain: _____

According to our record, the applicant ☐ has ☐ hasn't been disciplined by this or any other Board, state agency, or professional organization. If the applicant has been disciplined, please explain and attach a copy of the Order or Decree:

Date

Signature of Board Chair/Designated Official

Title of Official

Street Address

BOARD SEAL

City/State/Zip Code

MAIL: GA Composite Board, 237 Coliseum Drive, Macon, GA 31217

FAX: 866-888-7127 * E-Mail: ExamBoards-Healthcare@sos.state.ga.us