West Virginia Board of Examiners in Counseling
815 Quarrier Street, Suite 212
Charleston, West Virginia 25301
Telephone: (304) 558-5494 Email:
Cheryl.J.Henry@wv.gov
website: www.wvbec.org

Please print Or type

Application for Licensure by Endorsement as a Licensed Professional Counselor

1. NAME: _____
Last First Middle

2. Other Last Name (s) used on records or in practice: _____

3. Please print your name as you would like it to appear on your license:

_____

4. Social Security #: _____/_____/_____

5. Date of Birth: _____ 5a. County of Residence: _____

6. HOME ADDRESS: _____
Box or Street Number City State Zip Code

7. EMAIL ADDRESS: _____ ☐None
(If you have multiple addresses, please give WVBEC the one most frequently read)

8. PHONE NUMBERS: (_____) _____ - _____(_____) _____ - _____
Home Work

9. PROFESSIONAL ROLE (Check One): Counselor: _____ Supervisor: _____

10. EDUCATION (chronological order) Master's level and above

Name and Address of Institution	Dates MO/Yr.	Major/Minor	Degree & Year Awarded	Total # of Qtr/Semester hrs. completed

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11. PROOF OF HAVING PASSED THE NATIONAL COUNSELOR EXAM (NCE), or the national clinical mental health counseling examination (NCMHCE) or other certification examination in counseling approved by the board. (27-1-5.3.a.1) List name of exam and date passed: **Official passing exam scores are required by the board. Please see Instruction/Checklist for more information.**

Exam Name: _____ Date Passed: _____ Score: _____

12. VERIFICATION OF LICENSURE STANDING FROM ALL JURISDICTIONS WHERE CURRENTLY LICENSED: (27-1-5.3.a.3.) **ATTACHMENT A: OUT-OF-STATE LICENSE VERIFICATION FORM MUST ALSO BE COMPLETED. (See Page 7)**

State or Organization	Type / Number	Issue Date	Expiration Date

11. CERTIFICATIONS HELD –optional (e.g. NCC, CAC, CRC, etc.)

State and/or Organization	Type / Number	Issue Date	Expiration Date

Per Series 1, Licensing Rule – 27-1-5.3. Should the endorsement applicant have actively practiced mental health counseling as a licensed professional counselor by maintaining an ongoing caseload for at least five of the last seven years in another jurisdiction, immediately preceding application, YOU MAY SKIP # 12 and #13 and PROCEED, ITEM #14. (See Instruction Sheet for more information.)

12. PROFESSIONAL RECOMMENDATIONS

- **Two forms required with application. Please see Instruction/Checklist for more information. Form available on application CD and at wvbec.org**

1) _____
Name Address

2) _____
Name Address

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Name: _____

13. OFFICIAL GRADUATE TRANSCRIPTS (To be mailed directly from the institutions)
List institutions providing official transcripts.
APPLICANT MUST COMPLETE A TRANSCRIPT REVIEW FORM. See application CD for form and detailed instructions for completing the form:

1) _____2)_____

You will need to copy this page if you have more than two clinical counseling positions to report. Any position that is part of your supervised experience needs to be reported in this application.

14. PROFESSIONAL and CLINICAL EXPERIENCE (List current experience first)

Position: _____ Dates: _____
(Please attach a current job description with this application)

Employer: _____ Phone: (____) _____ -_____

Address: _____
Box or Street Number City State Zip Code

On-site Supervisor: _____Type of License_____ License #_____

Clinical Supervisor _____Type of License_____License #_____

14. PROFESSIONAL and CLINICAL EXPERIENCE (List current experience first)

Position: _____ Dates: _____

Employer: _____ Phone: (____) _____ -_____

Address: _____
Box or Street Number City State Zip Code

On-site Supervisor: _____Type of License_____ License #_____

Clinical Supervisor _____Type of License_____License #_____

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If space is inadequate, continue on separate sheet, noting attachment(s). All attachments must have name and social security number in upper right corner.

15. CONTINUING EDUCATION / SPECIAL TRAINING

List relevant continuing education in form of post-graduate seminars, workshops, etc. Give number of hours or name and credit. (Please do not attach certificates)

16. COUNSELING SPECIALIZATION / COMPETENCIES

Describe specific counseling areas you claim competence. Support each claim separately by identifying articles authored, awards and citations received, professional memberships held, specialized education completed, or other objective data.

17. STATEMENT OF COUNSELING PHILOSOPHY

Summarize your philosophy of counseling, identifying individuals whose teachings and/or writing have influenced your approach to counseling.

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18. GROUNDS FOR REFUSAL, REVOCATION, OR SUSPENSION

Have you in any State or Commonwealth:

For any "yes" response, use separate sheet for explanation. All attachments must have name and the last four digits in your social security number in the upper right corner.

1. Been delayed completing a graduate degree program in order to fulfill a written remediation program issued to you by the degree program? Yes _____ No _____
2. Terminated from a graduate degree program? Yes _____ No _____
3. Suspended a previous effort to be licensed? Yes _____ No _____
4. Attempted to obtain licensure by fraud, deceit, or willful misrepresentation? Yes _____ No _____
5. Been denied licensure in the past? Yes _____ No _____
6. Subject to disciplinary action by any counselor licensing agency, professional association, or agency that provides services to citizens? Yes _____ No _____
7. Have disciplinary action pending against you by any licensing agency, professional association, or agency that provides services to citizens? Yes _____ No _____
8. Had your license to practice suspended or revoked? Yes _____ No _____
9. Voluntarily surrendered a professional license? Yes _____ No _____
10. Named as a defendant in a civil suit related to your professional practice? Yes _____ No _____
11. Been convicted of a felony? Yes _____ No _____
12. Currently have any disease or condition that may interfere with your ability to competently and safely perform the essential functions of the counseling profession, including any disease or condition generally regarded as chronic by the medical community, i.e. (a) mental or emotional disease or condition; (b) alcohol or other substance abuse; (c) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in the practice of counseling? Yes _____ No _____

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Pursuant to WV Code 48 -15-303, each applicant for licensure must answer the following questions and certify, under penalty of false swearing, that these answers are true and correct.

1. Do you have a child support obligation?	☐ Yes ☐ No
2. If the answer to question 1, above, is yes, are you in arrearage?	☐ Yes ☐ No
3. If the answer to question 2, above, is yes, does your arrearage equal or exceed the amount of child support payable for six (6) months?	☐ Yes ☐ No
4. Are you the subject of a child support related subpoena or warrant?	☐ Yes ☐ No

If you make a false statement concerning any question on this application, you may be subject to disciplinary action including, but not limited to, immediate revocation or suspension of your license.

I, _____, do hereby certify, under penalties of perjury and false swearing, that the above questions are true and correct to the best of my knowledge.

I authorize the West Virginia Board of Examiners in Counseling to make such inquiry necessary in validating information contained in this application.

The undersigned, being sworn, deposes and says that he/she is the person who executed this application; that the statements contained herein are true in every respect; that he/she has not suppressed information that might affect this application; that he/she will conform to the Code of Ethics of the West Virginia Board of Examiners in Counseling; and that he/she has read and understands this affidavit.

_____
Signature of Applicant

Sworn before me this _____ day of

_____, _____

_____
Notary Public

Photograph must be attached prior to Notary Seal

Board Policy requires that each applicant attach a photograph taken within the last 12 months. Photograph must be attached prior to Notary Signature.

Photograph should be no larger than this square.

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Application for Licensure by Endorsement as a Licensed Professional Counselor

ATTACHMENT A

OUT- OF- STATE LICENSE VERIFICATION FORM

(Page 1 of 3)

Instructions:
Section 1 is to be completed by the applicant and then sent to the out of state board for completion. Additional copies of this form may be made and used as needed by the applicant.
Section 2 is to be completed by a representative of the out-of-state board and mailed directly to the board office.

I. Section I: This section is to be completed by the applicant:

A. Name: _____

B. Social Security #: _____/_____/_____ Date of Birth: _____

C. Maiden or other name in which license was issued: _____

D. Type of Credential held in the other state: _____

E. Type or Field of Practice: _____

F. License Number: _____

G. Date of Issuance: _____ H. Date of Expiration: _____

I. Level of Licensure (Bachelors, Masters, Doctorate): _____

J. Current licensing requirements to be submitted with out of state form? Yes __No __

II. Section 2: This section is to be completed by the State Licensing Board:

A. Type of Credential: Licensure _____ Registration _____ Certification _____

B. Type or Field of Practice: _____

C. License/Registration/Certificate Title: _____

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ATTACHMENT A

OUT- OF- STATE LICENSE VERIFICATION FORM

(Page 2 of 3)

PLEASE PRINT CLEARLY

D. License/Registration/Certificate Number: _____

E. Date Issued: _____ F. Date of Expiration: _____

F. Did License ever lapse or expire prior to date of expiration listed in Letter "D"?

Yes _____ No _____ If yes, please explain: _____

_____

G. Level of License/Registration/Certificate (Bachelor, Masters, Doctorate): _____

H. Does this license allow independent practice? Yes _____ No _____

I. Is License/Registration/Certificate in Good Standing? Yes _____ No _____

If no, please state reason(s): _____

_____

J. Has the Lic./Reg./Cert. ever been suspended or revoked? Yes _____ No _____

If yes, please state reason(s): _____

_____

K. Has the Lic./Reg./Cert./ ever been surrendered voluntarily in lieu of an investigation?

Yes _____ No_____ _____ If yes, please explain: _____

_____

L. Current licensing requirements are attached with this clearance form? Yes ___ No ___

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ATTACHMENT A

OUT- OF- STATE LICENSE VERIFICATION FORM

(Page 3 of 3)

PLEASE PRINT CLEARLY

M. Examination Information:

Name of examination taken? _____

Who administered the examination? _____

Through what state or jurisdiction? _____ Exam Date: _____

Required score to pass? _____ Score Received? _____ Passing Score? Yes ____ No_____

Additional Comments:

Signature of State Board Representative completing this form:

_____ Date: _____

Printed Name: _____

Official Title/Position: _____

State or Jurisdiction: _____

Agency: _____

Mailing Address: _____
Street City State Zip

Phone Number: _____ Fax #: _____

Email Address: _____

Website: _____

Upon completion, please return this form to:

WVBEC, Out-Of-State-License Verification,
815 Quarrier, St., Suite 212
Charleston, WV 25301

Place Official Seal here:

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Charleston, West Virginia 25301
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Attachment B
VERIFICATION OF ACTIVE CLINICAL PRACTICE

Complete **ONLY IF** you have been licensed for five (5) of the last seven (7) years immediately preceding the date of submission of application for licensure and meet the requirements as per Series 1, LPC Licensing Rule, 27-1-5-3.

The West Virginia Board of Counseling, in its consideration of the named applicant below, depends on information from persons and institutions regarding the candidate's ongoing clinical practice. **Please complete this form to the best of your ability and return directly to the board address OR to the applicant in a sealed envelope that includes your signature at the flap.**

By providing this form to references, the applicant authorizes past and present employers, businesses, professional associates and personal references to release to the West Virginia Board of Counseling any information requested by the Board in connection with the processing of the application for licensure.

I. TO BE COMPLETED BY THE APPLICANT:

Applicant Name: _____ Telephone #:_____

Current Address: _____
Street City State Zip

II. VERIFICATION INFORMATION:

Name: _____ Email Address: _____

Relationship to Applicant: _____

I certify that _____, an applicant for licensure in the state of West Virginia, was in active counseling practice, and maintained an ongoing case load from: _____ to: _____, located at
(Dates of practice)

_____.
Name of agency/company

_____ _____
Date Signature

_____ _____
Current Position & Title Agency Name and Address

_____ _____
Telephone # including area code City, State and Zip Code