



Washington State Department of

Health

Mental Health Credentialing

P.O. Box 47877

Olympia, WA 98504-7877

360-236-4700

Out-of-State Credential Verification

Applicant Name: _____ Birth date: _____
mm/dd/yyyy

I, _____, Secretary of _____,

hereby certify that _____
Official Name of Board

was granted state Registration Certificate License

Number: _____ to practice _____

in the State of _____ on the _____ day of _____, 20_____.

Legal/Disciplinary Action: Yes No

If Yes, explain: _____

On the basis of: _____

Did applicant take and pass the NBCC Exam?

Yes No Passing Score:

Yes No 100 hours immediate postgraduate supervision with an approved licensed mental health practitioner or equally qualified licensed mental health practitioner.

Yes No 3000 hours supervised postgraduate experience with approved licensed mental health practitioner or equally qualified licensed mental health practitioner.

Yes No 1200 hours must be direct counseling with individuals, couples, families or groups.

Yes No 36 months full time counseling with a qualified licensed mental health counselor.

Status of License: Current Expiration Date: _____

Expired Date: _____

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Official Name of Board Phone (enter 10 digit #)

Secretary

Date Certification Prepared