

**State of Oregon  
BOARD OF LICENSED  
PROFESSIONAL COUNSELORS & THERAPISTS**

**Diagnosis Training & Experience Attestation**

Name: \_\_\_\_\_ License #(s) \_\_\_\_\_

I attest that:

1) I have training in the diagnosis of mental disorders; Yes  No

and

2) I have 3 years of clinical experience that included diagnosis of mental disorders. Yes  No

or

3)  I am currently not practicing and have notified the Board; I plan to return to practice. \_\_\_\_\_

I swear/affirm that the information provided above is accurate.

\_\_\_\_\_  
Signature (required)

\_\_\_\_\_  
Date (required)

**Please return the completed and signed form to the Board office by December 15, 2009.** You may send the form by mail, facsimile, or as an attachment to an email message with the word "Attestation" in the subject line. You do not need to provide documentation of your training and experience. The Board will audit 10% of attestation forms through a random selection process. We will ask you for documentation only if you are selected for audit.

**Mail to:** Board of Counselors and Therapists  
3218 Pringle Road SE, #250  
Salem, OR 97302-6312

**Fax:** 503.373.1427

**Email:** [lpct.board@state.or.us](mailto:lpct.board@state.or.us)

**Background information and details about the requirements are attached to this form.**