**VERIFICATION OF LICENSURE (Form #4)**

**Oregon Applicant:** Complete this section authorizing release of information by another state licensing program and mail this form and any necessary fees to the appropriate state agency.

Name: ___________________________ Lic. / Cert./Candidate No. ___________________________

I hereby authorize the release of information to the Oregon Board of Licensed Professional Counselors and Therapists.

______________________________
Signature

______________________________
Date

**TO BE COMPLETED BY STATE IN WHICH THE ABOVE INDIVIDUAL IS LICENSED**

1. State of licensure: ___________________________ Title of license: ___________________________

2. The name of the licensee, as shown in your records: ___________________________

3. The license number is: ___________ First issue [date]: ___________________________

4. At the present time is this license: Current? ☐ YES ☐ NO Active? ☐ YES ☐ NO

5. Has the licensee ever received disciplinary action? ☐ YES (If YES, please attach an explanation) ☐ NO

   Does the licensee have a pending investigation? ☐ YES (If YES, please attach an explanation) ☐ NO

**6. REQUIREMENTS FOR LICENSE AT THE TIME THIS INDIVIDUAL WAS FIRST LICENSED:**

**EDUCATION**

Degree: ___________________________ In: ___________________________

**EXPERIENCE**

Years of supervised work experience: ___________ Hours of post-degree direct service: ___________

**EXAM**

Was passage of an exam required as a condition of licensure? ☐ Yes ☐ No

Name of exam passed to obtain this license: ___________________________

Date Taken: ___________________________ Minimum Passing Score: ___________________________

Licensee’s Score: ___________________________

☐ Yes ☐ No

**A COPY OF THE LICENSE REQUIREMENT RULES FOR THE INITIAL YEAR MUST BE ATTACHED.**

Was this license issued by:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reciprocity</td>
<td>☐</td>
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<tr>
<td>Portability</td>
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<td>☐</td>
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<tr>
<td>Mutual recognition</td>
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</tbody>
</table>

Recognition of non-governmental prof. certification or membership? ☐ Yes ☐ No

Grand parenting? ☐ Yes ☐ No

Waiver of education, examination, or experience requirements? ☐ Yes ☐ No

______________________________
Signature of Person Completing Form and Official Title

______________________________
Date

Printed Name and Title

Agency / Organizational Name

Address:

Affix Board Seal Here