

**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  
 Has the licensee ever received a reprimand?  YES (If YES, please attach an explanation.)  NO  
 Has the licensee ever received a letter of concern?  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: \_\_\_\_\_

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

**Was this license issued by:**

Reciprocity  Yes  No  
 Portability  Yes  No  
 Mutual recognition  Yes  No

Recognition of non-governmental professional 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 \_\_\_\_\_

*Affix Board Seal Here*

Agency / Organizational Name \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Please return form to:**  
 Oregon Bd. of Licensed Professional Counselors & Therapists  
 3218 Pringle Rd SE #120  
 Salem, OR 97302-6312  
 [503] 378-5499