Virginia Department of Health Professions
Board of Counseling

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# APPLICANT OUT-OF-STATE LICENSURE/CERTIFICATION VERIFICATION

**Part I. To be completed by the applicant:**

| **INSTRUCTIONS** | **PLEASE TYPE OR PRINT CLEARLY** |
|---|---|
| Name of Applicant (Last, First, Middle) | |
| Mailing Address (Street and/or Box Number, City, State, Zip) | |
| Applicants Email Address | Home and/or Cell Telephone Number |

**Part II. To be completed by state Licensing Authority:**

| **INSTRUCTIONS** | **PLEASE TYPE OR PRINT CLEARLY** |
|---|---|
| Title of License | License Number |
| Issue Date | Expiration Date |
| Obtained by Method<br>By Examination By Waiver By Endorsement Reciprocity | |
| Is there any public information relating to this license?<br>Yes (specify details on a separate sheet) No | |
| Certification by the authorized Licensure Official of the State of _____<br>I certify that the information is correct.<br>Authorized Licensure Official Name and Title _____ | |
| State Seal | Title of Board _____<br>Telephone Number _____<br>Email Address _____<br>Date _____ |