

Please return form to:
OBLPCT
3218 Pringle Rd SE #120
Salem, OR 97302-6312
(503) 378-5499

Oregon Board of Licensed Professional Counselors and Therapists

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: _____

 **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 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*