

COMMONWEALTH OF VIRGINIA
Department of Health Professions
Board of Counseling

Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Email: coun@dhp.virginia.gov
Phone: (804) 367-4610 Fax: (804) 527-4435
Website: www.dhp.virginia.gov/counseling

LPC APPLICATION INSTRUCTIONS
Initial Registration of Supervision for a Resident in Counseling

Completed Application: The application must be signed by the resident and supervisor. To avoid delays, please provide a complete application packet. Incomplete packets will not be reviewed by the Credential Reviewer.

Application Fee: A fee of **\$65.00** is required for an application to be processed. All fees paid by check or money order must be made payable to the “Treasurer of Virginia”. This fee is non-refundable. The application is valid for one year from date of receipt.

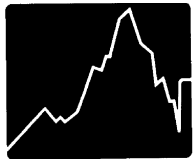
The below supplemental documentation must accompany your application and fee in one packet:

- Verification of Education:** An official graduate transcript with conferral date is required.
- Verification of Required Coursework and Internship:** To be completed by your graduate program and sent to the Board within your application packet.
- Supervisor must be a LPC or LMFT with Evidence of Supervision Training:** If your supervisor is not listed on the Supervisor Registry, you must submit evidence that your supervisor received professional training in supervision, consisting of three credit hours or 4.0 quarter hours in graduate-level coursework in supervision or at least 20 hours of continuing education in supervision offered by a provider approved under 18VAC115-20-106.
- Name Change:** If applicable, documentation must be provided if your name has legally changed through marriage, divorce, or a court order. A photocopy of your marriage license or a copy of the court order must be provided.

Please note:

In order to be considered for residency, all requirements outlined in Regulations 18VAC115-20-49 and 18VAC115-20-51 must be met.

Supervised work experience occurring in Virginia, in any setting, must be registered and approved by the Board prior to beginning that supervision. An applicant may not count hours towards licensure unless that supervised experience has been registered with the Board. Supervision that is not concurrent with a residency will not be accepted, nor will residency hours be accrued in the absence of board-approved supervision.



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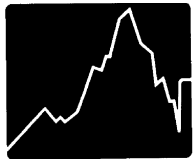
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Military/Military Spouse:

Are you active duty military personnel? **Yes** **No**

Are you the spouse of a member of the U.S. military who has been transferred to Virginia and who had to leave employment to accompany your spouse to Virginia? **Yes** **No**

<p align="center">LPC Licensed Professional Counselor</p> <p>Complete All Sections</p> <p>Application Fee of \$65.00 is Non-Refundable</p> <p>Application forms lacking a Social Security or VA DMV number will not be processed.</p> <p>Mail all required documentation and fee to:</p> <p>Board of Counseling 9960 Mayland Dr., Suite 300, Henrico, Virginia 23233</p> <p>All signatures must be original.</p>	<p>Legal Name (First, Middle, Last)</p> <div style="border: 1px solid black; height: 30px;"></div>																
	<p>Other Names Used on Official Documents (i.e. transcripts)</p> <div style="border: 1px solid black; height: 30px;"></div>	<p>Sex (Circle)</p> <p>Male Female</p>															
	<p>Public Address (Street/Box Number, City, State, Zip)</p> <div style="border: 1px solid black; height: 40px;"></div>																
	<p>Mailing Address (Street/Box Number, City, State, Zip)</p> <div style="border: 1px solid black; height: 40px;"></div>																
	<p>Home Phone Cell Phone</p> <div style="border: 1px solid black; height: 30px;"></div>																
	<p>Business Phone with extension</p> <div style="border: 1px solid black; height: 30px;"></div>																
	<p>Email</p> <div style="border: 1px solid black; height: 30px;"></div>																
	<p>Social Security Number (or VA DMV #) Date of Birth</p> <div style="border: 1px solid black; height: 30px;"></div>																
	<p>Education/Training (List in chronological order all graduate schools attended. Include transcripts.)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Degree Earned</th> <th style="width: 15%;">Date Degree Received</th> <th style="width: 15%;">Major</th> <th style="width: 15%;">Attendance Dates-mm/yr</th> <th style="width: 40%;">Institution Name/State</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>		Degree Earned	Date Degree Received	Major	Attendance Dates-mm/yr	Institution Name/State										
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Ethics Attestation: Please answer the five questions below. **If you answer yes to any question, include a detailed explanation or supporting documentation. Refer to Guidance Document 115-2 for detailed information on the requirements with a criminal conviction.**

1. Have you ever been denied the privilege of taking an occupational license or certification examination? Yes No
 If yes, state what type of occupational examination and where: _____
2. Have you ever had any disciplinary action taken against an occupational license to practice or are any such actions pending? If yes, explain in detail on a separate sheet of paper Yes No
3. Have you ever been convicted of a violation or pled nolo contendere to any federal, state or local statute, regulation or ordinance or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations and driving under the influence). Yes No
 If yes, explain in detail on a separate sheet of paper and provide court documents.
4. In the last twelve (12) months, have you been unable to practice counseling by reason of excessive use of alcohol, drugs, chemicals or any other type of material or as a result of any mental or physical condition? If yes, please provide an explanation on a separate sheet of paper. Yes No
5. Have you ever been censured, warned, or requested to withdraw from your employment, terminated from any health care facility, agency, or practice? If yes, provide an explanation on a separate sheet of paper. Yes No
6. Are you the respondent in any pending or unresolved board action in another jurisdiction or in malpractice claim? Yes No

Per the Regulations, only a qualified LPC or LMFT, can supervise a resident in counseling

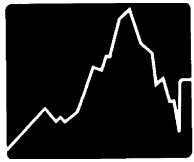
SUPERVISOR'S INFORMATION:		
Supervisor's Name: (Last, First)	License Number:	License Type:
Business Name and Address of Supervisor's worksite:		
Email Address:	Business Phone Number:	

Supervisors: If you are listed on the Supervisor registry on the Board's website, you are not required to complete this section. Otherwise, please provide the information requested below, along with certificates of completion or transcript.

Date	Organization that provided training	Title of the seminar/conference/workshop	Credit hours

Please indicate the NAME and ADDRESS of the location where the RESIDENT will provide counseling services. (one worksite)

Worksite Name:
Worksite Mailing Address (Street and/or Box Number, City, State, Zip)



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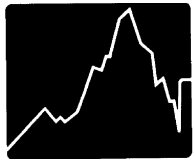
Please indicate if the supervised experience during the residency will be in the role of a professional counselor working with various populations, clinical problems and theoretical approaches in the following areas as required by 18VAC115-20-52.

Does this worksite and position incorporate all of the below requirements? If not, explain on separate page.	Yes	No
<ul style="list-style-type: none"> • Assessment and diagnosis using psychotherapy techniques • Appraisal, evaluation and diagnostic procedures • Treatment planning and implementation • Case management and recordkeeping • Professional counselor identity and function • Professional ethics and stands of practice 	If no, explain on separate page	
Will the supervisor be on-site in the same facility where the resident is providing services?	Yes	No

Resident's Initial	Supervisor's Initial	Statement of Assurance
		I have read, understand and intend to comply with the regulations that govern the Virginia Board of counseling licensees and applicants.
		I understand that the Supervisor is prohibited from providing supervision to any individual whose relationship with the Supervisor would compromise objectivity.
		I understand that the Supervisor assumes full responsibility for the clinical activities of the Resident for the duration of the residency. The Supervisor is responsible for ensuring that the Resident does not practice outside of the scope of his/her education.
		I understand that the Supervisor shall complete evaluation forms to be given to the Resident at the end of each three-month period.
		I understand that the Supervisor shall report the total hours of residency by completing the verification of supervision form at the end of the residency.
		I understand that the Supervisor must immediately report to the Board any unethical practice performed by the Resident, in accordance with regulation 18VAC115-20-130.
		I understand that the Supervisor must ensure that all clients of the Resident are informed of the Resident's status and the Supervisor's contact information.
		I understand that the residency must be completed in no less than 21 months and no more than four years.
		I understand that the Resident may only use the title "Resident in Counseling" and shall not present himself/herself in a way that may appear to be independent practice.
		I understand that the Supervisor will ensure that the Resident does not bill directly for services and that all payments, both cash and insurance, are paid to the Supervisor, or the Resident's employer.
		I understand that any violations of the regulations by the Supervisor or the supervisee, including but not limited to allowing unlicensed practice, misrepresenting the Resident's status to clients, allowing the Resident to bill directly, may result in disciplinary action before the Board of Counseling.

I attest that the information contained within the application is true and accurate to the best of my knowledge and belief.

Resident Signature:	Date:
Supervisor Signature:	Date:



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LICENSED PROFESSIONAL COUNSELOR (LPC)

VERIFICATION OF REQUIRED COURSEWORK AND INTERNSHIP FORM

TO BE COMPLETED BY THE APPLICANT

Applicant's Name (Last, First, Middle)

Institution where internship took place (include city and state)

Name of Program

Applicant's Student ID Number

Applicant's Social Security Number or VA DMV Number

**TO BE COMPLETED BY GRADUATE SCHOOL PROGRAM OFFICIAL OR
ADMINISTRATION OFFICE**

Please verify in the table below that the required coursework was successfully completed by the applicant by listing the relevant required core courses taken. All courses are required and must be graduate level from a college or university approved by a regional accrediting agency or CACREP. Do not list courses that are not directly related to counseling. If a course title is not clearly indicative on the transcript, please attach college catalog description(s) or course syllabi. **A graduate course cannot be counted for more than one core area.** All information provided is subject to Board review and approval.

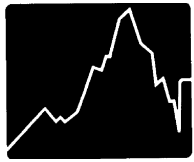
DESIGNATE SEMESTER HOURS WITH AN "S" AND QUARTER HOURS WITH A "Q"

- Professional counselor identity, functions and ethics.** This course provides a foundation in professional counselor identity and ethical practice, including the study of the history and philosophy of the counseling profession, professional counselor function and credentialing and ethical standards for practice in the counseling profession.

Course Code	Course Title	S/Q Hours	College/University

- Theories of Counseling and Psychotherapy.** This course provides an overview of the basic tenets and applications of currently preferred theories of counseling and psychotherapy including the study of humanistic, cognitive-behavioral, psychodynamic and post-modern theoretical orientations.

Course Code	Course Title	S/Q Hours	College/University



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3. **Counseling and Psychotherapy Techniques.** This course provides a didactic and experiential overview of basic techniques used in the counseling process including establishing the counseling relationship, setting treatment goals, applying listening and interviewing skills, initiating termination and referral, and recognizing parameters and limitations of the treatment process.

Course Code	Course Title	S/Q Hours	College/University

4. **Human Growth and Development.** This course provides an overview of contemporary theoretical perspectives regarding the nature of developmental needs and tasks from infancy through late adulthood, the influences of development on mental health and dysfunction and the promotion of healthy development across human life span.

Course Code	Course Title	S/Q Hours	College/University

5. **Group Counseling and Psychotherapy, Theories and Techniques.** This course provides a didactic and experiential overview of group counseling process and dynamics, contemporary group counseling theories, and group counseling leadership skills including group selection, group formation, group interventions and group evaluation.

Course Code	Course Title	S/Q Hours	College/University

6. **Career Counseling and Development Theories and Techniques.** This course provides an overview of career development and counseling including study of factors influencing career development, contemporary theories of career decision-making, career assessment and group and individual career counseling techniques.

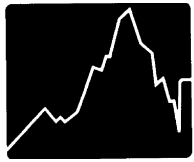
Course Code	Course Title	S/Q Hours	College/University

7. **Appraisal, Evaluation and Diagnostic Procedures.** This course introduces students to the selection, administration; scoring and interpretation of contemporary psychological assessments used by professional counselors and includes the study of formal and information assessment procedures, basic test statistics, test validity and reliability, and the use of test findings in the counseling process.

Course Code	Course Title	S/Q Hours	College/University

8. **Abnormal Behavior and Psychopathology.** This course provides students with an overview of the major categories of mental disorders including study of their etiology and progression, their prevalence and impact on individuals and society, their diagnosis according the DSM-V and the use of diagnosis in treatment planning and counseling intervention.

Course Code	Course Title	S/Q Hours	College/University



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9. **Multicultural Counseling.** This course provides students with an overview of the diverse social and cultural contexts that influence counseling relationships (e.g., culture, race, ethnicity, age, gender, SES, sexual orientation) including the study of current issues and trends in a multicultural society, contemporary theories of multicultural counseling, the impact of oppression and privilege on individuals and groups and personal awareness of cultural assumptions and biases.

Course Code	Course Title	S/Q Hours	College/University

10. **Research.** This course provides students with an overview of the principles and processes of performing counseling research including the study of quantitative and qualitative research designs and methods, methods of statistical analysis used in research, and reading and interpreting research results.

Course Code	Course Title	S/Q Hours	College/University

11. **Diagnosis and Treatment of Addictive Disorders.** This course provides students with an overview of addictive disorders including the study of contemporary theories of addictive behavior, pharmacological classification of addictive substances, assessment of addictive disorders and currently preferred models of addictions treatment.

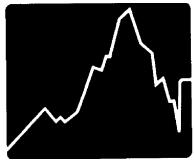
Course Code	Course Title	S/Q Hours	College/University

12. **Marriage and Family Systems Theory.** This course provides students with an overview of counseling with couples and families include the study of the rationale for family therapy intervention, the dynamics of general systems theory, the states of family life-cycle development, and contemporary theories of family therapy intervention.

Course Code	Course Title	S/Q Hours	College/University

13. **Supervised Internship.** This course provides students with a minimum of 600 hours of experience in a clinical field placement including (but not limited to) 240 hours of face-to-face client contact.

Course Code	Course Title	S/Q Hours	College/University



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VERIFICATION OF INTERNSHIP FOR LPC LICENSURE

USE THIS FORM TO DOCUMENT YOUR REQUIRED INTERNSHIP HOURS

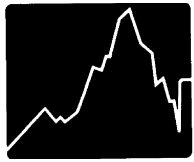
Applicant's Name (Last, First, Middle)

Applicant's Student ID Number

Applicant's Social Security Number or VA DMV Number

Is the college or university approved by a regional accrediting agency?	Yes	No
Is the college or university CACREP or CORE accredited?	Yes	No
Did internship begin after completion of 30 graduate semester hours?	Yes	No
Total number of supervised internship hours:		
Total face-to-face client contact internship hours:		
If applicable, what type of licensure did the supervisor hold?		
Number of individual supervision hours during internship?		
Number of group supervision hours during internship?		
If applicable, total direct client contact hours with couples and/or families :		
If applicable, total direct client contact hours treating substance abuse-specific treatment problems:		

Name of School	
Name of Program Official	Title
Email Address of School Official	Phone Number of School Official
Signature of School Official	Date



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QUARTERLY EVALUATION FOR LPC LICENSURE

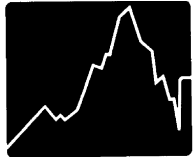
Section 115-20-52-D-3 of the Virginia LPC regulations requires that the applicant's supervisor provide quarterly evaluations to the resident. This form must be signed and dated by the supervisor. **This form is to be completed by the supervisor each quarter and provided to the resident to be held in their possession until they are ready to submit their licensure application.**

Name of Applicant (Last, First, Middle)	Applicant's Email Address	
SUPERVISOR'S EVALUATION:		
Supervisor's Name (Last, First)	License Number:	License Type:
Business Name and Address of Residency Work Site Where Clinical Hours Were Obtained (ONE LOCATION ONLY)		
Dates of supervision: From (mm/dd/yy): _____ To (mm/dd/yy): _____		

All Columns Must Be Completed	Hours per week	Total hours	Hours are duplicated on another supervisor's quarterly form
Total hours of supervised residency (face-to-face client contact hour + ancillary hours)			Yes No
How many <u>Face-to-face Client Contact</u> hours did the resident provide?			Yes No
How many <u>Individual Supervision</u> hours did the resident receive?			
How many <u>Group Supervision</u> hours did the resident receive?			
If applicable, Total number of face-to-face client contact with Couples and Families or both.			Yes No
If applicable, Total number of face-to-face client contact hours clinical substance abuse treatment services.			Yes No

These areas are outlined in Section 18 VAC 115-20-52 of the LPC Regulations. The resident must have supervised residency in the **role of a professional counselor working with various populations, clinical problems, and theoretical approaches** in the below areas.

Did the applicant provide assessment and diagnosis using psychotherapy techniques while under your direct supervision?	Yes	No
Did the applicant provide appraisal, evaluation and diagnostic procedures while under your direct supervision?	Yes	No
Did the applicant provide treatment planning and implementation while under your direct supervision?	Yes	No
Did the applicant provide case management and recordkeeping while under your direct supervision?	Yes	No
Did the applicant demonstrate minimum competencies of professional counselor identity and function while under your direct supervision?	Yes	No
Did the applicant demonstrate minimum competencies professional ethics and standards of practice while under your direct supervision?	Yes	No
Do you have any concerns about the competency of the resident? If yes, explain on separate page.	Yes	No
Supervisor's Signature: _____		Date: _____



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REQUEST FOR TERMINATION OF SUPERVISION

This form should be used to notify the Virginia Board of Counseling of the termination of a board-approved supervisory contract between a supervisor and resident-in-counseling. At the conclusion of the supervised residency, the supervisor shall provide the resident with a completed the Verification of Clinical Supervision form to be held in their possession until they are ready to submit their licensure application.

Resident-in-Counseling Information:

Resident's Name (Last, First)	Resident's Telephone Number
Resident's Email Address	

Supervisor's Information:

Supervisor's Name (Last, First)	Supervisor's Telephone Number
Supervisor's Email Address	Supervisor's License Number:

Supervised Residency Information:

Name of Supervision Work Site:
Address of Supervision Work Site (Street, City, State, Zip):
Date of Termination:

Please email, fax or mail this completed form to:

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