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
Licensed Professional Counselor (LPC) by Examination

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

Application Fee: A fee of **$175.00** 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. If you were previously approved for residency, a duplicate transcript is not required.

- ☐ **Verification of Required Coursework and Internship**: To be completed by your graduate program and sent to the Board within your application packet. If you were previously approved for residency, a duplicate Verification of Coursework and Internship is not required.

- ☐ **Verification of Supervision**: The Verification of Supervision form should be completed by your supervisor, verifying hours obtained during your supervised residency. Original signatures are required. Note: *A separate verification of supervision form must be submitted for each supervisor and/or location.*

- ☐ **Quarterly Evaluations**: The Quarterly Evaluation forms should be completed by your supervisor, verifying hours obtained during your supervised residency each quarter. Original signatures are required. Note: *A separate quarterly evaluation form must be submitted for each supervisor and/or location.*

- ☐ **Supervisor Summary Form**: The Supervisor Summary form should be completed and included with the application packet.

- ☐ **Out-of-State Licensure Verification**: If you have ever held or hold a licensure or certification as a mental health or health professional, whether current or expired, you must submit license verification. Please send the enclosed verification form to the issuing jurisdiction. This verification is to be completed by the issuing jurisdiction and mailed back to you and included in your application packet, or you can provide an online verification printed from your licensure jurisdiction website if the verification indicates that you have no disciplinary actions.

- ☐ **Licensure Verification of Out-of-State Supervisor**: If your supervision did not take place in Virginia, you must submit a verification of your supervisor's license. You may submit an online Verifications printed form the issuing license jurisdiction website or you may submit the enclosed verification form. The supervisor's license verification must be included in your application packet.

- ☐ **Clinical Scores***:* If you have passed the National Clinical Mental Health Counselors Examination **(NCMHCE**), prior to completing your supervision, please submit an official verification by contacting NBCC at (336) 482-2856.

- ☐ **NPDB Self-Query**: a current report from the U.S. Department of Health and Human Services National Practitioners Data Bank (NPDB) must be submitted. You may request a self-query at https://www.npdb.hrsa.gov.

- ☐ **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.

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Licensed Professional Counselor (LPC) by Examination Application

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**

LPC
Licensed Professional Counselor

Complete All Sections

Application Fee of $175.00 is Non-Refundable

Application forms lacking a Social Security or VA DMV number will not be processed.

Mail all required documentation and fee to:
Board of Counseling
9960 Mayland Dr., Suite 300,
Henrico,
Virginia 23233

All signatures must be original.

Legal Name (First, Middle, Last)

Other Names Used on Official Documents (i.e. transcripts)

Sex (Circle)
Male Female

Public Address (Street/Box Number, City, State, Zip)

Mailing Address (Street/Box Number, City, State, Zip)

Home Phone Cell Phone

Business Phone with extension

Email

Social Security Number (or VA DMV #) Date of Birth

Education/Training (List in chronological order all graduate schools attended. Include transcripts.)

Degree Earned	Date Degree Received	Major	Attendance Dates-mm/yr	Institution Name/State

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Licensed Professional Counselor (LPC) by Examination Application – Page 2

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? If yes, state what type of occupational examination and where: _____ □ **Yes** □ **No**

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). If yes, explain in detail on a separate sheet of paper and provide court documents. □ **Yes** □ **No**

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 of physical condition? If yes, please provide an explanation on a separate sheet of paper. □ **Yes** □ **No**

5. Have you ever been censored, 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**

Licenses / Certifications: List all mental health or health professional licenses or certificates that you hold or have ever held.

State	License #	Current License Status	Issue Date	Type of License

Attestation of Accuracy & Review of Virginia Regulations & Statutes: *By signing this document, I hereby certify that the information provided in this application is true, accurate and complete to the best of my knowledge and belief. I also certify that I have carefully reviewed and agree to apply the Statutes and Regulations Governing the Practice of Professional Counselors. I understand that my signature below must be notarized.*

Signature of Applicant: _____ Date: _____

AFFIDAVIT: The following statement must be executed by a Notary Public.

State of _____, County of _____

Name _____, being duly sworn, says that he/she is the person who is referred to in the foregoing application for licensure as a professional counselor in the Commonwealth of Virginia; that the statements herein contained are true in every respect, that he/she has complied with all requirements of the law; and that he/she has read and understands this affidavit.

Subscribed to and sworn to before me this _____ day of _____, 20_____.

Signature of Notary: _____.

My commission expires on _____.

My Commission # (if applicable): _____. SEAL

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APPLICANT OUT-OF-STATE LICENSURE/CERTIFICATION VERIFICATION

Part I. To be completed by the applicant:

PLEASE TYPE OR PRINT CLEARLY	
Name of Applicant (Last, First)	
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:

PLEASE TYPE OR PRINT CLEARLY			
Title of License		License Number	
Issue Date		Expiration Date	
Obtained by Method ☐ By Examination **Date taken:** **Name of Exam:** **Score:**	☐ By Waiver	☐ By Endorsement	☐ By Reciprocity
Is there any public information relating to this license? Yes (specify details on a separate sheet) No			

Certification by the authorized Licensure Official of the State of _____

I certify that the information is correct.

Authorized Licensure Official Name and Title _____

State Seal

Title of Board _____

Telephone Number _____

Email Address _____

Date _____

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VERIFICATION OF CLINICAL SUPERVISION FOR LPC LICENSURE

GENERAL INFORMATION - PLEASE TYPE OR PRINT CLEARLY			
Name of Applicant (Last, First)	Applicant's Email Address		
SUPERVISOR'S EVALUATION:			
Supervisor's Name (Last, First)	License Number:	License Type:	Supervisor's Telephone Number
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): _____ Total Months:_____			

Did the resident receive a minimum of one (1) hour and a maximum of four (4) hours of in-person supervision per 40 hours of work experience while under your **direct supervision**?	Yes No If no, explain on separate page	
Total amount of in-person hours of supervision with the resident.	Individual Hours:	Group Hours:
Did the applicant complete a minimum of 3,400 hours of supervised residency in the role of a professional counselor working with various populations, clinical problems and theoretical approaches under your **direct supervision**? If not, how many? _____	Yes No	
Did the resident complete at least 2,000 hours of face-to face client contact in providing clinical counseling services while under your **direct supervision**? If not how many? _____	Yes No	
Did the applicant demonstrate minimum competencies of **assessment and diagnosis using psychotherapy techniques** while under your direct supervision?	Yes No	
Did the applicant demonstrate minimum competencies of **appraisal, evaluation and diagnostic procedures** while under your direct supervision?	Yes No	
Did the applicant demonstrate minimum competencies of **treatment planning and implementation** while under your direct supervision?	Yes No	
Did the applicant demonstrate minimum competencies of **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	
In your opinion has the applicant demonstrated competency sufficient for licensing and the independent practice in clinical counseling services? If not, explain on separate page.	Yes No	

I declare that, to the best of my knowledge, the foregoing is true and correct. This evaluation has been discussed with the resident and a copy has been provided to the resident.

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 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"

1. **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

2. **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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SUPERVISOR OUT-OF-STATE LICENSURE/CERTIFICCATION 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	
Applicant's Email Address	Home and/or Cell Telephone Number

Part II. Supervisor's information to be verified:

Last Name _____ First Name _____ M.I. _____

Part III. To be completed by state Licensing Authority:

INSTRUCTIONS	**PLEASE TYPE OR PRINT CLEARLY**
Title of License	License Number
Issue Date	Expiration Date
Is there any public information relating to this license? Yes (specify details on a separate sheet) No	
Certification by the authorized Licensure Official of the State of _____ I certify that the information is correct. Authorized Licensure Official Name and Title _____	
State Seal	Title of Board _____ Telephone Number _____ Email Address _____ 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 Face-to-face Client Contact hours did the resident provide?			Yes No
How many Individual Supervision hours did the resident receive?			
How many Group Supervision 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:_____	