COMMONWEALTH OF VIRGINIA
Department of Health Professions
Board of Counseling

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VERIFICATION OF CLINICAL INDEPENDENT PRACTICE AS A LICENSED MARRIAGE AND FAMILY THERAPIST FOR 24 OF THE LAST 60 MONTHS IMMEDIATELY PRECEDING SUBMISSION OF APPLICATION FOR LICENSURE

The Virginia Board of Counseling, in its consideration of a candidate for licensure, depends on information from persons and institutions regarding the candidate's clinical independent practice for twenty-four of the last sixty months immediately preceding their licensure application in Virginia. Please complete this form to the best of your ability so the information you provide can be given consideration in the processing of this candidate's application in a timely manner.

By providing this form to references, the applicant authorizes past and present employers, businesses, professional associates and personal references to release to the Virginia Board of Counseling any information requested by the Board in connection with the processing of the application for licensure**.**

TO BE COMPLETED BY THE APPLICANT:

Last Name	First Name	M.I.
Street Address		
City	State	Zip Code
Email Address:	Phone Number:	

TO BE COMPLETED BY THE REFERENCE:

Last Name	First Name	M.I.
Street Address		
City	State	Zip Code
Email Address:	Phone Number:	

Relationship to Applicant:	

I certify that the above applicant for licensure in the Commonwealth of Virginia, was in active practice at:

Business Name of Agency or Private Practice:		
Street Address		
City	State	Zip Code
From: (mm/dd/yyyy)	To: (mm/dd/yyyyy)	
Reference Signature:		Date: