COMMONWEALTH OF 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:

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 _____