Virginia Department of Health Professions
Board of Counseling

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
www.dhp.virginia.gov/counseling

Email: coun@dhp.virginia.gov
(804) 367-4610 (Tel)
(804) 527-4435 (Fax

PAPER APPLICATION INSTRUCTIONS FOR LICENSURE AS A LICENSED PROFESSIONAL COUNSELOR (LPC) BY ENDORSEMENT

Completed Application: The application must have an **original signature**. 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:

- ☐ **Out-of-State Licensure Verification(s)**: 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 a 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.

- ☐ **Clinical Scores**: You must submit primary source of examination verification. This information must be provided by NBCC by calling (336) 482-2856. Your exam scores will be sent directly from NBCC to the Virginia Board of Counseling. If you took a state constructed exam, your scores will need to be provided directly from the licensing state.

- ☐ **NPDB Self-Query**: A current report from the U.S. Department of Health and Human Services National Practitioners Data Bank (NPDB) must be included. 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 by marriage, divorce, or a court order. A photocopy of your marriage license or a copy of the court order must be provided.

- ☐ **Verification of Education**: An official graduate degree transcript with conferral date is required.

- ☐ **Verification of Education/Experience**: In addition to submitting the above documentation, you will need to submit the following information from **either** option 1 OR option 2.

Option 1: **If you have 24 of the last 60 months of post-licensure active practice with an independent clinical counseling license, then you must submit all of the following:**

- **Original Application**: Provide a certified copy of your application materials from the jurisdiction where you were originally licensed.
- **Verification of Clinical Active Practice**: Provide evidence of post-licensure independent clinical active practice in counseling for 24 of the last 60 months by immediately preceding your application in Virginia.

Option 2: **If you hold an independent clinical counseling license but do NOT have 24 of the last 60 months of independent clinical counseling active practice you must submit all of the following:**

- **Verification of Required Coursework and Internship**: To be completed by your graduate program and submitted within your application packet.
- **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.* If you are not in contact with your supervisor, you will need to provide a certified copy of your application materials (which must include your supervision documentation) from the jurisdiction where you were originally licensed.
- **Licensure Verification of Out-of-State Supervisor(s)**: If your supervision did not take place in Virginia, you must submit a verification of your supervisor's license. You may submit an online verification printed from 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.

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Licensed Professional Counselor (LPC) by Endorsement 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)

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	Institution Name/State

** The address provided in this section is subject to disclosure under the Freedom of Information Act.*

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Licensed Professional Counselor (LPC) Endorsement Application – Page 2

Ethics Attestation: Please answer the ten questions below.

If you answer yes to any question, include a detailed explanation AND supporting documentation. Refer to Guidance Document 115-2 for detailed information on the requirements with a criminal conviction, past actions or possible impairment.

	Circle Yes or No	
1. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? If yes, please provide a full explanation.	Yes	No
(A) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior?	Yes	No
2. Have you ever been censored, warned, terminated, or requested to withdraw from your employment with any health care facility, agency, or practice? If yes, provide a full description of the circumstances and any supporting documentation.	Yes	No
3. Within the past five years, have you been disciplined by any entity? Please provide a full explanation and any associated orders or letters from the entity.	Yes	No
(A) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior?	Yes	No
4. Have you voluntarily surrendered your license, certification or registration while under investigation? If yes, provide detail(s), jurisdiction(s), date(s), and supporting documentation.	Yes	No
5. Have you ever been denied the issuance of a license, certification, or registration, or denied the privilege of taking an occupational examination by a licensing agency. If yes, provide detail(s), jurisdiction(s) and date(s).	Yes	No
6. Have you ever been convicted of, pled Nolo Contendere to, or entered into a plea agreement for a violation of any federal, state or local statute, regulation, or ordinance? (This includes convictions for driving under the influence, but does not include other traffic violations). If yes, include an explanation of the charges/convictions, and attach documentation required in the Board's Guidance Document #115-2.	Yes	No
7. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing LPC. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.)	Yes	No
8. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing LPC. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.)	Yes	No
9. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing LPC. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.)	Yes	No
10. Within the past 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? If yes, please provide a full explanation and any associated orders or letters from the entity. (NOTE: The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application, or have the program send this documentation directly to the Board.)	Yes	No

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Licensed Professional Counselor (LPC) Endorsement Application – Page 3

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 read, understand and agree to apply the Statutes and Regulations Governing the Practice of Professional Counseling. 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:	
Name of Applicant (Last, First, Middle)	
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:			
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 INDEPENDENT PRACTICE AS A LICENSED PROFESSIONAL COUNSELOR 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 of direct counseling services prior to submitting their licensure application. 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 and professional colleagues 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 providing clinical counseling services 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:

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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:_____			

Under your **direct supervision**, 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 and was the supervision concurrent with the residency?	Yes No If no, explain on separate page	
Total amount of in-person hours of supervision with the resident.	Individual Hours:	Group Hours:
How many total supervised residency hours, in the role of a professional counselor working with various populations, clinical problems and theoretical approaches did the resident provide under your **direct supervision**? (Do not include hours obtained under another supervisor)	_____ hours	
How many total hours of face-to face client contact, in providing clinical counseling services, did the resident provide while under your **direct supervision**? (Do not include hours obtained under another supervisor)	_____ hours	
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, DEGREE AND INTERNSHIP FORM

TO BE COMPLETED BY THE APPLICANT	
Applicant's Name (Last, First, Middle)	
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. (see attached documents will not be considered)

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

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

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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

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

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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 Degree and Internship for LPC Licensure

To be Completed by Student:	
Applicant's Name (Last, First, Middle)	
Applicant's Student ID Number	Applicant's Social Security Number or VA DMV Number

To be Completed by Graduate Program:		
1. Is the college or university approved by a regional accrediting agency?	Yes	No
2. Did the graduate degree program prepare individuals to practice counseling?	Yes	No
3. Is the graduate degree program CACREP or CORE accredited? (If yes, skip to question #7)	Yes	No
4. Did the graduate degree program have a sequence of academic study with the expressed intent to prepare individuals to practice counseling?	Yes	No
5. Did the degree program have identifiable counselor training faculty and an identifiable body of students who completed a counseling academic study?	Yes	No
6. Did the academic unit have clear authority and primary responsibility for the core and specialty areas?	Yes	No
7. Did internship begin after completion of 30 graduate semester hours?	Yes	No
8. **Total** number of supervised internship hours:		
9. Total **face-to-face client contact** internship hours:		
10. What type of licensure did the internship supervisor hold?		
11. Number of **individual** supervision hours during internship?		
12. Number of **group** supervision hours during internship?		
13. If applicable, total direct client contact hours with **couples and/or families**:(For LMFT licensure)		
14. If applicable, total direct client contact hours treating **substance abuse-specific** treatment problems: (For LSATP licensure)		

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/CERTIFICATION 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 _____