



NORTH CAROLINA BOARD  
OF LICENSED PROFESSIONAL  
COUNSELORS

P.O. Box 77819  
Greensboro, NC 27417  
TELEPHONE: 844-622-3572  
FAX: 336-217-9450  
http://www.ncblpc.org

**Verification of Graduate Counseling Experience**

[To be completed by University Faculty for LPCA/LPC Applicants]

**Indicate to which Applicant this verification form applies:**

Name: \_\_\_\_\_

**VERIFICATION OF GRADUATE COUNSELING EXPERIENCE INSTRUCTIONS**

1. **PRINT** or **TYPE** using **BLACK** Ink to complete this verification of graduate counseling experience. Person verifying graduate counseling experience must be a university faculty member as defined in Rule .0206.
2. **ALL SECTIONS** must be completed or the verification of graduate counseling experience will be returned.
3. The verification of graduate counseling experience should be enclosed in a sealed envelope and signed across the flap. Mail the signed and sealed envelope to the **NCBLPC Board Office at: NCBLPC, PO Box 77819, Greensboro, NC 27417**

**I. GENERAL INFORMATION** - *To be completed by person verifying graduate counseling experience.*

Name (Last, First, Middle):

Title:

University:

Department or Program Name:

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

Business Phone:

Email Address:

**II. VERIFICATION OF GRADUATE COUNSELING EXPERIENCE** - *To be completed by person verifying graduate counseling experience.*

Name of Agency where Graduate Counseling Experience Occurred:

Address (Street and/or Box Number, City, State, Zip Code):

Business Phone:

Were you the University Supervisor for the graduate counseling experience? Yes \_\_\_\_\_ No \_\_\_\_\_ If not, explain how you have verified the graduate counseling experience:

Total hours of Individual clinical supervision received during graduate counseling experience: \_\_\_\_\_

Total hours of Group clinical supervision received during graduate counseling experience: \_\_\_\_\_

	From (month/day/year)	To (month/day/year)	Total Hours of Direct Client Contact	Total Hours of Indirect Client Contact
<input type="checkbox"/> Practicum <input type="checkbox"/> Internship				
<input type="checkbox"/> Practicum <input type="checkbox"/> Internship				
<input type="checkbox"/> Practicum <input type="checkbox"/> Internship				
<input type="checkbox"/> Practicum <input type="checkbox"/> Internship				
Percentage (Board use only)				

I verify that the statements in this verification of professional counseling experience are true and correct to the best of my knowledge.

Signature of Person Verifying: \_\_\_\_\_ Date: \_\_\_\_\_