Reset Form

FORM P

VERIFICATION OF PRACTICUM FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC) OR A MENTAL HEALTH COUNSELOR ASSOCIATE (LMHCA)

Part of State Form 50319 (R11 / 8-24)

*Complete **SECTION A** and then forward this form to the educational institution at which you have completed your practicum.*

SECTION A / APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Date of birth *(month, day, year)*

My minimum one hundred (100) hour practicum was completed under the auspices of the following educational institution

_____ located at _____

(Name of institution) *(City and State)*

I completed the practicum between the following dates ***I completed the practicum at the following location***

_____ _____ _____

Date began *(Month/Year)* Date completed *(Month/Year)* *(Specific location of practicum)*

SECTION B / VERIFICATION OF COMPLETION OF THE ONE HUNDRED (100) HOUR PRACTICUM

***SECTION B** must be completed by an official of the institution that has granted you the academic credit for this supervised clinical experience.*

As an official of the school named above. I certify, that the above-named applicant has completed at least the following experience during the completion of the practicum:

(1) Applicant has completed at least a one hundred (100) hour practicum that enabled the applicant to develop basic counseling skills and to integrate professional knowledge and skills appropriate to the applicant's program emphasis.

(2) Applicant has completed a minimum of forty (40) hours of direct service with clients during this practicum and at least one fourth (1/4) of the hours were completed in group work.

As an official of the school named above, I certify that the above-named applicant did receive the following supervision during the completion of the practicum: Applicant received a minimum of one (1) hour per week of individual supervision and a minimum of one and one-half (1 1/2) hours per week of group supervision with other students over a minimum of one (1) academic term. For the purposes of this certification, individual supervision is defined as supervision rendered to one (1) person at a time, and group supervision is supervision rendered to at least two (2) and not more than twelve (12) individuals at one (1) time.

During the completion of this practicum, the applicant did receive the following total number of hours of face-to-face supervision: _____

I further certify that the supervision for this practicum was conducted by either a program faculty member or a supervisor working under the supervision of a program faculty member using audiotape, videotape and / or direct observation. The applicant's supervisor(s) held the following position(s), degree(s), license(s), and / or certification(s) - [*Provide name(s) and qualification(s) below*]:

Program faculty member

Site supervisor

Additionally, I certify the applicant's performance was evaluated throughout the practicum and a formal evaluation was performed at the conclusion of the practicum by the program faculty supervisor, in consultation with the site supervisor, if applicable.

Position held at the institution	Name of institution

Name (*last, first, middle, maiden or previous name*)

Work telephone number	Cellular telephone number	E-mail address
( )	( )	

Signature	Date *(month, day, year)*

RETURN THIS FORM TO:
Professional Licensing Agency
402 West Washington Street, Room W072
Indianapolis, IN 46204