IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 107/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

VERIFICATION OF EMPLOYMENT/EXPERIENCE

SUPPORTING DOCUMENT

VE-LCPC

APPLICANT: **Complete the applicant section of this form, then forward it to your employer. You are authorized to photocopy this form as necessary if you had multiple sites and/or multiple supervisors.**

One year of full-time experience equals 1680 clock hours obtained in not less than 52 weeks.

1. NAME LAST FIRST MIDDLE

2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ (Month Day Year)

3. SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __

4. ADDRESS STREET, CITY, STATE, ZIP CODE

5. MAIDEN OR GIVEN SURNAME

180 Licensed Clinical Professional Counselor

FOLLOWING SHOULD REFLECT INFORMATION AT TIME OF EMPLOYMENT/EXPERIENCE

6. SUPERVISOR NAME

7. BUSINESS/INSTITUTION NAME

8. SUPERVISOR TITLE

9. ADDRESS STREET, CITY, STATE, ZIP CODE

SUPERVISOR: **Complete the remainder of this form. <u>RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT IN A SEALED ENVELOPE</u>.**

PART I. - SUPERVISION INFORMATION

A. IMMEDIATE/DIRECT SUPERVISOR'S NAME

C. LICENSE NUMBER

D. STATE OF LICENSE

E. BUSINESS/INSTITUTION NAME

F. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE

G. BUSINESS TELEPHONE NUMBER

Area Code (__ __ __) __ __ __ — __ __ __ __

H. SUPERVISOR'S EMAIL ADDRESS

B. PROFESSIONAL DESIGNATION Date Awarded

- ☐ Counselor (Master's or Doctorate Level) _____
- ☐ Licensed Clinical Professional Counselor _____
- ☐ Certified Social Worker _____
- ☐ Licensed Clinical Social Worker _____
- ☐ Licensed/Registered Clinical Psychologist _____
- ☐ Psychiatrist _____
- ☐ Certified Rehabilitation Counselor _____

PART II. - APPLICANT EMPLOYMENT INFORMATION

A. APPLICANT'S JOB TITLE AT TIME OF EMPLOYMENT/ EXPERIENCE

B. DATES OF APPLICANT'S EMPLOYMENT/EXPERIENCE

From __ __ / __ __ / __ __ __ __ To __ __ / __ __ / __ __ __ __ (Month Day Year Month Day Year)

C. NUMBER OF HOURS APPLICANT WORKED PER WEEK

D. NUMBER OF HOURS YOU MET WITH THE APPLICANT PER WEEK

PART II. - APPLICANT EMPLOYMENT INFORMATION (Continued)

E. INDICATE YOUR OVERALL EVALUATION OF THE APPLICANT'S PERFORMANCE UNDER YOUR DIRECT SUPERVISION

Circle One	Excellent		Satisfactory		Poor
	5	**4**	**3**	**2**	**1**

F. CLOCK HOURS:

TOTAL CLOCK HOURS IN EXPERIENCE: _____

TOTAL CLOCK HOURS OF DIRECT FACE TO FACE IN PERSON SERVICE TO CLIENTS: _____

G. COMMENTS ABOUT APPLICANT'S JOB PERFORMANCE:

The above indicated experience has been performed by the applicant pursuant to my order, control, and full professional and legal responsibility as a supervisor. I do hereby declare that the information contained herein is true and correct.

_____
Signature

_____ _____
Date Title

NAME (Last, First, MI):

SS#:

Profession: