



Bureau of Professional Licensing
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COUNSELING WORK EXPERIENCE

Authority: 1978 PA 368

This form must be submitted directly to this office by your supervisor. If this form is submitted by the applicant, it will not be accepted.

Section of Form to be Completed by Applicant:

Applicant's Name (First, Middle, Last)		Date of Birth
Telephone Number	Limited License Professional Counselor #	

Remainder of Form to be Completed by Supervisor:

Name of Agency		
Address of Agency		
City	State	Zip Code

CERTIFICATION AND SIGNATURE

I certify the applicant named above practiced counseling under my supervision from _____
 to _____ (Month/Day/Year)
 _____ for a total of _____ hours including _____ hours in my immediate
 (Month/Day/Year)

physical presence. I also certify I have received training in the function of supervision pursuant to Administrative Rule 338.1757 and conducted supervision pursuant to applicable statutes and administrative rules. I was available on a regularly scheduled basis to review the practice of the applicant, to provide consultation, to review records, to further educate the applicant and there was continuous availability of direct communication in person or by radio, telephone or telecommunication.

 Signature of Supervisor Date

 Print or Type Name of Supervisor (Seal) If hospital has no seal, please indicate.

 Michigan Permanent ID Number, if applicable

 State licensed, if not Michigan Type of License or Certificate