Department of Health and Mental Hygiene
Board of Professional Counselors and Therapists
4201 Patterson Avenue – Suite 316
Baltimore, Maryland 21215

Out of State Verification Form

Applicant must complete items 1 thru 10 below and then forward this form to the state where license is currently held.

1. Name:	**2. DOB:**
3. Address (street, city, state, zip code):	
4. Social Security Number:	**7. Academic Institution:**
5. License Name and No.:	**8. Degree:**
6. Years of Experience practicing as a LCPC:	**9. Date Rec'd.:** **10. Total credits:**

I authorize the information requested below to be provided to the Maryland Board of Professional Counselors and Therapists.

_____ _____

Signature Date

Items 11 thru 17 must be completed by the state where professional counselor incense is currently held. Return this directly to the Maryland Board of Professional Counselors and Therapists. Do not return to applicant.

11. License Title:	
12. Issuing State:	**13. Date of Original Issue:**
14. Issued by: **___ Examination** **___ Endorsement/ Reciprocity** **___ Grandfathering**	**15. License is :** **___ Active (Expiration Date: _____)** **___ Inactive (Expired on: _____)**
16. If applicant was credentialed by examination, indicate title of the licensing exam taken: **_____ NCE, _____NCMHCE Other:**	
17. Has this license ever been revoked, suspended, restricted or placed on probation? **___ Yes ___ No IF YES, PLEASE EXPLAIN ON REVERSE SIDE.**	

_____ _____

Name (print) **Date**

_____

Signature SEAL

_____

Title