Degree Program Work Experience Form

Instructions to Applicant

1. Fill in your name, and the name of your graduate program or department, sign waiver for release of information, and submit to your graduate program or department.

2. Request a school representative to complete the form; you may discuss your expectations, but the completed form must be returned to you in a **sealed** envelope with the attesting individual **signing across the seal or submitted via email directly from the graduate school to the Oregon Board of Licensed Professional Counselors and Therapists.**

3. Of the total 1,900 client contact hours required for licensure, **up to 400 client contact hours may be attained as part of your degree program.** Clinical experience should be reflected on your transcript.

Instructions to Graduate School Representative

1. The applicant for licensure in the State of Oregon has authorized you to provide information to document his/her experience as a counselor while enrolled in your degree program.

2. Please complete this form, sign it, and place it in an envelope with the applicant's name on the front. **Seal the envelope and sign across the sealed flap.** Return the sealed envelope to the applicant. This form may also be sent via email directly from the Graduate School to the Oregon Board of Licensed Professional Counselors and Therapists. Email address: lpct.board@mhra.oregon.gov

Oregon Board of Licensed Professional Counselors and Therapists

DEGREE-PROGRAM WORK EXPERIENCE

Waiver: ***I,*** _____ *hereby authorize* _____ *to provide the Oregon Board of Licensed Professional Counselors and Therapists with all information relevant to my qualifications as an applicant for licensure. I hereby release and discharge the reference from all claims arising out of the provision of such information.*

_____ _____
Signature of Applicant *Date*

1. When and where did the supervised clinical experience take place?

A. From **[Mo/Day/Yr.]:** _____ To **[Mo/Day/Yr.]:** _____ **Course No[s]:** _____
Agency/Business: _____
Address: _____
City, ST, Zip: _____

Applicant's job title: _____

Activities performed by Applicant:
_____
_____
_____

Number of **direct client contact hours** during this time period: _____
Number of Couple and Family (relational) hours during this time period: _____
Total (direct and relational) hours: _____

B. From **[Mo/Day/Yr]:** _____ To **[Mo/Day/ Yr]:** _____ **Course No[s]:** _____
Agency/Business:
Address:
City, ST, Zip:
Applicant's job title: _____

Activities performed by Applicant:
_____
_____
_____

Number of **direct client contact hours** during this time: _____
Number of Couple and Family (relational) hours during this time period: ____
Total (direct and relational) hours: _____

2. The Applicant was supervised by a Masters or higher-level clinical supervisor? [ ] Yes [ ] No

3. Do you know of any reason why the applicant should **not** be licensed? [ ] Yes [ ] No
If yes, please explain.

I attest the information I have provided the Board is true and I take responsibility for the information I have provided.

_____
Signature of Graduate School Representative, including title **Date**

Printed or Typed Name of Representative, Program Name, Address, and Telephone Number:
_____
_____
_____
_____