

**EMPLOYMENT VERIFICATION OF
CLINICAL MENTAL HEALTH COUNSELING EXPERIENCE**

Applicant Instructions:

Complete top portion of the form only. If more than one person is needed to verify the required amount of professional counseling experience, please copy this form and submit it to each individual to submit directly to the Board.

Applicant's Name: _____ **DOB:** _____
(Please print)

Applicant's signature: _____ **Date:** _____

APPLICANT: Do not write below this line.

I have applied for a counseling credential with the State of Nevada Board of Examiner for Alcohol, Drug and Gambling Counselors and am required to provide documentation of previous counseling experience. **Please complete the requested information regarding my previous counseling experience, notarize and mail the form to the Board at the address below.** My application cannot be processed until this form is received.

**HOURS VERIFICATION
FOR PRIOR EXPERIENCE PROVIDING COUNSELING OUTSIDE OF NEVADA**

Applicant named above is/was employed by (agency/institution) _____
for the period from _____ to _____. They held the position of _____

Definition of Counseling: To qualify as counseling experience, the individual must be involved in the provision of direct services to clients in either an individual or group setting. It is therefore assumed that individual would be responsible for treatment plans, case notes, etc. If there is not documentation of counseling activities, experience will not be granted. Simply being employed by an agency which provides counseling services does not qualify as counseling experience (i.e., the receptionist or bookkeeper). **Please include a detailed job description.**

I verify that _____ total number of hours were spent in **CLINICAL MENTAL HEALTH COUNSELING** activities during these dates (include direct counseling hours and indirect activities used to support counseling hours). The maximum hours permitted for full time employment is 40 hours per week or 2000 hours per year.

Verifier Name: _____ **Title:** _____
Agency/Institution: _____ **Address:** _____
Telephone: _____
Signature: _____ **Date:** _____

NOTARIZATION:

Subscribed and sworn to before me this _____ day of _____ 20____
In the State of _____, County of _____ (SEAL)
Notary public signature _____
Printed Name _____
My commission expires _____

After completing mail this form with original signatures and notarization to:

**BOE for Alcohol, Drugs and Gambling Counselors
4600 Kietzke Lane, B-115
Reno, NV 89502**

If you have any questions, please contact our office at: 775-689-0562/0563
licensingsspecialist@adgc.nv.gov