



Creating  
a State  
of Health

**PROTECTIVE  
HEALTH  
SERVICES**

Oklahoma State Department of Health

Protective Health Services

Professional Counselor Licensing - 0504

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<http://pcl.health.ok.gov>

**OUT-of-STATE LICENSE VERIFICATION FORM**

**SECTION 1: APPLICANT INFORMATION (This section is to be completed by the applicant)**

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Type of credential held in other state: \_\_\_\_\_ License Number: \_\_\_\_\_

Date Issued: \_\_\_\_\_ Date of Expiration: \_\_\_\_\_

**SECTION 2: CURRENT STANDING (To be completed by the State Board)**

Name of credential held (Licensure/Certificate): \_\_\_\_\_

Licensure/Certificate #: \_\_\_\_\_

Date of Issue: \_\_\_\_\_ Date of Expiration: \_\_\_\_\_

Is the license in good standing? Yes \_\_\_\_\_ No \_\_\_\_\_

**If "no", please state reason(s):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the Licensee/Certificated have a record of disciplinary action(s)? Yes \_\_\_\_\_ No \_\_\_\_\_

**If "yes", please state the nature of the disciplinary action(s):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION 3: TEST**

Did the applicant complete an examination in order to receive licensure? Yes \_\_\_\_\_ No \_\_\_\_\_

**If "yes" please complete the following:**

Name of Exam: \_\_\_\_\_

Date of Exam: \_\_\_\_\_ Pass \_\_\_\_\_ Fail \_\_\_\_\_

Applicants Score: \_\_\_\_\_ Passing Score: \_\_\_\_\_

**SECTION 4: SUPERVISION**

Did the applicant accrue supervised experience to become licensed/certified? Yes \_\_\_\_\_ No \_\_\_\_\_

**If “yes” please complete the following:**

Number of hours of supervised experience: \_\_\_\_\_

Number of months: \_\_\_\_\_

Number of face-to-face direct client contact hours: \_\_\_\_\_

Number of face-to-face hours with supervisor: \_\_\_\_\_

Supervisor qualifications: \_\_\_\_\_

**I certify that the information provided on this form is true and correct to the best of my knowledge.**

Print name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of State Board: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Please return this form - in a sealed envelope - to the applicant listed in SECTION 1.**