**REQUEST FOR TEMPORARY LICENSURE
AS A PROFESSIONAL COUNSELOR WITH
MENTAL HEALTH SERVICE PROVIDER DESIGNATION**

Applicant: If you desire a temporary license, have your supervisor complete this page, and add $150 to the fee requested in instruction #2 on the first page of this application. Do not send this page separately; a request for temporary license must be returned with entire application.
NOTE: Documentation of twelve (12) contact hours related to counseling supervision and other related supervision topics. Contact hours must be provided by an approved professional association or approved by a counseling related credentialing organization. This documentation must accompany this form.

Name of Applicant ____
(Please Print) Last First Middle

I, the undersigned, hereby accept responsibility for direct supervision of the above named applicant.

____
Name of Supervisor (Please Print)

____
License Number of Supervisor Date of Initial License

Title of Supervisor's License:______________________________
(i.e., M.D., D.O., L.P.C./M.H.S.P., L.M.F.T., L.C.S.W., Lic. Psychologist)
If license is M.D. or D.O., are you certified by the American Board of Psychiatry and Neurology? ___ Yes ___ No

For Office Use Only
Temporary License

Number _________

Issued ___________

Expires __________

Extended ________

Supervisor's Name:

____

Street Address:

____

____
City State Zip

Telephone #: (____)______________________________________

____ ________
Signature of Supervisor Date