



Virginia Department of
Health Professions
Board of Counseling

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APPLICANT OUT-OF-STATE LICENSURE/CERTIFICATION VERIFICATION

Part I. To be completed by the applicant:

INSTRUCTIONS		PLEASE TYPE OR PRINT CLEARLY	
Name of Applicant (Last, First, Middle)			
Mailing Address (Street and/or Box Number, City, State, Zip)			
Applicants Email Address		Home and/or Cell Telephone Number	

Part II. To be completed by state Licensing Authority:

INSTRUCTIONS		PLEASE TYPE OR PRINT CLEARLY	
Title of License	License Number		
Issue Date	Expiration Date		
Obtained by Method			
By Examination	By Waiver	By Endorsement	Reciprocity
Is there any public information relating to this license?			
Yes (specify details on a separate sheet)		No	
Certification by the authorized Licensure Official of the State of _____			
I certify that the information is correct.			
Authorized Licensure Official Name and Title _____			
State Seal	Title of Board _____		
	Telephone Number _____		
	Email Address _____		
	Date _____		