STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

DEGREE/INTERNSHIP VERIFICATION FORM

To: Board of Counseling Professionals Licensure
35 State House Station
Augusta, ME 04333-0035

Date:

Student Name:	Student ID Number:	
Institution:		
Mailing Address:		
City:	State:	Zip Code:

Degree Verification	
Date of Graduation:	Program:
Degree Awarded:	Concentration of Degree Awarded:
Accreditation:	

Internship Verification		
Dates of Internship:	Direct Client Contact Hours:	Total Contact Hours:

Internship Experience: Please indicate whether the counseling activities, setting and supervisor were or were not clinical in nature ("clinical" is defined as the diagnosis and treatment of mental health disorders).
☐:Clinical
☐:Non-Clinical

Signature of Person Verifying Degree/Internship:_____

Printed Name: _____ Title: _____

Department: _____ Date: _____