Attachment A

STATEMENT OF REGISTRATION, CERTIFICATION OR LICENSURE AS A COUNSELOR OR THERAPIST IN ANOTHER STATE

Applicant completes only the top portion of this form and sends it to the state(s) in which he/she holds, or has held a license.

Section 1: To be completed by applicant:

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>M.I.:</th>
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<tr>
<th>Date of Birth:</th>
<th>Social Security #:</th>
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<tr>
<th>Address:</th>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
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<th>License No.:</th>
<th>Expiration:</th>
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Section 2: to be completed by the state

This certifies that the above individual was licensed as ________________ (profession) with license number ________________, issued ____________ (original date of licensure), expired ____________, entitling him/her to practice alcohol and drug abuse counseling or a related occupation.

1. Current license status: ___Active ___Inactive ___Lapsed
2. Licensed on the basis of: ___NBCC Examination. Date Taken: __________ Score: __________
___State Examination
___Endorsement. Please identify licensing states: ________________
___Credentials. Please attach an explanation.
___Other. Please attach an explanation.

3. Was your state the state of original licensure? ___Yes ___No
4. The educational requirements for the above-referenced title at the time of the applicant’s licensure/certification:

   Required Field of Study___________________________________________________________________
   Number of face-to-face supervised hours_____________ Number of client contact hours_____________
5. At the time this applicant was licensed, what were the licensing requirements with respect to post-degree experience and supervision?

__________________________

6. Has this license ever been subjected to disciplinary action? ___Yes ___No
   (e.g. revoked, suspended, surrendered, restricted, limited, placed on probation)?
7. Are there any complaints pending: ___Yes ___No

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

Seal

Name ___________________________ Title ___________________________

Name of State Board

Address/City/State/Zip _____________________________

Please return this form to:
NM Counseling & Therapy Practice Board PO Box 25101, Santa Fe, NM 87504

Revised 02/2017