

## FORM #2A INSTRUCTIONS

### Instructions to Applicant for LPC

1. Fill in your name, and the name of your graduate program or department, sign waiver for release of information.
2. Request a school representative to complete the form; you may discuss your expectations, but the completed form must be returned to you in a **sealed** envelope with the attesting individual **signing across the seal**.
3. Of the total 2,400 client contact hours required for licensure, **up to 800 client contact hours may be attained as part of your degree program**. Clinical experience should be reflected on your transcript.

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### Instructions to Graduate School Representative

1. The applicant for licensure in the State of Oregon has authorized you to provide information to document his/her experience as a counselor while enrolled in your degree program.
2. Please complete this form, sign it, and place it in an envelope with the applicant's name on the front. **Seal the envelope and sign across the sealed flap**. Return the sealed envelope to the applicant.

**Form #2A: DEGREE-PROGRAM WORK EXPERIENCE**  
[for **LPC** applicants only]

**Waiver:** I, \_\_\_\_\_ hereby authorize \_\_\_\_\_  
to provide the Oregon Board of Licensed Professional Counselors and Therapists with all  
information relevant to my qualifications as an applicant for licensure. I hereby release and  
discharge the reference from all claims arising out of the provision of such information.

\_\_\_\_\_  
*Signature of Applicant* *Date*

**1. When and where did the supervised clinical experience take place?**

**A.** From [Mo/Day/Yr]: \_\_\_\_\_ To [Mo/Day/Yr]: \_\_\_\_\_ Course No[s]: \_\_\_\_\_  
Agency/Business: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, ST, Zip: \_\_\_\_\_  
Applicant's job title: \_\_\_\_\_

Activities performed by applicant:  
\_\_\_\_\_  
\_\_\_\_\_

Number of **direct client contact hours** during this time period: \_\_\_\_\_

**B.** From [Mo/Day/Yr]: \_\_\_\_\_ To [Mo/Day/ Yr]: \_\_\_\_\_ Course No[s]: \_\_\_\_\_  
Agency/Business: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, ST, Zip: \_\_\_\_\_  
Applicant's job title: \_\_\_\_\_

Activities performed by applicant:  
\_\_\_\_\_  
\_\_\_\_\_

Number of **direct client contact hours** during this time period: \_\_\_\_\_

**2. Do you know of any reason why the applicant should **not** be licensed? [ ] Yes [ ] No** If  
yes, please explain. I attest the information I have provided the Board is true and I take  
responsibility for the information I have provided.

\_\_\_\_\_  
**Signature of Graduate School Representative, including title** **Date**

Printed or Typed Name of Representative, Program Name, Address, and Telephone Number:  
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