# Wisconsin Department of Safety and Professional Services

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**MARRIAGE AND FAMILY THERAPY, PROFESSIONAL COUNSELING, AND SOCIAL WORK EXAMINING BOARD**

## PROFESSIONAL COUNSELOR CERTIFICATE OF PROFESSIONAL EDUCATION

IMPORTANT NOTE: Submit this form (#1960) **only if** your program is in the following list AND was CORE or CACREP accredited at the time of graduation or completion: Addiction Counseling; Clinical Mental Health Counseling; Clinical Rehabilitation Counseling; Marriage, Couple, and Family Counseling; or a Doctoral Program in Counselor Education and Supervision. **Otherwise**, alternative Form #2239 is required from the applicant **and** official transcripts are required from the school directly to DSPS. **Failure to submit the correct forms may delay your application.**

**APPLICANT: Complete this section and submit it to your professional school for completion. Form must be returned directly from the school to the Department.**

| Last Name | First Name | MI | Former / Maiden Name(s) |
|---|---|---|---|
| | | | |

| **Address** (number/street) | (city) | (state) | (zip code) |
|---|---|---|---|
| | | | |

| **Date of Birth** | **Social Security Number:** (voluntary-for school's use in locating your records) | **Date of Graduation** (Anticipated dates of graduation will not be accepted.) |
|---|---|---|
| __ __ / __ __ / __ __ __ __ | __ __ __ - __ __ - __ __ __ __ | __ __ / __ __ / __ __ __ __ |

ATTESTATION OF APPLICANT: I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations. I hereby authorize the school named below to provide the Department with the information requested below.

| **Applicant Signature** (If unable to provide a digital signature, print and sign form.) | **Date** | **Application Number** |
|---|---|---|
| | __ __ / __ __ / __ __ __ __ | |

**SCHOOL: Complete this section for the above-named applicant and return directly to the Department using the LicensE Third-Party* Upload Portal at license.wi.gov. You will need the application number shown above.** (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

| | |
|---|---|
| **Name of Institution** | |
| **Location of Institution** (city) | (state) __ __ |
| **Type of Degree Awarded** | |

**Major/Specialty** ☐ **Addiction Counseling** ☐ **Clinical Mental Health Counseling** ☐ **Clinical Rehabilitation Counseling** ☐ **Marriage, Couple, and Family Counseling** ☐ **Doctoral Program in Counselor Education and Supervision**

**Graduation or Conferral Date** __ __ / __ __ / __ __ __ __ **NOTE: Anticipated dates of graduation or completion will not be accepted.**

**Name of the Accrediting Body at the time student received degree:**

☐ **Yes** ☐ **No** **Was program CORE or CACREP accredited at time of graduation.** (Effective 7/1/2017, CORE incorporated into CACREP.)

*Continued on next page.*

# Wisconsin Department of Safety and Professional Services

**ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT** I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.

| **Signature of Dean or Department Head**<br>(If unable to provide a digital signature, print and sign form.) | **Date** |
|---|---|
| | __ __ / __ __ / __ __ __ __ |
| **Printed Name** | **Daytime Phone Number** (including area code) |
| | |
| **Title** | |
| | |



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