REGENT UNIVERSITY | Christian Leadership to Change the World

SCHOOL OF PSYCHOLOGY & COUNSELING

PERSONAL THERAPY/COUNSELING VERIFICATION FORM

By my signature below, I verify that _____ completed
Student Name

four (4) individual Counseling/Therapy sessions with me on the following dates:

_____ _____

_____ _____

Students cannot do more than one session in any week and cannot complete these sessions in less than 30 days.

By the student's signature below, he/she indicates that he/she gives permission for me to release this information to Regent University's School of Psychology and Counseling for the purposes of Internship Clearance.

Name of Practice (if applicable): _____

Counselor's Name: _____

Counselor's License Type (check one): ☐ LPC/LMHC/LCMHC ☐ LMFT ☐ LCSW
☐ Psychologist or Psychiatrist

Counselor's License Number: _____

Counselor's Phone Number: _____

_____ _____
Counselor's Signature Date

_____ _____
Student's Signature Date