

Wisconsin Department of Safety and Professional Services

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

VERIFICATION OF CREDENTIAL - RECIPROCITY

Complete only if you are credentialed in a state other than Wisconsin

Please check credential type: Social Worker Professional Counselor
 Marriage and Family Therapist

The top portion of this form (numbers 1, 2, 3, 4, 5, and 6) must be completed by the applicant before forwarding to the jurisdiction where previously credentialed.

1. Name		2. Previous Name(s)	
3. Address (number, street, city, state, zip code)			
4. Date of Birth (month, day, year)	5. Credential Number	6. Date Credential Issued	

I authorize the requested information to be furnished to the Wisconsin Marriage and Family Therapy, Professional Counseling, and Social Work Examining Board.

Signature

Date

APPLICANT: DO NOT WRITE BELOW THIS LINE – To be completed by a state other than Wisconsin

The lower portion of this form, beginning with number 7, must be completed by the state where you are credentialed (certified, registered, licensed) and returned directly to the Marriage and Family Therapy, Professional Counseling, and Social Work Examining Board, at the above address before your application can be considered for certification.

7. Profession Credentialed (Please include level of credential.)		8. Date Originally Credentialed and level of credential	
9. Credential was Issued by: ___ Examination ___ Waiver ___ Endorsement/Reciprocity ___ Grandfathered		10. Credential is: ___ Active (Date Expires _____) ___ Inactive	
11. Has This Credential Ever Been Revoked, Suspended, Surrendered, Restricted, Limited, Placed on Probation? ___ Yes ___ No If yes, explain on reverse side.			
12. If The Applicant Was Credentialed by Examination, Which Exam?			
13. Name of Education Program Completed		14. Name of School	
15. Location of School		16. Year of Graduation	



Signature: _____

Title: _____

State: _____

Date: _____