

**LETTER OF RECOMMENDATION**  
**TO**  
**Arkansas Board of Examiners in Counseling**

*The applicant must complete items 1-3. Item 4 is optional. Address is required for return of recommendation directly to the applicant in sealed & signed envelope.*

1. Applicant's Name (Print): \_\_\_\_\_

2. Applicant's Address: \_\_\_\_\_

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3. Proposed Area(s) of Counseling Practice: LAC \_\_\_ LPC \_\_\_ LAMFT \_\_\_  
LMFT \_\_\_ Dual LAC/LAMFT \_\_\_ Dual LPC/LMFT \_\_\_

4. I waive the right by the Family Education Rights and Privacy Act of 1974  
(Buckley Amendment) to view this letter of recommendation on file with Board.

Signature: \_\_\_\_\_

*Forward this form to an individual well acquainted with your education and counseling.*

**To Writer of Letter of Recommendation:**

Length of time you have know applicant: Dates from: \_\_\_\_\_ to \_\_\_\_\_

**Please rate the applicant in the following categories:**

No Opinion 1=Poor 2=Fair 3=Good 4=Very Good 5=Excellent

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Professional Ethics: \_\_\_\_\_

\_\_\_\_\_

Professional Knowledge: \_\_\_\_\_

\_\_\_\_\_

Personal Character: \_\_\_\_\_

\_\_\_\_\_

Professional Training: \_\_\_\_\_

\_\_\_\_\_

Counseling Skill Application: \_\_\_\_\_

\_\_\_\_\_

***Please comment in detail regarding the applicant and the basis for your judgment in rating the applicant on the space below: (add additional pages if desired)***

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**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Institution Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Do you hold a license or certificate to practice as a:

• Counselor \_\_\_\_\_ • Therapist \_\_\_\_\_ • Psychologist \_\_\_\_\_

• Other \_\_\_\_\_ (Specify) \_\_\_\_\_ • N/A \_\_\_\_\_

***Return this form directly to: Applicant's Address listed above (seal and signature across the sealed envelope. Candidates must collect all four references and then send all to the board office.***