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: _________________________________________________

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

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)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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.