



Professional Art Therapist (PAT)

Verification Of Education for Licensure

Instruction To Applicant: Upon completion of the demographic information and waiver below, this form should be signed, notarized, and forwarded to the college or university where you obtained your degree.

Name (Last, First, Middle Initial)	Maiden Name or Given Surname		
Address (Street, City, State and Zip Code)	Phone No.	Home	Work
Social Security Number	Date of Graduation		

Waiver For the Release Of Information:

I am applying for licensure as a PAT in the State of Mississippi. I hereby authorize the verification of my degree conferred and further authorize the release of any transcript or other information, favorable or otherwise, to the Mississippi State Department of Health, Professional Licensure – Art Therapy, should this information be requested at any time.

Subscribed and sworn to before me this day of _____ 20__

My commission expires _____ 20__.

Notary Public

Seal

Date

Signed

Instructions To Educational Institution:

Upon completion of this form please attach a certified transcript and send it directly to:

Mississippi State Department of Health
Professional Licensure - Art Therapy
Post Office Box 1700
Jackson, Mississippi 39215-1700
MSDHPProfLicensure@msdh.ms.gov

Name of Institution	Location of Institution (City-state)
Dates of Attendance (Month/Year) From: _____ To: _____	Has applicant successfully completed all academic requirements and field work requirements? No Yes, date _____
Date Degree Conferred	Degree Conferred
Program Name & Curriculum Description	Practicum Direct Client (Individual, Group, Family) Art Therapy Contact Hours: _____ Total Number of Hours: _____
Art Therapy Program Accreditation (on date degree conferred) Program Accredited by AATA <input type="checkbox"/> No <input type="checkbox"/> Yes	

Seal of the College or University

Signature

Title

Telephone Number

Date