Douglas J. W. Bartholomew, Application file MH30000460			
Beginning Page	**Ending Page**	**Entire page or group of pages withheld**	**Exemption**
1			None
2		Licensee's social security number	RCW 42.56.350(1), and 42 USC Section 405(c)(2)(C)(vii)(1).
3		Personal data answers	RCW 42.56.360(2) and RCW 70.02.020.
4	14		None
15		1 page of transcript	20 USC Section 1232(g)
16			None

MENTAL HEALTH COUNSELOR APPLICATION WORKSHEET

MASTERS OR HIGHER _____ ALTERNATE TRAINING _____

EXAM _____ ENDORSEMENT _____ GRANDFATHERING ✓

NAME Bartholomew, Douglas J.W. DATE RECEIVED 11/17/88

DATE OF BIRTH 1/13/50

****

~~$63.00~~ 31.50 APPLICATION FEE ✓ $35.00 RE-EXAM FEE _____

PERSONAL DATA COMPLETE ✓ ATTESTATION SIGNED ✓

Registered by 7/29/88

****

SCHOOL TRANSCRIPTS RECEIVED ✓ SCHOOL ACCREDITED? ✓

NACCMHC VERIF RECEIVED na COURSE CONTENT COMPLETED ✓

****

		FINAL TOTAL
POST GRADUATE SUPERVISION: (TOTAL OF 100 HOURS)		
	48mos @ 4hrs 192	
POST GRADUATE PROFESSIONAL EXPERIENCE: (TOTAL OF 2000 HOURS)		
	24/mo 212	
ALTERNATE TRAINING: (TOTAL OF FIVE YEARS)		
SELF EMPLOYED - LETTER(S) OF VERIFICATION OF PRACTICE (VERIFICATION OF AT LEAST FIVE YEARS)		

****

OUT OF STATE VERIFICATION RECEIVED na

APPROVED FOR:

EXAMINATION ____ ENDORSEMENT ____ GRANDFATHERING ✓

STATE OF WASHINGTON

DEPARTMENT OF LICENSING

FOR VALIDATION ONLY

4334 800 578 111788 21.50

02G-070-207-0003

APPLICATION FOR CERTIFICATION AS A MENTAL HEALTH COUNSELOR

Check one: ☒ Master's or Higher Degree ☐ Equivalency (Alternate training experience)

FOR OFFICE USE ONLY								
PROG (1)	TRANS (3)	PROF CODE (4)	PIC/CIC (5)		EXPIRATION DATE (9)	EXPT (10)	STAT (11)	TYPE (12)
LA		20703			71391		9	
KEY DATE (13)	CLASS (14)	ASSN (15)	BILLED AMOUNT (16)		SIGN	SPLIT	QTRD	

PLEASE TYPE OR PRINT CLEARLY

Applicant's Name (20) BARTHOLOMEW (LAST) DOUGLAS (FIRST) J.W. (MIDDLE)

Preferred Address (21) 10230 111TH Ave NE Kirkland (WILL APPEAR ON CERTIFICATION DOCUMENT)

City (24) KIRKLAND State (25) WA Zip (26) 98033 County (27) KING

Telephone Number (39) 827-1888 (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.)

Social Security Number (40) ___ (REQUESTED FOR IDENTIFICATION PURPOSES ONLY. ENTERING SSN IS VOLUNTARY AND IS NOT REQUIRED FOR LICENSING APPROVAL.)

Sex (F or M) M Birthdate 1 (MONTH) 13 (DAY) 50 (YEAR)

Above Address Is: ☒ Home Address ☐ Business Address

FOR OFFICE USE ONLY	
CERT DATE (44)	041489
CERT NO. (45)	460
APPROVED BY	TF
DATE	41489

Other Contact Address Eastside Mental Health, 2840 Northup WAY

City Bellevue State WA Zip 98004 County KING

Are you currently registered in the State of Washington as a Counselor or Hypnotherapist ..... ☒ Yes ☐ No

If Yes, FULL name under which you are registered DOUGLAS J.W. BARTHOLOMEW

Registered Number 20701 20702 0005458 Reference Number BA·RT·HD·U508BL (AS IT APPEARS ON YOUR REGISTRATION FORM)

Are you applying for other certification categories? ..... ☐ Yes ☒ No

Check appropriate category(ies): ☐ Marriage/Family Therapist ☐ Social Worker

PERSONAL DATA

	Yes	No
1. Within the past ten years, have you engaged in any of the conduct described in the Uniform Disciplinary Act, 18.130,180 RCW, excluding the conduct described in 18.130.180(6) and 18.130.180(23)?	☐	☒
2. Within the past ten years, have you been found guilty in a criminal, civil, administrative agency, professional association or certifying agency proceeding of any of the conduct described in the Uniform Disciplinary Act, 18.130.180 RCW, or have you agreed to a stipulation or settlement in lieu of or as a result of such a proceeding?	☐	☒

*Applicants who have had their registration, certification, or licensure suspended, revoked, restricted, or denied in any state, federal or foreign jurisdiction must submit a letter of explanation and certified copies of records and orders from the agency which took the action.

*Applicants who have had privileges revoked, suspended or restricted on grounds of unprofessional conduct, incompetence, negligence, unsafe practices or impairment must submit a letter of explanation and certified copies of the decisions and statement of charges and final orders from the decision makers and any witnesses or patients involved in the cases leading to the action.

*Applicants who have voluntarily given up privileges (registration, certification or license to practice) or agree to restrict practice in lieu of or to avoid formal action must submit a letter of explanation and certified copies of records and orders from the agency which took the action.

*Applicants who have been named in any civil suits alleging incompetence or negligence in the practice of the profession must submit a letter of explanation and certified copies of court records or court filings and any supporting records and statements.

*Applicants who have been convicted of any gross misdemeanor or felony which might relate to the profession must submit a letter of explanation and certified copies of the court conviction.

*Applicants who have been reprimanded, entered a stipulated agreement or agreed to discontinue an act alleged as a violation of the law or an unsafe practice must submit a letter of explanation and certified copies of the records and order from the agency which issued the disciplinary action or agreed to the stipulation or discontinuance.

*Applicants who have been convicted of a violation of any state or federal controlled substance law or any drug or narcotic law must submit a letter of explanation and certified copies of the court documents.

3. Within the past five years, have you used drugs or alcohol in an addictive fashion, or have you been diagnosed as addicted to drugs or alcohol?

*Applicants who have voluntarily submitted or been required to submit for treatment for alcohol/drug dependency must submit a letter of explanation and treatment records. If treament included membership in AA, a letter from your sponsor explaining your progress is to be submitted.

*Applicants who have been involved in the possession, use, prescription for use, or diversion of controlled substances or legend drugs for other than legitimate or therapeutic purposes must submit a letter of explanation and certified copies of court, agency, institution records and/or treatment records.

4. Do you have, or have you in the past five years been diagnosed as having or been hospitalized for a psychotic condition; or do you have, or have you in the past five years been diagnosed as having or been hospitalized for any other mental condition that significantly impaired your ability to function?

*Applicants who have received treatment for a mental illness must submit a letter of explanation, copies of clinical records and a letter of evaluation from the treating practitioner.

5. Do you have, or have you in the past five years been diagnosed as having a physical or medical condition which may result in you being unable to practice counseling with reasonable skill and safety?

*Applicants who have received treatment for a physical or medical condition that may result in inability to practice counseling must submit a letter of explanation from applicant AND a diagnosis and prognosis must be submitted directly by treating physician or institution to this office.

EDUCATION

Is/Was your Mental Health Counselor Program acccredited by the Western Association of Schools and Colleges OR, an essentially equivalent national or regional accrediting body recognized by the Council on Postsecondary Accreditation at the time you completed the required education? . . . . . ☐Yes ☐No

List in chronological order the name of each college/university attended, degree earned and the year granted. A certified copy of an official transcript from each college/university listed must accompany the application.

PRINT OR TYPE CLEARLY — ATTACH ADDITIONAL 8½x11 SHEET IF NECESSARY

Name of Institution	Degree Granted (BA, MASTERS, ETC.)	Year Degree Granted
Western Washington University	M S	1978
Whitman College	BA	1972

POSTGRADUATE SUPERVISION

NOTE: Postgraduate supervision is defined as consisting of a total of one hundred documented hours of individual face-to-face case consultation with an approved supervisor, with no more than six hours per month to be allowed to accrue toward the total.

PRINT OR TYPE CLEARLY — ATTACH ADDITIONAL 8½x11 SHEET IF NECESSARY

Facility and Supervisor Name	From MONTH	From YEAR	To MONTH	To YEAR	Number of Hours PER MONTH	Number of Hours TOTAL
Mental Health Services Inc., Everett Dr. Caroline Rinke Ph.D Dr. Al Leider MD	1	1979	5	1982	4	160
Lewis County Mental Health Dr Ralph T. Hummel MD	10	1975	1	1979	6	234
Eastside Mental Health Dr. Lawrence Jacobs / Dr Robert Thompson	8	82	present		4	296

POSTGRADUATE PROFESSIONAL EXPERIENCE

NOTE: Postgraduate professional experience is defined as consisting of face-to-face counseling service with an individual or with a group of individuals for at least fifty percent of counseling service hours per week for a full or part time employee. The total number of supervised counseling hours is two thousand or more documented hours accumulated over a minimum of twenty-four months but not more than forty-eight months.

PRINT OR TYPE CLEARLY — ATTACH ADDITIONAL 8½x11 SHEET IF NECESSARY

Facility and Supervisor Name	Face-To-Face INDIVIDUAL	Face-To-Face GROUP	% of Counseling Service Hours PART-TIME	% of Counseling Service Hours FULL-TIME	Hours FROM MO/YR	Hours TO MO/YR	Hours TOTAL
Lewis County Mental Health Dr. Ralph Hummel MD	all	✓		✓	10/75	1/79	
Mental Health Services Inc Dr. Al Leider MD					1/79	5/82	
Family Counseling Services Inc. Virginia Reppman ACSW			✓ 10hrs/wk		12/79	5/83	
Eastside Mental Health Dr Lawrence Jacobs & Robert Thompson					8/82	present	

SUPERVISED EXPERIENCE—Equivalency Applicants Only

Alternate training and experience. Minimum requirement; at least 5 years of documented experience employed in a mental health setting with 2,000 hours of supervised face-to-face counseling

N/A

PRINT OR TYPE CLEARLY

ATTACH ADDITIONAL 8½x11 SHEET IF NECESSARY

Mental Health Practice Setting/Supervisor Name	From-To		Supervised Hours
	MONTH/YR	MONTH/YR	FACE-TO-FACE COUNSELING
		Total	

COMBINATION: SUPERVISED & UNSUPERVISED EXPERIENCE—Equivalency Applicants Only

2½ hours without supervision is equal to 1 hour with supervision

N/A

TYPE OR PRINT CLEARLY

ATTACH ADDITIONAL 8½x11 SHEETS IF NECESSARY

Mental Health Practice Setting/Supervisor Name	From-To		Supervised Hrs	Unsupervised Hrs
	MONTH/YR	MONTH/YR		
		Totals		

CREDENTIALED IN ANOTHER STATE

List all licenses/certifications obtained in other states (include if active or inactive). NONE

TYPE OR PRINT CLEARLY

ATTACH ADDITIONAL 8½x11 SHEETS IF NECESSARY

State	Date Issued	Number	Active/Inactive	Expiration

NOTE: The License and/or Credentialing Certification form enclosed must be completed by the State Board for each state listed above, regardless of the status of the license/certificate. The form may be duplicated as is necessary.

APPLICANT'S ATTESTATION

I, Douglas J. W. Bartholomew, certify that I am the person described and identified in this application, that I have read 18.130.170 RCW and 18.130.180 RCW, the Uniform Disciplinary Act. I attest that I have answered all questions truthfully and completely and the documentation provided in support of the application is, to the best of my knowledge, accurate. I further understand the Department may require additional information from me prior to making a determination regarding my application.

Douglas JW Bartholomew MS — 10/29/88

APPLICANT'S SIGNATURE — DATE

COURSE CONTENT IDENTIFICATION
MENTAL HEALTH COUNSELORS

(Return this form with your application.)

Applicant's Name Douglas J. W. Bartholomew Birthdate 01/03/50

REQUIREMENT

A master's or doctoral degree in mental health counseling or related field from a regionally accredited college or university, or a bachelor's degree and successful completion of at least 30 graduate semester hours or 45 graduate quarter hours in the field of mental health counseling or the substantial equivalent in the subject contact. Subject content includes a core of study relating to counseling theories, counseling philosophy, counseling practicum, counseling internship, and should incorporate content in professional ethics and law.

Please list below your courses which correspond to the given content areas. Attach course description if title does not clearly reflect course content. One course may satisfy more than one content area.

The core of study shall include at least 5 content areas (a) through (h) below and at least 2 additional content areas from the entire list.

CONTENT AREA	COURSE TITLE
a) assessment/diagnosis	12 credits, "psychological assessment"
b) career development counseling	3 credits "psychology of occupations"
c) counseling individuals	3 "clinical counseling" 5 "counseling/psych techniques"
d) counseling groups	3 credits - "group counseling"
e) counseling couples & families	
f) developmental psychology (may be child, adolescent, adult or life span)	3 - "developmental psychology"
g) abnormal psychology/ psychopathology	3 - "psychopathology" 2 - "behavioral pathology"
h) research and evaluation	6 - "design + analysis of experiments" 4 - "research"
i) multicultural concerns	
j) substance/chemical abuse	
k) physiological psychology	2 - physiological psychology
l) organizational psychology	
m) mental health consultation	
n) developmentally disabled persons	
o) abusive relationships	
p) chronically mentally ill	

STATE OF WASHINGTON
DEPARTMENT OF LICENSING

VERIFICATION OF
MENTAL HEALTH POSTGRADUATE SUPERVISION

APPLICANT: Use a separate form for each person verifying your postgraduate supervision and for each practice setting. This form may be duplicated. Complete applicant portion and forward supervisors.

PRINT OR TYPE CLEARLY

1. **Applicant**

Name Barthdolomew Douglas J.W. Birthdate 01/13/50
(LAST / FIRST / MIDDLE)

Preferred Street Address 10230 111th Ave NE

City Kirkland WA State WA Zip 98033

DIRECT SUPERVISOR: The above individual is seeking certification as a mental health counselor in Washington state and requires verification of postgraduate supervision. It will be appreciated if you would complete the following. Postgraduate supervision is defined as hours of individual face-to-face care consultation with an approved supervisor, with no more than 6 hours per month to be allowed to accrue toward the total.

48 mos x 4 hrs/mo = 192 hrs

2. **Employment**

Supervisor Name Dr. Lawrence Jacobs Phone (206) 827-9100

Facility Name Eastside Mental Health

Facility Street Address 2840 Northup Way NE

City Bellevue WA State WA Zip 98004

Dates applicant was under your supervision ..... From 8/8/82 to current

Total number of hours worked PER MONTH 160

Of the total hours PER MONTH, the number of hours of individual face-to-face case consultation with you .. 4+

3. **Supervisor**

Please provide a summary of your qualifications and credentials as a supervisor. *Note:* "Approved Supervisor" shall include a certified mental health counselor, licensed psychologist, licensed psychiatrist, or other mental health care provider who meets or exceeds the requirements of a certified mental health counselor. The supervisor may NOT be a blood or legal relative or cohabitant of the applicant.

Licensed or certified as Psychiatrist
(IF APPLICABLE)

7

3. **Supervisor** Continued

Qualifications Associate Clinical Professor, Univ of Wash Psychiatry Dept.
Full-time faculty, training residents and others 1965-9.
Eastside mental health (consultant).

I certify that the above information is, to the best of my knowledge, accurate and complete. I understand that Department may request additional information, if it is needed, to evaluate the application of the individual named on this document.

Signature Lawrence P Jacobs, MD
SUPERVISOR

Date 10-26-88

STATE OF WASHINGTON
DEPARTMENT OF LICENSING

VERIFICATION OF
MENTAL HEALTH POSTGRADUATE PROFESSIONAL EXPERIENCE

APPLICANT: Use a separate form for each person verifying your postgraduate professional experience and for each practice setting. This form may be duplicated. Complete applicant portion and forward to the individual who will provide verification.

PRINT OR TYPE CLEARLY

1. **Applicant**

Name Bartholomew (LAST) Douglas (FIRST) J. W. (MIDDLE) Birthdate 01/13/50

Preferred Street Address 10230 111th Ave NE

City Kirkland State WA Zip 98033

FACILITY/SUPERVISOR: The above individual is seeking certification as a mental health counselor in Washington state and requires verification of postgraduate experience. It will be appreciated if you would complete the following.
Postgraduate professional experience is defined as consisting of face-to-face counseling service with an individual or with a group of individuals for at least 50 percent of counseling service hours per week for a full-time or part-time employee. The total number of supervised hours is 2,000 or more documented hours accumulated over a minimum of 24 months but not more than 48 months.

2. **Employment**

24mos x 88 hrs/mo = 2112

Supervisor Name Cheryl Cebula Phone (206) 827-9100

Facility Name Eastside Mental Health

Facility Street Address 2840 Northup Way

City Bellevue State WA Zip 98004

Dates applicant was employed . . . . . From 8/2/82 to present

Applicant was a . . . . . ☑ Full-time employee ☐ Part-time employee

Number of face-to-face counseling service hours per week with an individual 40 10

Number of face-to-face counseling service hours per week with a group 48 12

Total number of supervised counseling service hours documented
(accumulated over a MINIMUM of 24 months but NOT MORE THAN 48 months) . . . . approx 6,000

3. **Supervisor**

Please provide a summary of your qualifications and credentials as a supervisor. *Note:* "Approved Supervisor" shall include a certified mental health counselor, licensed psychologist, licensed psychiatrist, or other mental health care provider who meets or exceeds the requirements of a certified mental health counselor. The supervisor may NOT be a blood or legal relative or cohabitant of the applicant.

Licensed or certified as (IF APPLICABLE) CMH Cebula MSW eligible for MHP, SW, MFT

3. **Supervisor** Continued

Qualifications_____

I/We certify that the above information is, to the best of my/our knowledge, accurate and complete. I/We understand that Department may request additional information, if it is needed, to evaluate the application of the individual named on this document.

Signature_____
SUPERVISOR/FACILITY REPRESENTATIVE

Date 11.2.99

Mental Health App

NAME _____

STATE OF WASHINGTON

DEPARTMENT OF LICENSING

Highways-Licenses Building • Olympia, Washington 98504 • (206) 753-6918

DATE: 5/87

THIS IS TO ADVISE YOUR APPLICATION FOR CERTIFICATION IS INCOMPLETE. THE ITEM CIRCLED INDICATES WHAT IS REQUIRED TO COMPLETE YOUR FILE.

1. APPLICATION SUBMITTED WITHOUT APPROPRIATE FEE: _____ $31.50
   (MAKE CHECK PAYABLE TO STATE TREASURER) _____ $63.00

2. PERSONAL DATA QUESTIONS ARE NOT ANSWERED COMPLETELY. APPLICATION WILL NOT BE REVIEWED UNTIL COMPLETED. FOLLOW INSTRUCTIONS FOR ANY QUESTIONS ANSWERED AFFIRMATIVELY.

3. PAGE 3 AND/OR 4 OF APPLICATION INCOMPLETE. (SEE ENCLOSED).

4. APPLICANT'S ATTESTATION NOT SIGNED OR DATED. (SEE ENCLOSED).

(5.) THE FOLLOWING SUPPORTING DOCUMENT(S) IS/ARE STILL REQUIRED:

_____

_____

_____

6. THE APPLICATION DOES NOT APPEAR TO MEET ONE OR MORE OF THE FOLLOW-REQUIREMENTS:

   A. EDUCATION _____

   B. SUPERVISION _____

   C. EXPERIENCE _____

IF YOU HAVE ANY QUESTIONS, OR NEED ANY ASSISTANCE, PLEASE CONTACT THIS OFFICE.

CORDIALLY,

THERESA FITZGERALD
COUNSELOR REGISTRATION/CERTIFICATION
P. O. BOX 9649
OLYMPIA, WA 98504
(206) 753-6936

MENTAL HEALTH/NORTH

AIDS TRAINING FOR MENTAL HEALTH CARE PROVIDERS

This is to certify that Doug Bartholomew attended and successfully completed a seven hour continuing education seminar "DEALING WITH HIV INFECTION AND AIDS IN THE MENTAL HEALTH SETTING" AT MENTAL HEALTH/NORTH on April 12, 1989.

The seminar included the following topics:

I. Etiology and epidemiology of HIV
   - A. Etiology
   - B. Reported AIDS cases in the United States and Washington
   - C. Risk groups/behaviors

II. Transmission and infection control
   - A. Transmission of HIV
   - B. Infection control precautions
   - C. Factors affecting risk for transmission
   - D. Risk for transmission to health care workers

III. Testing and counseling
   - A. HIV test information
   - B. Pre-test counseling
   - C. Post-test counseling

IV. Clinical manifestations and treatment
   - A. Clinical manifestations of HIV infection
   - B. Case management
   - C. Physical care
   - D. Psychosocial care
   - E. Home care
   - F. Resources
   - G. Neuropsychiatric aspects of HIV infection

V. Legal and ethical issues
   - A. Confidentiality as defined in the AIDS omnibus bill
   - B. Informed consent
   - C. Legal reporting requirements
   - D. Ethical issues
   - E. Civil rights
   - F. Specific application in the mental health setting

VI. Psychosocial issues
   - A. Personal impact of HIV continuum
   - B. The human response to death and dying
   - C. Issues for care providers
   - D. Family issues
   - E. Special populations including chronic mentally ill and developmentally disabled.

The seminar was designed, with assistance from the AIDS Training Project, to meet the requirements for AIDS education under the Omnibus AIDS Bill.

Carl Gaddis

Carl Gaddis, ACSW
Director Clinical Programs and Services
MENTAL HEALTH/NORTH

STATE OF WASHINGTON

DIVISION OF PROFESSIONAL LICENSING

THIS CERTIFIES THAT THE PERSON NAMED HEREON IS LICENSED AS PROVIDED BY LAW AS A

CERTIFIED MENTAL HEALTH COUNSELOR

REF # BA-RT-HD-J508BL

BARTHOLOMEW,DOUGLAS J W
10230 111TH AVE NE
KIRKLAND WA 98033

Mary Faulk
DIRECTOR

NUMBER	ISSUED DATE	EXPIRATION DATE
207-03 0000460	04-14-89	01-13-91

EMH
EMH
EMH

EASTSIDE MENTAL HEALTH

Equal Opportunity/Affirmative Action Agency, Member of United Way

David W. Briggs, M.S.W.
Executive Director

May 12, 1989

Washington State Department of Professional Licensure
Olmpia WA

To Whom It May Concern

Enclosed please find a copy of my verification for the AIDS training and a copy of my certification. I understand taht you needed a copy of this material to keep my certification current.

Thank you,

Douglas JW Bartholomew MS
Manager
Eastside Behavioral Responsibility Program

Main Center
Northup West Office Park
2840 Northup Way
Bellevue, WA 98004
827-9100

Bellewood Office
301 151st Pl. N.E.
Bellevue, WA 98007
641-2999

Bothell Office
18310 101st N.E.
Bothell, WA 98011
486-7181

Eastside Employee Programs
Northup West Office Park
2840 Northup Way
Bellevue, WA 98004
827-1990

Eastside Professional Associates
Northup West Office Park
2820 Northup Way
Bellevue, WA 98004
827-0717

Kirkland Office
Open Monday 1-5
486-7181

Mental Health app

NAME Bartholomew, Doug

STATE OF WASHINGTON

DEPARTMENT OF LICENSING

Highways-Licenses Building • Olympia, Washington 98504 • (206) 753-6918

DATE: 2-1-89

THIS IS TO ADVISE YOUR APPLICATION FOR CERTIFICATION IS INCOMPLETE. THE ITEM CIRCLED INDICATES WHAT IS REQUIRED TO COMPLETE YOUR FILE.

1. APPLICATION SUBMITTED WITHOUT APPROPRIATE FEE: _____ $31.50
   (MAKE CHECK PAYABLE TO STATE TREASURER) _____ $63.00

2. PERSONAL DATA QUESTIONS ARE NOT ANSWERED COMPLETELY. APPLICATION WILL NOT BE REVIEWED UNTIL COMPLETED. FOLLOW INSTRUCTIONS FOR ANY QUESTIONS ANSWERED AFFIRMATIVELY.

3. PAGE 3 AND/OR 4 OF APPLICATION INCOMPLETE. (SEE ENCLOSED).

4. APPLICANT'S ATTESTATION NOT SIGNED OR DATED. (SEE ENCLOSED).

(5.) THE FOLLOWING SUPPORTING DOCUMENT(S) IS/ARE STILL REQUIRED:

Graduate School Transcripts

6. THE APPLICATION DOES NOT APPEAR TO MEET ONE OR MORE OF THE FOLLOW-REQUIREMENTS:

   A. EDUCATION _____

   B. SUPERVISION _____

   C. EXPERIENCE _____

IF YOU HAVE ANY QUESTIONS, OR NEED ANY ASSISTANCE, PLEASE CONTACT THIS OFFICE.

CORDIALLY,

Theresa Fitzgerald

THERESA FITZGERALD
COUNSELOR REGISTRATION/CERTIFICATION
P. O. BOX 9649
OLYMPIA, WA 98504
(206) 753-6936

RECEIVED
APR 12 1989
LICENSING DIVISION