STATE OF CALIFORNIA

MENTAL HEALTH THERAPIST VERFICATION FORM

VCB-71-00003 (Rev. 08/2021)

Instructions: Please complete all fields on this form. When submitting the form, please include a copy of licenses for all providers listed.

SECTION 1 – PROVIDER'S INFORMATION

Licensed Provider Name	License Type
License Number	Expiration Date
Agency Name (if applicable)	
Work Mailing Address	
E-mail Address	Phone Number

Please list intern(s) that you supervise here, if applicable. Attach additional sheets if necessary.

SECTION 2 – INTERN'S INFORMATION (if applicable)

Name	License Type
License Number	Expiration Date
Work Mailing Address	
E-mail Address	Phone Number

Name	License Type
License Number	Expiration Date
Work Mailing Address	
E-mail Address	Phone Number

Please mail or fax this Reply Form to:
CALIFORNIA VICTIM COMPENSATION BOARD
PO Box 3036 • Sacramento, California 95812

Fax: 1-866-902-8669