STATE OF CALIFORNIA

MENTAL HEALTH THERAPIST VERIFICATION FORM

VCB–30–24010 (Rev. 12/2021)

Instructions: Please complete all fields on this form. When submitting the form, please include a copy of licenses for all providers listed. If the work mail address has changed in Section 1 include a current W-9 form located at https://victims.ca.gov/.

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:______________

Section 2 – Intern's Information *(if applicable)*

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

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, Email Or Fax This Reply Form To:

California Victim Compensation Board

Po Box 3036 • Sacramento, California 95812

Email: Maintenanceprovider@Victims.ca.gov • Fax: 1-866-902-8669