NATIONAL BOARD FOR CERTIFIED COUNSELORS®

NBCC Examination Request Form
for Recertification or Reinstatement

Name: _____

Address: _____

Daytime Telephone: _____ Certificate Number: _____ Certification Expiration Date: _____

Please register me for the following NBCC examination:

- ☐ National Counselor Examination (NCE)—for the NCC certification
- ☐ National Clinical Mental Health Counseling Examination (NCMHCE)—for the CCMHC certification

Examination Fee: $150

Past-Due Fees: $_____ (Contact NBCC if you are unsure of the past-due amount.)

Total: $_____

I understand that my payment is nonrefundable and my registration is contingent on available space at my chosen examination site.

FOR OFFICE USE ONLY
REF.#1:_____
BATCH #1: _____
DATE: _____
AMOUNT:_____

Signature: _____

Date: _____

SUBMIT YOUR REGISTRATION FORM

- By mail: NBCC; P.O. Box 63160; Charlotte, NC 28263-3160
- By fax: 336-547-0017

PAYMENT FORM

☐ Enclosed is a check or money order **payable to NBCC.**

☐ Please charge the credit card listed on the right.

Card Type: ☐ VISA ☐ MasterCard ☐ American Express Amount: $ _____

Name on Card: _____

Card Number: _____ Expiration Date: ___/___

Verification Code Numbers (from back of card): _____

Cardholder Signature: _____ Date: _____

Daytime Telephone: _____ Evening Telephone : _____