Secretary of State
Office of Professional Regulation
Board of Allied Mental Health Practitioners

Disclosure Document for Clinical Mental Health Counselors

First Name	Middle Initial	Last Name
Kathryn	W	Russell
		License #
Previous Name(s) (Maiden)		

Formal Education	Name of Institution:	The George Washington University
	Dates Attended:	8/26/2015 - 5/20/2019
	Degree(s) awarded, if any:	B.A., English
Formal Education	Name of Institution:	The University of Vermont
	Dates Attended:	8/27/2021 - 8/20/2023 (ongoing)
	Degree(s) awarded, if any:	
Experience	Description of Practice:	The University of Vermont, Counseling Program practicum
	Location: City/State/Zip	Burlington, VT
	Duration:	1/18/2022 - 5/6/2022
	Status:	Full-Time Part-Time
	Receive supervision or peer consultation?	(YES) NO
	How often?	weekly
Experience	Description of Practice:	
	Location: City/State/Zip	
	Duration:	___/___/___ - ___/___/___
	Status:	Full-Time Part-Time
	Receive supervision or peer consultation?	YES NO
	How often?	
Experience	Description of Practice:	
	Location: City/State/Zip	
	Duration:	___/___/___ - ___/___/___
	Status:	Full-Time Part-Time
	Receive supervision or peer consultation?	YES NO
	How often?	

Scope of Practice	**Therapeutic Orientation:**	Narrative and feminist
	Area of Specialization:	Anxiety management, sexual violence, LGBTQ issues
	Treatment Methods:	
	Special Qualifications:	

My practice is also governed by the Rules of the Board of Allied Mental Health Practitioners. It is unprofessional conduct to violate those rules. A copy of the rules may be obtained from the Board or online.

Client's Disclosure Confirmation

My signature acknowledges that I have been given the professional qualifications and experience of (Name, Name), a listing of actions that constitute unprofessional conduct according to Vermont statutes, and the method for making a consumer inquiry or filing a complaint with the Office of Professional Regulation. This information was given to me no later than my third office visit.
Kathryn Purcell 9/8/22
Client's Signature or Parent/Guardian Date
Practitioner's Signature Date