

**Mississippi Board of Examiners for
Social Workers/Marriage & Family Therapists
P.O. Box 4508
Jackson, MS 39296-4508
(601) 987-6806/Fax (601) 987-6808
www.swmft.ms.gov**

Application to Enter into Contract for Supervision toward Licensure as a Marriage and Family Therapist

Please type or print in black ink

I. Personal Information

1. Name _____
(Last First MI Maiden)

2. Mailing Address _____

(City State Zip County)

3. Date of Birth _____

4. Telephone Number: (____) _____

5. Email Address (not required) _____

6. Date of Birth ____/____/____

7. Social Security Number ____/____/____

8. Have you ever been licensed as a Marriage and Family Therapist in another jurisdiction?
Yes___ No___ If "Yes" please list each jurisdiction: _____

9. Are you licensed as a mental health professional by any other board (e.g., LPC, LMSW, etc)? Yes___ No___ If "Yes" please list each license/ jurisdiction: _____

10. Have you ever had a suit filed against you, or have you entered a malpractice settlement related to the practice of a profession? Yes No

11. Have you had a license to practice a profession revoked, suspended or otherwise sanctioned in Mississippi or any other jurisdiction? Yes No

12. Have you had any public or private disciplinary action taken against you by any authority issuing a professional license? Yes No

13. Have you been refused issuance of a license, or denied permission to take an examination for license, or pursuant to disciplinary action, denied renewal of a license by any board or agency in Mississippi or any other jurisdiction? Yes No

14. Have you knowingly failed to renew a license during an investigation or disciplinary action? Yes No

15. Have you been subject to disciplinary actions or had your membership revoked by a professional organization? Yes No

16. To the best of your knowledge, is there any disciplinary action pending against you by an agency, licensing board and/or professional organization? Yes No

17. Have you ever been arrested, charged, sentenced, or received a deferred judgment for the commission of a felony, or any crime involving moral turpitude in the United States or a foreign country? Yes No

18. Are you now, or have you been at any time during the past five (5) years, unable to practice a profession with reasonable skill and safety to the residents of the State of Mississippi due to any illness, mental or physical condition, or the use of alcohol, drugs, narcotics, chemicals, or any other material? Yes No

19. Have you ever voluntarily surrendered a professional licensure in any jurisdiction or state? Yes No

20. Have you ever had your hospital staff privileges revoked or restricted, or have you resigned from a staff position instead of facing a disciplinary action? Yes No

If you answered 'Yes' to any of the preceding questions 10 through 20, attach a full explanation, relevant documents and a description of your status.

II. Education Information

Qualifying degrees must be granted from a **COAMFTE (Commission on Accreditation for Marriage and Family Therapy Education) accredited marriage and family therapy program**. List your master's or doctoral degree in marriage and family therapy. **A transcript of degree must be sent directly to the Board by the institution.**

1. Institution Granting Degree _____

2. Degree Earned _____

3. Is this degree earned in a COAMFTE accredited program? Yes No

4. Date Degree earned (month/year) _____

III. Employment information

An individual seeking licensure must complete two years of documented clinical experience following the first qualifying *graduate* degree in the practice of marriage and family therapy **within an agency, institution, or group practice setting** under supervision approved by the Board. **An individual seeking status as a Licensed Marriage and Family Therapist who does not have the documented clinical experience in an agency, institution, or a group practice setting will be practicing outside of Board's Rules and Regulations, and his or her Plan of Supervision will not be approved by the MFT Discipline Specific Committee or the Board. This experience must include a minimum of 1,000 client contact hours.** All documentation of both the clinical experience and the supervision as requested in the application process must be sent by the agency or supervisor directly to the Board.

1. Current Employer's Business Name and Address

(City State Zip County)

2. Position/Title _____

IV. Supervision Agreement

Please list below information about the approved supervisor you will be working with as a supervisee:

1. Name _____

(Last First MI Maiden)

2. Mailing Address

(City State Zip County)

3. MFT License Number, Date of Issue, State of Issue _____

5. Telephone Number: (____) _____

6. Email Address (not required) _____

V. This Section is to be completed by the Supervisor:

1. Are you a Board approved supervisor? Yes No
 2. How many (not including this applicant) supervisees are you currently supervising toward licensure to become an LMFT in Mississippi? _____
 3. To the best your knowledge, has the applicant's license, clinical privileges, hospital staff membership, professional association membership, or other professional status ever been denied, challenged, suspended revoked, modified, or voluntarily surrendered in lieu of disciplinary action? Yes No
 4. To the best of your knowledge, is there any disciplinary action pending against the applicant? Yes No
 5. To the best of your knowledge, has the applicant ever had a suit filed against him/her or entered into a malpractice settlement related to the professional practice? Yes No
 6. To the best of your knowledge, has the applicant ever been arrested, charged, sentenced, or received a deferred judgment for the commission of a felony, or any crime of moral turpitude in the United States or a foreign country? Yes No
 7. To the best of your knowledge, is the applicant now, or has he/she been at any time during the past five (5) years, unable to practice a profession with reasonable skill and safety to clients, due to any illness, mental or physical condition, or the use of alcohol, drugs, narcotics, chemicals or any other material? Yes No
- If you answered "YES" to any of the questions numbered 3 to 7, please attach a full explanation to this form.**
8. If you have any additional information which would assist the Board in making a decision on approval of this application, please provide the information below (or send in a separate communication):
-

Signature of Proposed Supervisor _____

Date _____

VI. Acceptance of Responsibility for Accuracy of Information

Do you fully understand that any inaccurate information or misrepresentation of facts on this application, or any form submitted to the Board, may result in a denial of this application, denial of licensure, or revocation of the license later? Yes No

VII. Oath and Consent for Investigation of Qualification for Licensure

I, the undersigned, do hereby affirm under the penalty of perjury that all statements made and information contained in this application are true and correct to the best of my knowledge and belief. Further, I consent to a thorough investigation by the Board and its representatives, of my education, employment, and clinical records, and any other information that may be necessary to verify my qualifications for this approval.

Signature of Applicant Printed Name Date

Subscribed and sworn to before me this _____ day of _____, 2____;
County _____ State _____

Notary Seal _____
Notary Signature _____
My Commission expires: _____

Submit application along with \$100.00 processing fee, a Passport-like Photo, a completed Supervisor’s Statement, and a Plan of Supervision (see Guide to Supervision provided by Board) to the Mississippi Board of Examiners for Social Workers & Marriage and Family Therapists, P.O. Box 4508, Jackson, MS 39296-4508. As a reminder, a transcript of your degree must be sent directly to the Board by the institution.

(No exceptions, fee is non-refundable.)

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Supervisor's Statement

As a supervisor, I agree to work with _____ to complete a written, detailed plan of supervision, and will strongly consider including, but not necessarily limit to, the following (see manual Guide to Supervision for Candidates Seeking Licensure as an LMFT for further guidance):

<u>Orientation</u>	<u>Professional Development</u>	<u>Practice Content</u>
Purpose of Supervision	Knowledge	Application of Theories/Models
Goals of Supervision	Skills	Responsibilities to yourself, your clients, and your community
	Values	Commitment to learning and service
	Research	

As a supervisor, I agree to Face-to-face interaction with _____, in periods of approximately one (1) hour each on a weekly basis or two (2) hours each on a biweekly basis for a period not to exceed thirty-six (36) months, during which time the declarations of this plan of supervision will be addressed. I understand that the supervisee must complete a total of 100 hours of post graduate supervision. More specifically, I agree to base my supervision on an integration of marriage and family therapy clinical and supervision constructs.

I understand I am required to submit evaluations each six months following the approval of the Plan of Supervision by the Board, with a copy to the supervisee, a copy to be sent to the Board, and a copy maintained in my files for a period of three years. If this contract is terminated by either party, I will promptly complete the relevant evaluation and termination forms and submit them to the Board of Examiners.

I do hereby declare I am I am a currently a Board approved supervisor in good standing, and I am willing to practice within the AAMFT Code of Ethics and within the boundaries of the laws of the State of Mississippi and the United States. I further agree to keep my approval as a supervisor in good standing throughout the process of this supervisory experience.

Signed _____

Print Signature _____

Date _____

INSTRUCTIONS: Make a copy of this document for your records and return the original to the applicant for submission as part of the Plan of Supervision to the Board of Examiners.