CONFIDENTIAL PROFESSIONAL REFERENCE

Notice to Applicant: Complete the first section of this form, and mail copies to at least three (3) licensed mental health professionals for a personal reference. Make copies of the original form as needed.

I. TO BE COMPLETED BY THE APPLICANT

Name of
Applicant ____
Last First Middle Maiden(if applicable)

Address ____
Street City State Zip Phone

I hereby authorize__________________________________ to release the requested information.

____ __________________________
Applicant Signature Date

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II. TO BE COMPLETED BY LICENSED MENTAL HEALTH PROFESSIONAL

1. How long have you known the applicant? __________________________________

2. In what capacity have you known the applicant?______________________________

   ____

3. During what time period have you had an opportunity to observe directly the applicant's clinical practice of marriage and family therapy? _______________________________

   ____

4. Based on personal knowledge and observation, I believe the applicant has: (mark one) Poor____, Marginal____, Average____, Good____, Outstanding____, qualifications and skills for the clinical practice of marriage and family therapy.

5. 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

6. To the best of your knowledge, is there any disciplinary action pending against the applicant? Yes No

7. 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

8. To the best of your knowledge, has the applicant ever been arrested, charged, sentenced, or received a deferred judgement for the commission of a felony, or any crime of moral turpitude in the United States or a foreign country? Yes No

9. 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 preceding questions 5 through 9, please attach a full explanation to this form.

10. If you have any additional information which would assist the Board in making a decision on licensure for this applicant, please provide the information below:

____

____

11. How would you summarize your recommendation of this applicant for licensure as a marriage and family therapist?

____ Recommend without reservation
____ Recommend
____Would not recommend
____ Unable to make a judgement

____
Signature of Reference Printed Name Title Date

____
Your Discipline Type of License License# Expiration Date

____
Street Address City State Zip Phone

Please return the completed form directly to the following Board address:

Mississippi Board of Examiners for
Social Workers& Marriage and Family Therapists
P.O. Box 4508 ● Jackson, MS 39296-4508