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

Application for Licensure as a Licensed Marriage and Family Therapist

Please type or print

I. Personal Information

1. Name _____
Last First MI Maiden

2. Mailing Address _____

_____
City State Zip County

3. Business Address _____

_____
City State Zip County

4. Current Employer _____ Position/Title _____

5. Telephone Number(s): Home (____) _____ Business (____) _____

6. Date of Birth ____/____/_____ Social Security Number _____/____/_____

7. 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 □

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

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

10. 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 □

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

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

13. 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 □

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

15. 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 □

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

17. 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 7 through 19, 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 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.** ***(No exceptions, application fee is non-refundable.)***

Name of Institution	**Location City, State**	**Degree Obtained**	**Month, Yr. Degree granted**

III. Clinical Practice Experience As A Marriage and Family Therapist

Beginning with your current position, please list your clinical experience in the field of marriage and family therapy. A minimum of 1,000 client contact hours is required (attach additional sheets if necessary).

Date Begin - End	**Employer or Site**	**Title or Responsibility**	**Total Client Hours**

Please forward the attached **Verification of Post Degree Experience in Clinical Practice of Marriage and Family Therapy** form to the employer(s) or site(s) you are using to qualify for licensure.

IV. Supervision of Clinical Experience

Please list below the supervision you have had in the professional practice of marriage and family therapy. A total of 200 hours of supervision is required. At least a100 hours must be completed by a AAMFT approved supervisor.

Date(s) Begin - End	Name of Supervisor	Hours by Type Individual	Group

Please send the attached **Documentation of Supervision of Marriage and Family Therapy** form to the above supervisor(s) you are using to qualify for licensure

V. Other Marriage and Family Therapy Licensure or Certification

Have you ever been licensed as a Marriage and Family Therapists in another jurisdiction?
Yes □ No □ If "Yes" please list each jurisdiction:_____

If you are requesting licensure by endorsement, please forward the enclosed **Verification of Licensure** form to each state which you have ever been licensed as a marriage and family therapists..

Do you now hold or have you in the past held a professional license or certification in a mental health field in Mississippi or any other state or jurisdiction? Yes □ No □
If yes, complete the following (attach extra sheets if necessary).

Certification or License Title	Jurisdiction	Certification/ License #	Date Issued	Expiration Date

VI. Method of Licensure

Please **circle** the method by which you are applying for licensure. Attach or have forwarded to the Board, all supporting documents related to that method of licensure.

a. Education, Clinical Experience and Examination - official transcript from a COAMFTE program, clinical supervision and experience, and a passing score on the AMFTRB Examination.

b. Endorsement, if the requirements in that state are, on the date of licensure, substantially equal to the current requirements of the Mississippi Board of Examiners. That includes documentation of a current MFT license in another state, official transcript, clinical supervision and experience, and a passing score on the AMFTRB Examination. The Board may waive the examination requirement only under exceptional circumstances.

2. 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 licensure or revocation of the license later? Yes □ No □

3. 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 the practice of marriage and family therapy.

I have read and understand the current edition of the Mississippi Board of Examiners for Social Workers and Marriage and Family Therapists Rules and Regulations for Licensed Marriage and Family Therapists within the preceding 90 days. Furthermore, I agree to comply with the requirements stated therein.

_____ _____
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 cashier's check or money order for the amount of <u>$100.00 for application fee</u> and passport-like photo to the address at the top of this page.

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CONFIDENTIAL PROFESSIONAL REFERENCE

Notice to Applicant: Complete the first section of this form, and mail to at least three (3) licensed mental health professionals for a professional 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

++

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 □

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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 Board at the address at the top of this page. Thank you for your assistance.

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Verification of Post-Degree Experience in the Clinical Practice of Marriage and Family Therapy

Notice to Applicant: Please complete the first section of this form and send a copy to the director or supervisor of each practice site or agency in which you practiced marriage and family therapy following the receipt of the master's or doctoral degree in marriage and family therapy. You need documentation of at least two years of experience with a minimum of ten (10) hours of marriage and family therapy per week.

I. TO BE COMPLETED BY THE APPLICANT

Applicant's Name _____ SS# _____ - ____- _____

Address _____
Street City State Zip Phone

Practice Site or Agency_____

Address _____
Street City State Zip Phone

Position/Title _____

Description of Responsibilities _____

_____

Dates of Practice: From _____ To _____
Month/Year Month/Year

Total weeks of practice at this site: _____ Average MFT clinical hours/week _____

Total clinical hours at this site: Individual _____ Groups _____ Couples/Families _____
_____

Oath and Authorization to Release

I attest that the above information is a true and accurate representation of my experience in the clinical practice of marriage and family therapy at the above site. Further, I authorize the above agency, director or supervisor to release the requested information.

_____

Signature of Applicant Printed Name Date

Continued on reverse side

II. TO BE COMPLETED BY PRACTICE SITE DIRECTOR OR SUPERVISOR

Please review the applicant's description of his/her clinical practice of marriage and family therapy at your site/agency. If you have any additional information which would assist the Board in making a decision on licensure for this applicant, please provide that information below:

_____

_____

_____

I attest that I served as (please indicate) director or supervisor for the applicant during the clinical experience described above and that this description is a true and accurate representation of the applicant's clinical experience in marriage and family therapy at this site.

_____
Director or Supervisor's Signature Printed Name Date

Name of Site_____ Phone _____

_____
Address City State Zip

(If the director or supervisor who worked with the applicant cannot be located, the current director or supervisor may verify the applicant's experience based on a review of the available records.

After a diligent and thorough search of available records, I attest that this description is a true and accurate record of this applicant's clinical experience in marriage and family therapy at this site.

_____
Director or Supervisor's Signature Printed Name Date

Name of Site_____ Phone _____

_____
Address City State Zip

Please return this completed form directly to the Board at the address listed on top of this page. Thanks for your cooperation.

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Documentation of Supervision of Marriage and Family Therapy

Notice to applicant: Please complete the first section of this form and mail a copy to each person who provided supervision for at least two years of your clinical experience in marriage and family therapy. Make extra copies of the blank form as needed.

I. TO BE COMPLETED BY THE APPLICANT

Applicant's name _____ SS#_____- _____- _____

_____
Address City State Zip

Name of Supervisor _____ Title _____

Location of Supervision _____

Dates of Supervision: From _____ To: _____
Month/Year Month/Year

Number of hours of MFT Supervision: Individual _____ Group _____ Total _____

Description of your clinical practice which was supervised _____

_____

_____

Description of your supervision _____

_____

Oath and Authorization to Release Requested Information

I attest that the above information is a true and accurate representation of my supervision in the clinical practice of marriage and family therapy. Further, I authorize the above-named supervisor to release the requested information.

_____
Applicant's Signature Printed Name Date

Continued on reverse side

II. TO BE COMPLETED BY SUPERVISOR

Please review the applicant's description of his/her supervision during the clinical practice of marriage and family therapy. If you have any additional information which would assist the Board in making a decision on licensure for this applicant, please provide that information below:

_____

_____

I attest that I am aware of applicant's supervision experience described on this form and that this description is a true and accurate representation of the supervision of marriage and family therapy I provided for the applicant.

_____

Supervisor's Signature Printed Name Date

_____

Address City State Zip

_____

Supervisor's Discipline Type of License License # State Expiration Date

(In the event the above-named person who provided the supervision cannot be located, if the supervision was provided in a training center or other agency, the current supervisor may attest to the supervision based on a review of the available records.)

After a diligent and thorough search of available records, I attest that this applicant's description of his/her supervision of marriage and family therapy is a true and accurate record of the supervision provided through this office by the above-named supervisor.

_____

Current Supervisor's Signature Printed Name Date

Name of Agency or Center_____

_____

Address City State Zip Phone

Reason supervisor could not be located_____

_____

Please return this completed form directly to the Board at the address listed on top of this page. Thanks for your assistance.

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State Board of Examiners for Social Workers and Marriage & Family Therapists
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Verification of Licensure in Marriage and Family Therapy

Part I - TO BE COMPLETED BY APPLICANT

Applicant's
Name_____
Last First Middle Maiden(if applicable)

Address_____
Street City State Zip

_____
Type of License License # Date First Issued Expiration Date

Authorization to release information: I hereby authorized _____
(Name of Agency)
_____ to release information requested below.

_____
Applicant's Signature Date

Part II - TO BE COMPLETED BY LICENSURE BOARD

Verification of Licensure: This is to certify that the above-named applicant was issued license or certificate number _____ on date _____ entitling her/him to use the title Marriage and Family Therapists and/or the right to practice marriage and family therapy.

Current Status: Active _____ Inactive _____ Lapsed _____ Suspended _____

The license was granted on the basis of: Graduated degree with clinical experience _____,

State examination, _____ Endorsement with license from the State of_____

_____.

1. At the time of licensure was this applicant required to pass an examination, the content of which tested competence to practice marriage and family therapy? Yes □ No □

2. At the time of licensure, did this applicant show proof of have a graduate degree in marriage and family therapy? Yes □ No □

3. At the time of licensure, did this applicant show proof of at least two years of clinical practice under supervision in marriage and family therapy? Yes □ No □

4. Has this license ever been encumbered in any way (suspended, revoked, surrendered, restricted, limited, or placed on probation)? Yes □ No □

5. Are there any complaints pending against this applicant? Yes □ No □

6. Do your agency records concerning this applicant contain any information that is derogatory in nature? Yes □ No □

7. Do you know of any reason why this individual would be unable to practice marriage and family therapy with reasonable skill and safety to the residents of the State of Mississippi due to any mental or physical condition, illness, or use of alcohol, drugs, narcotics, chemicals or any other type of material? Yes □ No □

If you answered "YES" to any of the questions 4 through 7 above, please explain.

_____

_____

_____

Signature_____ Date _____

Title _____

State Board _____

Address_____
Street or P.O. Box

City_____ State _____ Zip _____

Thank you for your assistance.

Please return this form to the Board at the following address:

MS Board of Examiners for SW/MFT
Post Office Box 4508
Jackson, MS 39296-4508