



BOARD OF EXAMINERS
P.O. BOX 4508
Jackson, MS 39296-4508
Phone (601)987-6806/Fax (601)987-6808
www.swmft.ms.gov
info@swmft.ms.gov

Confidential
Professional Reference

Indicate type of licensure you are applying for at this time: LMFTA LMFT

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 _____ Email _____

I hereby authorize _____ to release the requested information to the MS Board of Examiners for Social Workers and Marriage and Family Therapists.

Applicant Signature Print Name 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
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 judgment 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 judgment

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 address above.