Reset Form

APPLICATION FOR LICENSURE AS A MARRIAGE AND FAMILY THERAPIST (LMFT) OR A MARRIAGE AND FAMILY THERAPIST ASSOCIATE (LMFTA)

State Form 50710 (R12 / 3-25)
Approved by the State Board of Accounts, 2017

BEHAVIORAL HEALTH AND HUMAN SERVICES LICENSING BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 234-2054
E-mail: pla8@pla.in.gov
www.pla.IN.gov

INSTRUCTIONS:

1. *The fee for this application is $50.00, payable to the Indiana Professional Licensing Agency, in accordance with 839 IAC 1-2-5.*
2. *If applying for a temporary permit, please include your fee of $25.00 in accordance with 839 IAC 1-2-5. Please note that only LMFT examination applicants are eligible to request the temporary permit per IC 25-23.6-8-1.5(b).*
3. *Completed application and fees should be mailed to the address listed in the upper right-hand corner of this form.*
4. *All fees are non-refundable and non-transferable.*
5. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

FOR OFFICE USE ONLY

Application fee	Permit fee
Date fee paid *(month, day, year)*	Date fee paid *(month, day, year)*
Receipt number	Receipt number
License number issued	Permit number issued
License issuance date *(month, day, year)*	Permit issuance date *(month, day, year)*

DO NOT WRITE ABOVE THIS LINE

BASIS FOR LICENSURE

License Type:
☐ Marriage and Family Therapist ☐ Marriage and Family Therapist Associate

Obtained by Method: *Associate applicants must apply by examination.*
☐ Examination ☐ Reciprocity

Do you wish to apply for a temporary permit?*
**One (1) permit allowed per applicant. Temporary permit applicants are required to meet and are subject to the requirements provided under:*
(1) IC 25-23.6-8-1.5, for marriage and family therapist associate (LMFTA) license applicants.
(2) IC 25-23.6-8-10 and 839 IAC 1-4-6, for marriage and family therapist (LMFT) license applicants.

Yes No

APPLICANT INFORMATION

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory, and this record cannot be processed without it.
** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

Name of applicant *(last, first, middle)*	Social Security number *
Date of birth *(month, day, year)*	Gender ** ☐ Male ☐ Female
Address of applicant *(number and street or rural route)*	City, state, and ZIP code
Telephone number *(daytime)*	E-mail address

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select one of the following.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 1641). ☐ I am authorized by the federal government to work in the United States.

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? Yes No	Are you an active-duty member of the military? *(Optional)* Yes No

ORGAN & TISSUE DONOR

In 2022, the Indiana State Legislature passed a law (SEA 260) allowing Indiana residents to sign up as organ donors when seeking or renewing professional licenses via the Indiana Professional Licensing Agency. More than 100,000 people are awaiting a lifesaving transplant, and more than 1,000 of those waiting are Hoosiers, so your decision to say "yes" can truly help save lives.

By selecting "yes", I affirm that I wish to be an organ donor upon my death. I would like to donate all organs for transplant, research, and education. At the time of my death, I understand that my family cannot override my decision. I understand this online sign-up is binding and is a legal document of gift. I do solemnly swear, affirm or certify that I am the applicant described in this application and that the information entered herein is true and correct.

Do you want to sign up to be an organ and tissue donor? ☐ Yes ☐ Not Today

EXAMINATION INFORMATION

ELIGIBILITY FOR EXAMINATION PRIOR TO GRADUATION [MARRIAGE AND FAMILY THERAPIST ASSOCIATE (LMFTA) APPLICANTS ONLY]

Pursuant to IC 25-23.6-8-3, marriage and family therapist associate (LMFTA) applicants who are:

(1) Enrolled in the last "term" of the last year of their program leading to their degree that meets the requirements of IC 25-23.6-8-1.5(a)(1); and
(2) provide a "Letter of Good Standing" from the director of the marriage and family therapy department or the director's designee;

may take the examination provided by the Behavioral Health and Human Services Board [the Association of Marital and Family Therapy Regulatory Boards (AMFTRB) National Examination] prior to graduation.

The "Letter of Good Standing" provided by the director or the director's design must include the follow information:

(1) The applicant's first and last name.
(2) The type of degree and program in which the applicant is enrolled.
(3) A statement confirming that the applicant is currently in the final term of the program.
(4) The anticipated date of completion of the program.
(5) A statement confirming that the applicant is in good academic standing.

LMFTA applicants who meet these eligibility requirements and are interested in being approved to register and take the AMFTRB National Examination during their last "term" prior graduation should indicate their interest by "checking" (✓) the box below and supply their "Letter of Good Standing" with this application.

☐ I affirm that I meet the eligibility requirements provided above, and I would like to be approved to register and take the Behavioral Health and Human Services Board's examination (the AMFTRB National Examination), towards my LMFTA license. I affirm that I am including my "Letter of Good Standing" with this application.

If you have already passed the AMFTRB National Examination, please provide the following information:

Date the examination was completed *(month, day, year):* _____	State in which the examination was completed*:* _____

GRADUATE EDUCTION (Master's or Doctoral)

Name of academic institution	Department	Program title
Location *(city and state)*	Dates attended *(mm/yy – mm/yy)*	Degree earned
Name of academic institution	Department	Program title
Location *(city and state)*	Dates attended *(mm/yy – mm/yy)*	Degree earned
Name of academic institution	Department	Program title
Location *(city and state)*	Dates attended *(mm/yy – mm/yy)*	Degree earned

EMPLOYMENT HISTORY FOR THE PAST FIVE (5) YEARS

Please list all places of professional employment, including self-employment.

Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed *(mm/yy – mm/yy)*	Average number of hours per week
Duties and responsibilities		

Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed *(mm/yy – mm/yy)*	Average number of hours per week
Duties and responsibilities		
Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed *(mm/yy – mm/yy)*	Average number of hours per week
Duties and responsibilities		
Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed *(mm/yy – mm/yy)*	Average number of hours per week
Duties and responsibilities		
Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed *(mm/yy – mm/yy)*	Average number of hours per week
Duties and responsibilities		

STATES LICENSED

List all states and territories, ***including Indiana***, in which you have been licensed to practice any regulated health occupation. Verification of all listed licenses must be submitted directly to the board from the state / territory that issued each license. *Licenses issued by the Indiana Professional Licensing Agency will not need verifications.*

Type of License / Certificate / Registration / Permit	State	Number	Date Issued *(month, day, year)*	Status

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit pursuant to this application.

1.	Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold of have held?	Yes	No
2.	Have you ever been denied license, certificate, registration or permit to practice any regulated health occupation in any state *(including Indiana)*, country, or U.S. Territory?	Yes	No
3.	Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice in a competent, ethical, and professional manner?	Yes	No
4.	*Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*		
	(1) have you ever been arrested;	Yes	No
	(2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;	Yes	No
	(3) have you ever been convicted of any offense, misdemeanor, or felony in any state;	Yes	No
	(4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or	Yes	No
	(5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state?	Yes	No

5.	Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline of limitations?	Yes	No
6.	Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	Yes	No
7.	Have you ever had a malpractice judgment against you or settled any malpractice action?	Yes	No

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency or any of its authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions from any liability with regard to such inspection or furnishing of any information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I affirm, under penalties for perjury, that the foregoing representations are true.

Signature of applicant	Date *(month, day, year)*

(Continued on the reverse side.)

FORM I VERIFICATION OF SUPERVISION FOR MARRIAGE AND FAMILY THERAPIST (LMFT) LICENSURE APPLICANTS

Part of State Form 50710 (R11 / 8-24)

GENERAL INSTRUCTIONS: *All information on this form must be typed or clearly printed. You are authorized to photocopy this form as necessary. Sign the form and upload to your (the applicant's) online application as applicable or mail them to the address provided in the top right corner of the first page of this application.*

SECTION A / APPLICANT INFORMATION

SECTION A INSTRUCTIONS FOR APPLICANT: *Complete this section and then forward this form to your direct supervisor(s) of your previous or current employer(s) for completion of* ***SECTION B.*** *You must submit proof that you have acquired at least two hundred (200) hours of post-graduate clinical supervision comprised of at least one hundred (100) hours of individual supervision as described in IC 25-23.6-8-2.7. This supervision must be completed in no less than twenty-four (24) months while employed. The supervision must have been provided by a "qualified supervisor" as defined in 839 IAC 1-4-5. If you obtained your hours in another state or jurisdiction, it will be reviewed by the Board. If you are no longer able to contact your direct supervisor(s) of your previous employer(s), a professional colleague of your previous employer(s) should complete* ***SECTION C*** *(on the reverse side of this form) for each previous direct supervisor.*

Name *(last, first, middle)*	Date of birth *(month, day, year)*
Name of supervisor	Name of business / institution of supervisor
Supervisor title	Business address of supervisor *(number and street, city, state, and ZIP code)*
Applicant's employer during time of supervision	

I hereby authorize _____ to furnish the Professional Licensing Agency with the information below.

Signature of applicant	Date *(month, day, year)*

SECTION B / SUPERVISOR INFORMATION

SECTION B INSTRUCTIONS FOR APPLICANT'S DIRECT SUPERVISOR: *Complete this section. All supervision may be completed either in person or virtual. However, any completed virtual supervision is required to meet the definition of "virtual supervision" under IC 25-23.6-8-2.7.*

Name of supervisor *(last, first, middle)*	State license / certificate number / type of license / certificate	
License / Certificate issued by	Name of business / institution of supervisor	Business telephone number ( )
Business address of supervisor *(number and street, city, state, and ZIP code)*		E-mail address
Number of years experience in Marriage and Family Therapy		
Applicant's job during the time of supervision	Applicant's employer during the time of supervision	
Date supervision began *(month, day, year)*	Date supervision ended *(month, day, year)*	
Total number of supervision hours completed	Number of hours of individual supervision	

Confirm direct service types provided under supervision per IC 25-23.6-8-2.7. Select all that apply:

☐ Unmarried Couples ☐ Married Couples ☐ Separating or Divorced Couples ☐ Family Groups, including children

A. I was present at the applicant's place of work.	☐ True	☐ False
B. The applicant's place of work was at a different site but:		
(1) There was an equivalent supervisor on site.	☐ True	☐ False
(2) The applicant was not engaged in independent private practice.	☐ True	☐ False

Brief description of how supervision was conducted:

I affirm that the supervision provided above is true to the best of my knowledge and belief. I affirm that any virtual supervision completed met the definition of "virtual supervision" under IC 25-23.6-8-2.7.

Signature of Supervisor, [please provide your professional credential (i.e., LMFT)]:	Title:
Printed Name of Supervisor:	Date *(month, day, year)*:

FORM I VERIFICATION OF SUPERVISION FOR MARRIAGE AND FAMILY THERAPIST (LMFT) LICENSURE APPLICANTS *(continued)*

Part of State Form 50710 (R11 / 8-24)

SECTION C / AFFIRMATION OF SUPERVISION [UNABLE TO CONTACT DIRECT SUPERVISOR(S)]

SECTION C INSTRUCTIONS FOR PROFESSIONAL COLLEAGUE OF APPLICANT'S EMPLOYER: *This section is to be completed by a professional colleague of the applicant's previous employer, if the applicant's previous direct supervisor is no longer able to complete* ***SECTION B*** *(on reverse side of this form). Please indicate below the reason why the applicant's previous direct supervisor is no longer able to complete* ***SECTION B*** *(on the reverse side of this form).* ***If you are affirming supervision received from more than one previous direct supervisor of a previous employer, this form may be duplicated but you must submit one AFFIRMATION OF SUPERVISION for each previous direct supervisor that is no longer able to complete SECTION B (on the reverse side of this form).***

Please indicate below the reason why the applicant's direct supervisor is no longer able to complete SECTION B.

The applicant's direct supervisor named below is:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please briefly explain:

Name of supervisor *(last, first, middle, maiden)*	License number

Applicant's job duties during the time of supervision:	Applicant's employer during the time of supervision:
Date supervision began *(month, day, year)*	Date supervision ended *(month, day, year)*
Total number of supervised hours	Number of hours of individual supervision

Confirm direct service types provided under supervision per IC 25-23.6-8-2.7. Select all that apply:

☐ Unmarried Couples ☐ Married Couples ☐ Separating or Divorced Couples ☐ Family Groups, including children

Brief description of how supervision was conducted

I hereby swear or affirm, under the penalties of perjury, that the statements made are true, complete, and correct.

Signature of professional colleague	Date *(month, day, year)*

(Continued on the reverse side.)

FORM II VERIFICATION OF EMPLOYMENT / EXPERIENCE FOR MARRIAGE AND FAMILY THERAPIST (LMFT) LICENSURE APPLICANTS

Part of State Form 50710 (R11 / 8-24)

GENERAL INSTRUCTIONS: All information on this form must be typed or clearly printed. You are authorized to photocopy this form as necessary. Sign the form and upload to your (the applicant's) online application as applicable or mail them to the address provided in the top right corner of the first page of this application.

SECTION A / APPLICANT INFORMATION

SECTION A INSTRUCTIONS FOR APPLICANT: *Complete this section and then forward this form to your direct supervisor(s) of your previous or current employer(s) for completion of* ***SECTION B****. You must submit proof that you have completed one thousand (1000) hours of post-graduate clinical experience, during which at least fifty percent (50%) of your clients were receiving marriage and family therapist services. This clinical experience must be obtained in no less than twenty-four (24) months. If you obtained your hours in another state or jurisdiction, it will be reviewed by the Board. This form may be duplicated if your experience was completed at more than one place of employment. If you are no longer able to contact your direct supervisor(s) of your previous employer(s), a professional colleague of your previous employer(s) should complete* ***SECTION C*** *(on the reverse side of this form) for each previous direct supervisor.*

Name *(last, first, middle)*	Date of birth *(month, day, year)*

Employer's name of business	Employment Business Address *(number and street, city, state, and ZIP code)*
Name of direct supervisor	Direct supervisor title

I hereby authorize _____ to furnish the Professional Licensing Agency with the information below.

Signature of applicant	Date *(month, day, year)*

SECTION B / EMPLOYER / EMPLOYMENT INFORMATION

SECTION B INSTRUCTIONS FOR APPLICANT'S DIRECT SUPERVISOR: Complete this section.

Name of direct supervisor/employer *(last, first, middle)*

Name of business / institution where employed	Business E-mail address

Business address *(number and street, city, state, and ZIP code)*

Telephone number of business / institution ( )	Date employment began *(month, day, year)*	Date employment ended *(month, day, year)* *If currently employed, please indicate*

Average hours worked per week	Total clinical hours earned	Total relational hours earned

Provide a brief description of job duties:

The applicant pursuant to my order, control, and full professional and legal responsibility as an employer has performed the above-indicated experience. I do hereby declare that the information contained herein is true and correct.

Signature of direct supervisor/employer	Title
Printed Name of direct supervisor/employer	Date *(month, day, year)*

(Continued on the reverse side.)

FORM II VERIFICATION OF EMPLOYMENT / EXPERIENCE FOR MARRIAGE AND FAMILY THERAPIST (LMFT) LICENSURE APPLICANTS *(continued)*

Part of State Form 50710 (R11 / 8-24)

SECTION C / AFFIRMATION OF EXPERIENCE [UNABLE TO CONTACT DIRECT SUPERVISOR(S)]

SECTION C INSTRUCTIONS FOR PROFESSIONAL COLLEAGUE OF APPLICANT'S EMPLOYER: *This section is to be completed by a professional colleague of the applicant's previous employer, if the applicant's previous direct supervisor is no longer able to complete* ***SECTION B*** *(on reverse side of this form). Please indicate below the reason why the applicant's previous direct supervisor is no longer able to complete* ***SECTION B*** *(on the reverse side of this form).* ***If you are affirming experience received from more than one previous direct supervisor of a previous employer, this form may be duplicated but you must submit one AFFIRMATION OF EXPERIENCE for each previous direct supervisor that is no longer able to complete SECTION B (on the reverse side of this form).***

The applicant's director supervisor is unable to complete SECTION B for the following reason:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please briefly explain:

Name of employer

Name of business / institution where employed	E-mail address

Business address *(number and street, city, state, and ZIP code)*

Telephone number of business / institution ( )	Date employment began *(month, day, year)*	Date employment ended *(month, day, year)* *If currently employed, please indicate*

Position held	Number of hours of applicant worked per week

Total clinical hours	Total relational hours

Confirm direct service types provided at this location. Select all that apply:

☐ Unmarried Couples ☐ Married Couples ☐ Separating or Divorced Couples ☐ Family Groups, including children

Brief description of job duties

I hereby swear or affirm, under the penalties of perjury, that the statements made are true, complete and correct.

Signature of professional colleague	Date *(month, day, year)*

(Continued on the reverse side.)

FORM III – A VERIFICATION OF MARRIAGE AND FAMILY THERAPIST (LMFT) AND MARRIAGE AND FAMILY THERAPIST ASSOCIATE (LMFTA) COURSEWORK

Part of State Form 50710 (R11 / 8-24)

All information on this form must be typed or clearly printed. This is a two (2) page form.

Please list the course titles in the areas indicated below as they appear on your transcript, that in your opinion, meet the following requirements. If two or more courses combined meet the criteria, list all courses that may apply.

Name of educational institution	Course number	Course title	Credit hours	Semester / Quarter
Theoretical Foundations of Marriage and Family Therapy				
Major Models of Marriage and Family Therapy				
Individual Development				
Family Development and Family Relationships				
Clinical Problems				
Collaboration with Other Disciplines				
Sexuality				
Gender and Sexual Orientation				
Issues of Ethnicity, Race, Socioeconomic Status, and Culture				
Therapy Techniques				

(Continued on the reverse side)

Behavioral Research That Focuses on the Interpretation and Application of Research Data as it Applies to Clinical Practice				
Name of educational institution	Course number	Course title	Credit hours	Semester Quarter
The previously mentioned content areas may be combined into any one (1) graduate level course.				
Legal, Ethical, and Professional Standards Issues in the Practice of Marriage and Family Therapy				
Name of educational institution	Course number	Course title	Credit hours	Semester Quarter
Appraisal and Assessment for Individual or Interpersonal Disorder or Dysfunction				
Name of educational institution	Course number	Course title	Credit hours	Semester Quarter

I, the undersigned applicant for marriage and family therapist's license, do hereby certify that I have also completed the following:

A specified clinical practicum, internship or field experience in marriage and family therapy of at least five hundred (500) hours of face-to-face client hours with individuals, couples and families for the purpose of assessment and intervention, that was conducted over a period of one (1) year at an average rate of ten (10) hours of clinical contact per week. Of the five hundred (500) hours, no more than fifty percent (50%) of this time was spent with individuals. This practicum also included a minimum of one hundred (100) hours of supervision administered by a licensed marriage and family therapist who has at least five (5) years of experience as a qualified supervisor.

The following graduate work may NOT be used to satisfy the content area requirements above:

(1) Thesis or Dissertation Work
(2) Practicum, Internships, or Field Work

Signature of applicant	Date *(month, day, year)*
Printed name of applicant	Date of Birth:

(Continued on the reverse side)

FORM III - B
GRADUATE COURSEWORK CONTENT AREAS
Part of State Form 50710 (R11 / 8-24)

THEORETICAL FOUNDATIONS OF MARRIAGE AND FAMILY THERAPY
Studies that provide an understanding of the epistemology of family therapy.
A. Theories of individual and family development and transitions across the life-span
B. Theories of family therapy

MAJOR MODELS OF FAMILY THERAPY
Studies that provide an understanding of clinical practices and treatments of Family Therapy.
A. Structural and Strategic Family Therapy
B. Brief Family Therapy
C. Solution Oriented Family Therapy
D. Narrative Family Therapy

INDIVIDUAL DEVELOPMENT
Studies that provide an understanding of a person's development.
A. Life-span human development
B. Child psychology and development
C. Adolescent developmental stages
D. Adult in mid-life or menopausal women, etc.

FAMILY DEVELOPMENT AND FAMILY RELATIONSHIPS
Studies that provide an understanding of family development and varying relationships within the family.
A. Advanced family studies,
B. Family stages during the life cycle

CLINICAL PROBLEMS
Studies that provide an understanding of problems affecting a family system
A. Treating the abusing family
B. Family treatment of incest
C. Clinical treatment of alcoholism and other addictions in the family
D. Helping a family cope with crisis

COLLABORATION WITH OTHER DISCIPLINES
Studies that provide an understanding of family therapy approaches cooperating with other professionals
A. Behavior disorders
B. Medical management and family therapy in ADD and ADHD
C. Psychological Testing and how it relates to borderline families
D. Family therapy in a school setting

SEXUALITY
Studies that provide an understanding of sexuality in the family.
A. Human sexuality
B. Treating sexual dysfunction
C. Principles, practices, and applications of sexual abuse treatment

GENDER AND SEXUAL ORIENTATION
Studies that provide an understanding of the range of sexual differences.
A. Human sexuality
B. Gender and transgender clinical problems
C. Comparing and contrasting treatment regarding issues of heterosexuality, bisexuality and homosexuality
D. Homosexual and bisexual couples and families

ISSUES OF ETHNICITY, RACE, SOCIOECONOMIC STATUS AND CULTURE
Studies in this area include, but are not limited to, the following:
A. Special clinical problems pertaining to treatment of African American, Asian and Hispanic families
B. Clinical problems of the working poor
C. First generation immigrant families

(Continued on the reverse side.)

THERAPY TECHNIQUES

Studies in this area include, but are not limited to, the following:

A. Family therapy skills
B. Family sculpting
C. The use of genograms in family therapy

BEHAVIORAL RESEARCH THAT FOCUSES ON THE INTERPRETATION AND APPLICATION OF RESEARCH DATA

Studies in this area include, but are not limited to, the following:

A. Research methods in child and family studies
B. Qualitative research in marriage and family studies

LEGAL, ETHICAL, AND PROFESSIONAL STANDARDS AND ISSUES IN THE PRACTICE OF MARRIAGE AND FAMILY THERAPY

A. Professional issues in marriage and family therapy
B. Ethical issues in marriage and family therapy

APPRAISAL AND ASSESSMENT FOR INDIVIDUAL OR INTERPERSONAL DISORDER OR DYSFUNCTION

A. The use of the DSM in diagnosis
B. Comparing and contrasting the GAF and the GARF

(Continued on the reverse side)

FORM P – 1 VERIFICATION OF PRACTICUM FOR MARRIAGE AND FAMILY THERAPIST ASSOCIATE (LMFTA) AND MARRIAGE AND FAMILY THERAPIST (LMFT) LICENSURE APPLICANTS

Part of State Form 57010 (R11 / 8-24)

INSTRUCTIONS:
1. *The applicant must complete Section A, then forward to the educational institution at which the practicum was completed*
2. *Section B must be completed by an official of the institution that has granted the academic credit for this supervised clinic.*
3. *Sign the form and upload to your (the applicant's) online application as applicable or mail them to the address provided in the top right corner of the first page of this application.*

SECTION A – APPLICANT INFORMATION	
Name of applicant *(last, first, middle, maiden or previous)*	Date of Birth:
My minimum three hundred (300) hour practicum was completed under the auspices of the following education institution:	
Name of institution	
Location *(city and state)*	
Date practicum began *(month, year)*	Date practicum was completed *(month, year)*
I completed the practicum at the following location:	
Specific location of field experience	

SECTION B – VERIFICATION OF COMPLETION OF THREE HUNDRED (300) HOUR PRACTICUM

As an official of the school named above, I certify that the above-named applicant has completed at least the following experience during the completion of the practicum:

1. During at least twelve (12) months of clinical practice, the applicant provided at least three hundred (300) face-to-face client contact hours, of which at least one hundred (100) hours must be relational, under the supervision of a licensed marriage and family therapist (LMFT) who has at least five (5) years of experience or a qualified supervisor approved by the board.
2. The applicant received a minimum of at least one hundred (100) hours of supervision from a licensed marriage and family therapist who has at least five (5) years experience as a qualified supervisor.

As an official of the school named above, I certify that the above-named applicant did receive the following supervision during the completion of the practicum. For the purposes of this certification, "individual supervision" is supervision rendered to not more than two (2) individuals at a time and "group supervision" is supervision rendered to at least two (2) and not more than ten (10) individuals at a time.

During the completion of this practicum, the applicant did receive the following number of hours of supervision: _____

Signature of school official	Date *(month, day, year)*
Printed name of school official	Title of school official
Name of program faculty member	Name of alternate supervisor
Name of site supervisor	Position held at the institution
Name of the institution	
Name of applicant *(last, first, middle, maiden or previous)*	