Clear Form

UTAH DEPARTMENT OF COMMERCE

Division of Professional Licensing

Marriage and Family Therapist

APPLICANT INFORMATION

Full Legal Name: _____ _____ _____
First *Middle* *Last*

All Previous Legal Names: _____

Other DOPL Licenses Held: _____

SSN: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

_____ _____ _____
City *State* *ZIP Code*

Phone: _____ **Email:** _____
Note: All Division notices and communication will be sent to this email

Please Select ONE:

☐ I am a United States citizen OR a non-citizen of the United States who is lawfully present.
☐ I am a foreign national not physically present in the United States.
☐ None of the above, please explain: _____

Driver License or State ID Card _____ _____ _____
State of Issue *License Number* *Expiration Date*

NOTE: If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of lawful presence in the United States.

AFFIDAVIT AND RELEASE

1. I certify that I am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Division of Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
5. I certify that I do not currently pose a direct threat to myself, to my clients, or to the public health, safety or welfare because of any circumstance or condition.
6. I understand that I am responsible to update the Division of any changes relating to my license/certification/registration.

Signature of Applicant: _____ Date _____

QUALIFYING QUESTIONNAIRE

Do not leave any question blank.

DOPL may request additional documentation if the information submitted is insufficient.

1. ☐ Yes ☐ No Have you EVER had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, resigned, or surrendered while under investigation, or otherwise **disciplined in any way**?

2. ☐ Yes ☐ No Do you CURRENTLY have **any criminal action active or pending**?

3. ☐ Yes ☐ No WITHIN THE PAST 10 YEARS, have you pled **guilty** to, **no contest** to, entered into a **plea in abeyance,** or been **convicted** of **a misdemeanor** in any jurisdiction?

4. ☐ Yes ☐ No Have you EVER pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a **felony** in any jurisdiction?

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "Yes" to questions 2,3, or 4 you must submit the following for EACH and EVERY incident:

- personal account of the incident
- police report(s)
- court record(s)
- probation/parole officer report(s)

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

NOTE:

- **DISCLOSE** charges that were later held in abeyance, diverted, reduced, or dismissed.
- **DISCLOSE** motor vehicle offenses such as driving while impaired or intoxicated. But you do not need to disclose minor traffic offenses such as parking or speeding violations.
- You do **not need to disclose** juvenile offenses, unless you were tried as an adult.
- **DISCLOSE** if you are restricted from possession, purchase, transfer, or ownership of a firearm or ammunition (even if your restriction is based on a non-reportable juvenile conviction).
- You do **not need to disclose** legally expunged or sealed criminal history incidents.

For more information, see DOPL's criminal history FAQs.

PROFESSIONAL LICENSES

List all other licenses, registrations or certification issued by any state which you now hold or have ever held in any profession. *(Use additional sheets if necessary.)*

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

MEDICAL QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer each question. Do not leave any question blank.

A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: _____

2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: _____

3. Is any action pending against you now by:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: _____

4. ☐ Yes ☐ No Have you been named as a defendant in a malpractice suit?

5. ☐ Yes ☐ No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered **"Yes"** to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. *NPDB website: http://www/npdb.hrsa.gov.*

If you answered **"Yes"** to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

EDUCATIONAL COURSE REQUIREMENTS

To be completed by applicants who have NOT graduated from a COAMFTE accredited program in marriage and family therapy. Graduates from COAMFTE accredited programs are not required to complete this section.

Use each course only once. *(Use additional sheets if necessary.)*

Theoretical Foundations of Marital and Family Therapy: *(minimum 6 semester or 9 quarter hours)*

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Assessment and Treatment in Marriage and Family Therapy, including the DSM *(minimum 9 semester or 12 quarter hours)*

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Human Development and Family Studies: *(minimum 6 semester or 9 quarter hours)*

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Professional Ethics: *(minimum 3 semester or 4 1/2 quarter hours)*

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Research Methodology and Data Analysis *(minimum 3 semester or 4 1/2 quarter hours)*

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Electives in Marriage and Family Therapy: *(minimum 3 semester or 4 1/2 quarter hours)*

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Supervised Clinical Practicum: *(minimum 600 hours, at least 500 direct contact hours of which 250 hours are with couples or families present and 100 hours of face to face supervision)*

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

NOTE: *You can expedite the review process by providing a copy of the graduate catalog course description and/or syllabus of any identified course.*

Verification of Active Practice as an MFT in Another State

For endorsement applicants only.
Each employer must complete a separate form.

APPLICANT INFORMATION

To be completed by the applicant.

Full Legal Name: _____ _____ _____
First *Middle* *Last*

Mailing Address: _____ _____ _____
Street/PO Box *City* *State/Zip*

License Number: _____ **State of Issue:** _____

EMPLOYMENT INFORMATION

To be completed by the employer or human resources.

Name of Establishment: _____

Establishment Address: _____
Street/PO Box *City* *State/Zip*

Telephone Number _____ **Email:** _____

Dates of Employment: _____ to _____
MM/DD/YYYY *MM/DD/YYYY*

How many hours did the applicant work per week? _____

Number of hours practicing mental health therapy: _____

Total number of hours practiced as an MFT: _____

Describe the applicant's duties: _____

_____

_____

Was the applicant a W-2 employee or contracted labor? _____

Is the applicant still employed? ☐ **Yes** ☐ **No**

If no, is the applicant re-hirable? ☐ **Yes** ☐ **No: Please explain:** _____

_____

I do hereby certify that the applicant for licensure as a marriage and family therapist was actively engaged in the lawful practice as a MFT at the above named establishment for the time frame listed.

I further certify that the applicant is qualified and competent to practice as a marriage and family therapist.

Signature of certifying individual: _____

Relationship to Applicant: _____ Date: _____

License Number *(if applicable)*: _____ State of Licensure: _____

SUPERVISION RECORD OF
POST-GRADUATE MENTAL HEALTH PRACTICE HOURS

Use this form to report your supervision after obtaining licensure as an AMFT. Each Supervisor must complete a separate form. The hours from all forms must total 3,000.

APPLICANT INFORMATION

To be completed by the supervisee.

Full Legal Name: _____
First *Middle* *Last*

License Number: _____ **License Type:** _____

SUPERVISION INFORMATION

To be completed by the supervisor.

Name of Establishment: _____

Name of Supervisor: _____
First *Middle* *Last*

Email Address: _____
*Note: **REQUIRED** All Division notices and communication regarding supervision will be sent to this email.*

License Number: _____ **License Type:** _____

Date of Supervision as a W-2 Employer: _____ **to** _____
Note: Intern/Practicum hours CANNOT be counted *MM/DD/YYYY* *MM/DD/YYYY*

	Documented hours of supervised mental health therapy with clients *As defined in Utah Code 58-60-102(7) and 58-60-305(1)(e)*
	Documented hours of mental health training gathered under Direct Supervision *As defined in Utah Code 58-60-205(1)(e), 58-60-305(1)(e), 58-60-405(1)(e), and 58-60-502(3)*
	Documented hours of mental health counseling training
	Documented hours of couple and/or family therapy with two or more clients participating *As defined in Utah Code 58-60-305(1)(e)*
	TOTAL HOURS of documented training under this supervisor *As defined in Utah Code 58-60-305(1)(d)*

☐ **Yes** ☐ **No** **Did the supervisee meet the expectations of supervision outlined in the written plan, with regards to the quality of work performed? If no, submit a written statement regarding the performance to the Division at B8@utah.gov.**

☐ **Yes** ☐ **No** **Did the supervisor and supervisee work at the same place of employment? If no, describe how you were able to perform supervision:** _____

_____

I certify that the applicant for licensure as a marriage and family therapist has successfully completed the above hours of post-graduate supervised experience as a W-2 employee of the facility listed above and that the experience meets the requirements outlined in Utah Admin. Code R156-60b-302b, and Utah Admin. Code R156-60-302. I further certify that the applicant is qualified and competent to practice as a marriage and family therapist.

Signature of Supervisor: _____ **Date:** _____

APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience; you do not need to include it with your application.
NOTE: Incomplete applications will be denied.

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

ALL APPLICANTS

The following items are required to complete your application:

- ☐ $120.00 non-refundable application-processing fee, made payable to "DOPL".
- ☐ Supporting documentation for any "yes" answers provided on either of the qualifying questionnaires.

INITIAL LICENSURE

If applying for **Initial Licensure**, *in addition* to the items required for all applicants, you must submit:

- ☐ If you are not currently licensed as a Utah AMFT, you must document meeting the education requirement *(submit one of the options below)*:
  - Official transcripts documenting completion of a master's or doctorate degree from a marriage and family program accredited by COAMFTE.
  - Official transcripts evidencing completion of a clinical master's degree in marriage and family therapy from an institution which is accredited by a professional accrediting body approved by CHEA and completion of course requirements. Please use page 4 of this application to record the required courses. ***NOTE:*** *You can expedite the review process by providing a copy of the graduate catalog course description and/or syllabus of any identified course.*

  Note: Transcripts are considered "official" when they are sent directly from the school to DOPL or sealed in an envelope bearing the school's stamp/seal on the envelope flap.
- ☐ Official documentation of your passing score on the Marital and Family Therapy National Examination administered by AMFTRB.
- ☐ "Supervision for Post-Graduate Mental Health Practice Hours" form found in this application. ***NOTE:*** *Each supervisor must complete the form for the hours they supervised and the hours from all supervisors must total 3,000*
- ☐ Documentation of a two-hour suicide prevention training course.

LICENSURE BY ENDORSEMENT

If you are currently licensed as the equivalent of a marriage and family therapist in another state, and have been engaged in lawful practice for not less than 3,000 hours, of which at least 1,000 hours are in mental health therapy, you may apply for **Licensure by Endorsement**. *In addition* to the items required by all applicants, you must submit the following:

- ☐ Official verification of license from one or more states in which you are currently licensed. Verifications must cover the time period used to qualify for endorsement outlined above.
- ☐ Verification of Active Practice as an MFT in Another State Form found in this application. ***NOTE:*** *You must have each employer or licensed professional associate complete a separate form, and the hours from all forms must total 3,000.*

If you do not qualify for endorsement and do not hold a Utah AMFT license, please contact the board to determine the items needed to complete your application.

Submit the above items with your completed application to:

In person or via express delivery:
Division of Professional Licensing
Heber M Wells Building, 1st Floor Lobby
160 E 300 S
Salt Lake City, UT 84111

US Postal Service:
Division of Professional Licensing
PO BOX 146741
Salt Lake City, UT 84114-6741

If you have questions, please contact the Division via our direct email address, B8@utah.gov, or via the phone or fax listed below. **Do not submit application or payment to this email address.**