



- 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 voluntarily surrendered a professional licensure in any jurisdiction or state? Yes  No
- 18. 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.)**

<b>Name of Institution</b>	<b>Location City, State</b>	<b>Degree Obtained</b>	<b>Month, Yr. Degree granted</b>
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**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).

<b>Date Begin - End</b>	<b>Employer or Site</b>	<b>Title or Responsibility</b>	<b>Total Client Hours</b>
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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

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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
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**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 \$100.00 for application fee and passport-like photo to the address at the top of this page.**

## 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

Continued on next page

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:

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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

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Signature of Reference	Printed Name	Title	Date
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Your Discipline	Type of License	License#	Expiration Date
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Street Address	City	State	Zip	Phone
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Please return the completed form directly to the Board at the address at the top of this page. Thank you for your assistance.

## 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:

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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.

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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.

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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.

## 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 \_\_\_\_\_

**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:

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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.

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Supervisor's Signature	Printed Name	Date
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Address	City	State	Zip	
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Supervisor's Discipline	Type of License	License #	State	Expiration Date
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(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.

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Current Supervisor's Signature	Printed Name	Date
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Name of Agency or Center \_\_\_\_\_

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Address	City	State	Zip	Phone
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Reason supervisor could not be located \_\_\_\_\_

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

## 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

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### 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

MISSISSIPPI

State Board of Examiners for Social Workers and Marriage & Family Therapists

❖ P.O. Box 4508, Jackson, MS 39296-4508

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.

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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**