



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

State Form 53737 (R / 2-11)

Approved by State Board of Accounts, 2011

BEHAVIORAL HEALTH AND HUMAN SERVICES
LICENSING BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2064
E-mail: pla5@pla.IN.gov

* Your Social Security number is being requested by this state agency in accordance with IC 25-1-5-11. Disclosure is mandatory and this record cannot be processed without it.

FOR OFFICE USE ONLY	
APPLICATION FEE:	
DATE FEE PAID (month, day, year):	
RECEIPT NUMBER	
LICENSE NUMBER ISSUED:	
PERMIT NUMBER ISSUED:	
DATE LICENSE ISSUED:	

Attach one
passport quality
photograph here
(See instructions)

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION		
Name of applicant (last, first, middle, maiden or previous)		
Current address (number and street, city, state, and ZIP code)		
Permanent address (if different from above)		
Work telephone number ()	Home telephone number ()	E-mail address
Social Security number *	Date of birth (month, day, year)	Place of birth (city and state)

Please indicate exactly how you wish your name to appear on your license.

Please check all that apply:

- I am applying for licensure by examination.
- I am applying for licensure by exemption from examination (ENDORSEMENT)
 - I successfully passed the AAMFTRB examination.
Date: _____ State taken in: _____
 - OR**
 - I have passed the (name of examination) _____
Date: _____ State taken in: _____

GRADUATE EDUCATION (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

OTHER STATE LICENSURE / CERTIFICATION

Do you hold, or have you ever held, a license / certification / registration / permit to practice any regulated health profession by a state licensing board?
(If yes, list all states below, including Indiana, in which you have held a license / certification / registration / permit to practice any state regulated occupation.)

Yes No

Type of License / Certificate / Registration / Permit	State	Number	Date Issued	Status
1.				
2.				
3.				
4.				
5.				

ALL APPLICANTS MUST ANSWER THE FOLLOWING QUESTIONS

If your answer is "yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location and date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

- Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? Yes No
- Have you ever been denied license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state (including Indiana) or country? Yes No
- Are you now being, or have you ever been treated for drug or alcohol abuse? Yes No
- Have you ever been convicted of, plead guilty to or nolo contendere to:
 - (A) a violation of a Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substance or drug addiction? Yes No
 - (B) any offense, misdemeanor or felony in any state? (except for minor violations of traffic laws resulting in fines) Yes No
- 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 or limitations? Yes No
- 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
- Have you ever had a malpractice judgment against you or settled any malpractice action? Yes No

APPLICATION AFFIRMATION

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

Signature of applicant	Date (month, day, year)
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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, or the Behavioral Health and Human Services Licensing Board, any files, documents, records or other information pertaining to the undersigned requested by the Agency, or the Board, or any of their authorized representatives in connection with processing my application for licensure.

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

I further authorize the Professional Licensing Agency, or the Behavioral Health and Human Services Licensing Board, 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, and the Board 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 hereby swear or affirm, that I have read the above statements and agree to same.

Signature of applicant	Date signed (month, day, year)
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FORM III - A**VERIFICATION OF MARRIAGE AND FAMILY THERAPIST ASSOCIATE COURSEWORK**

Part of State Form 53737 (R / 2-11)

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

Please list the course titles in the areas indicated below, or the graduate courses, as they appear on your transcript, that in your opinion, meet the following requirements. If the title of the course you are wishing to apply towards these requirements does not clearly reflect these content areas, you should also submit additional supporting documentation, such as course descriptions from your college or university's catalog.

Twenty-seven (27) semester hours or forty-one (41) quarter hours of graduate coursework that must include graduate course credits with material in at least the following content areas. Please indicate whether these are semester or quarter hours below.

Theoretical Foundations of Marriage and Family Therapy

Name of educational institution	Course number	Course title	Credit hours	Semester
				Quarter

Major Models of Marriage and Family Therapy

Name of educational institution	Course number	Course title	Credit hours	Semester
				Quarter

Individual Development

Name of educational institution	Course number	Course title	Credit hours	Semester
				Quarter

Family Development and Family Relationships

Name of educational institution	Course number	Course title	Credit hours	Semester
				Quarter

Clinical Problems

Name of educational institution	Course number	Course title	Credit hours	Semester
				Quarter

Collaboration with Other Disciplines

Name of educational institution	Course number	Course title	Credit hours	Semester
				Quarter

Sexuality

Name of educational institution	Course number	Course title	Credit hours	Semester
				Quarter

Gender and Sexual Orientation

Name of educational institution	Course number	Course title	Credit hours	Semester
				Quarter

Issues of Ethnicity, Race, Socioeconomic Status, and Culture

Name of educational institution	Course number	Course title	Credit hours	Semester
				Quarter

Therapy Techniques

Name of educational institution	Course number	Course title	Credit hours	Semester
				Quarter

(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
<p>The previously mentioned content areas may be combined into any one (1) graduate level course, if the applicant can prove that the coursework was devoted to each content area.</p> <p>One graduate level course of two (2) semester hours or three (3) quarter-hours in the following areas. Please indicate whether these are semester or quarter hours below.</p>				
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
<p>I, the undersigned applicant for marriage and family therapist associate's licensure, do hereby certify that I have also completed the following:</p> <p>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.</p> <p>The following graduate work may NOT be used to satisfy the content area requirements above:</p> <p>(1) Thesis or Dissertation Work (2) Practicum, Internships, or Field Work</p>				
Signature of applicant			Date (<i>month, day, year</i>)	
Printed name of applicant			Social Security number *	

FORM III - B GRADUATE COURSEWORK CONTENT AREAS

Part of State Form 53737 (R / 2-11)

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 persons 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

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

FORM P - 1**VERIFICATION OF PRACTICUM FOR LICENSURE AS A MARRIAGE AND FAMILY THERAPIST ASSOCIATE (LMFTA)**

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- 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 clinical experience.

SECTION A - APPLICANT INFORMATION

Name of applicant (<i>last, first, middle, maiden or previous</i>)		Social Security number *
My minimum five hundred (500) hour practicum was completed under the auspices of the following educational institution:		
Name of institution		
Location (<i>city and state</i>)		
Date practicum began (<i>month, year</i>)	Date practicum was completed (<i>month, year</i>)	
I completed the practicum at the following location:		
Specific location of field experience		

SECTION B - VERIFICATION OF COMPLETION OF FIVE HUNDRED (500) 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. The applicant has completed at least five hundred (500) face-to-face client hours with individuals, couples, and families for the purpose of enabling the student to develop basic therapy skills and to integrate professional knowledge and skills.
2. The applicant has conducted the required five hundred (500) hours over a period of one (1) year, at an average rate of ten (10) hours of clinical contact per week and no more than fifty percent (50%) of this time was spent with individuals.

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: _____

I further certify that the supervision for this practicum was conducted by either a program faculty member or a supervisor working under the supervision of a program faculty member using audiotape, videotape, and/or direct observation. The applicant's supervisor(s) held the following position(s), degree(s), license(s), and/or certification(s). (*Provide name(s) and qualifications below.*)

Signature of school official		Date (<i>month, day, year</i>)
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 institution		
Name of applicant (<i>last, first, middle, maiden or previous</i>)		

Return this completed form to:

PROFESSIONAL LICENSING AGENCY
 402 West Washington Street, Room W072
 Indianapolis, Indiana 46204