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

State Form 50710 (R2 / 1-11)
Approved by State Board of Accounts, 20011

BEHAVIORAL HEALTH AND HUMAN SERVICES LICENSING BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room 072
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 *(month, day, year)*:	

Attach One Passport Quality Photograph Here (*See Instructions*)

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden or previous*)

Current address (*number and street*)

City	State	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*)

Are you applying for a temporary permit?
☐ Yes ☐ No

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 currently hold an active LMFTA.
- ☐ I am currently licensed / certified in another state.
  Type of licensure / certification: _____
  Issued by (*name of State Board*): _____
  AND
- ☐ I successfully passed the AAMFTRB examination.
  Date *(month, day, year)*: _____ State taken in: _____
  OR
- ☐ I have passed the (*name of examination*)
  _____
  Date *(month, day, year)*: _____ 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

GRADUATE EDUCATION (Master's or Doctoral) (*continued*)

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:		

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.

1.) Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or 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*) or country?	☐ Yes ☐ No
3.) Are you now being, or have you ever been treated for drug or alcohol abuse?	☐ Yes ☐ No
4.) Have you ever been convicted of, plead guilty to or nolo contendre 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? (B) any offense, misdemeanor or felony in any state? (e*xcept for minor violations of traffic laws resulting in fines*)	☐ Yes ☐ No ☐ 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

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*)

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*)

FORM I VERIFICATION OF SUPERVISION FOR LMFT LICENSURE APPLICANTS

Part of State Form 50710 (R2 / 1-11)

APPLICANT: Complete the top section of this form, then forward it to your supervisor. You are authorized to photocopy this form as necessary.

Name (*last, first, middle*)		Maiden or given surname
Address (*number and street, city, state, and ZIP code*)		
Social Security number *	Date of birth (*month, day, year*)	Telephone number (*daytime*) ( )
Name of supervisor	Name of business / institution	
Supervisor title	Address (*number and street, city, state, and ZIP code*)	

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

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

SUPERVISOR: Complete the remainder of this form. Return the completed form directly to the Professional Licensing Agency, 402 West Washington Street, Room W072, Indianapolis, IN 46204.

SUPERVISOR INFORMATION

Name of supervisor (*last, first, middle*)		Name of business / institution
State license / certificate number / type of license / certificate	License / Certificate issued by	Business telephone number ( )
Business address (*number and street, city, state, and ZIP code*)		E-mail address
Number of years experience in Marriage and Family Therapy	Marriage and Family Therapy supervision training	Supervisor of supervision Contact information of supervisor

APPLICANT EMPLOYMENT INFORMATION

Applicant's job during the time of your supervision		Applicant's employer during the time of your supervision	
Date supervision began (*month, day, year*)		Date supervision ended (*month, day, year*)	
Number of hours you supervised applicant per week		Number of hours of individual supervision	
Number of direct service hours	Number of clinical hours per week	Number of Family Therapy hours per week	
Number of hours applicant spent in direct service seeing:	(A) Unmarried couples	(B) Married couples	(C) Separating or divorced couples	(D) Family groups, including children

Brief description of how supervision was conducted:

(*Continued on the reverse side*)

A. I was present at the applicant's place of work. ☐ True ☐ False

B. The applicant's work requirement 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

The above indicated supervision was performed by me pursuant to my order, control, and full professional and legal responsibility as a supervisor. I do hereby declare that the information contained herein is true and correct.

SEAL OF NOTARY PUBLIC	Signature of supervisor
	Printed name of supervisor
	Title
	Date (*month, day, year*)

FORM II VERIFICATION OF EMPLOYMENT/EXPERIENCE FOR LMFT LICENSURE APPLICANTS

Part of State Form 50710 (R2 / 1-11)

APPLICANT: Complete the top section of this form, then forward it to your employer. You are authorized to photocopy this form as necessary.

Name (*last, first, middle*)	Maiden or given surname
Address (*number and street, city, state, and ZIP code*)	
Social Security number * / Date of birth (*month, day, year*)	Telephone number (*daytime*) ( )
Name business / institution / Address (*number and street or rural route, city, state, and ZIP code*)	
Name of supervisor	Supervisor title

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

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

EMPLOYER: Complete the remainder of this form and have it notarized by a Notary Public. Return the completed form directly to the Professional Licensing Agency, 402 West Washington Street, Room W072, Indianapolis, IN 46204.

Name of employer	
Name of business / institution where employed	E-mail address
Business address (*number and street, city, state, and ZIP code*)	

APPLICANT EMPLOYMENT INFORMATION

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 applicant worked per week
Number of direct service hours per week	Number of clinical hours per week	Number of Family Therapy hours per week

Number of hours employee spent in direct service doing:	(A) Individual	(B) Group	(C) Marriage and Family Therapy

Number of hours employee spent in direct service seeing:	(A) Unmarried couples	(B) Married couples	(C) Separating or divorced couples	(D) Family groups, including children

Brief description of how supervision was conducted:

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.

SEAL OF NOTARY PUBLIC	Signature of employer
	Printed name of employer
	Title
	Date (*month, day, year*)

FORM III - A
VERIFICATION OF MARRIAGE AND FAMILY THERAPY COURSEWORK

Part of State Form 50710 (R2 / 1-11)

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

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.

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.

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 licensure, 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	Social Security number *

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

(*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