



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
**BOARD FOR PROFESSIONAL COUNSELORS, MARITAL & FAMILY THERAPISTS,
AND CLINICAL PASTORAL THERAPISTS**
665 Mainstream Drive
NASHVILLE, TENNESSEE 37243
<http://tennessee.gov/health/topic/pcmft-board>
(800) 778-4123, ext. 741-5735 -- (615) 741-5735
APPLICATION FOR LICENSE AS A MARITAL AND FAMILY THERAPIST

INSTRUCTIONS

1. Complete this application, sign and mail it to the above address. **Please type or print legibly.**
2. Enclose a non-refundable check for \$210, payable to the Board for Professional Counselors, Marital & Family Therapists, and Licensed Pastoral Therapists. If you are seeking to upgrade your status from “certified” to “licensed,” make your check for \$60.
3. If you are seeking to upgrade your status from “certified” to “licensed,” enclose a photocopy of your current renewal certificate. If you have current A.A.M.F.T. clinical membership, or if you can verify fifteen (15) years of work experience since receiving your Tennessee certification, or if you have received two hundred (200) hours of clinical supervision, disregard instructions 4, 5, 8, 9, and 10 and do not complete pages 4 or 7. Instead, enclose, or have sent, proof of the work experience, or the clinical supervision (page 7) or the A.A.M.F.T. clinical membership.
4. If you are applying by endorsement, disregard instructions 3, 8, and 11, and do not complete page 6. Instead enclose, or have sent, proof of your A.A.M.F.T. clinical membership.
5. Enclose a certified photocopy of your birth certificate or a notarized copy of a certified birth certificate.
6. All applicants must complete the Declaration of Citizenship form and **have it notarized**. The form may be found at: <https://www.tn.gov/health/health-program-areas/health-professional-boards/pcmft-board/pcmft-board/applications.html>
7. Attach a recent (within the last twelve (12) months) “passport” style photograph to the front of this application.
8. Have your graduate transcript(s) sent directly from the educational institution(s) to the above address.
9. Have the A.A.M.F.T. send proof of successful completion of their examination directly to the above address unless you have not yet taken the exam.
10. Enclose, or have sent to the above address, two (2) original and recent letters typed on the signatory’s letterhead. These letters must verify your good moral character and ethics.
11. Have your supervisor of post-masters experience complete page 9 and enclose it or have it sent to the above address.
12. If you have ever been licensed in any other state as a Marital and Family Therapist or any other profession, you must request a verification from each and every state. The verification must be mailed directly to the Board’s Office from the other state(s) enclose a copy of those state’s statutes and rules and. Also enclose a copy of your original licenses and renewal certificates from those states. The verification must be mailed directly to the Board’s Office from the other state(s).
13. A Criminal Background Check is required. For instructions go to: (<http://tn.gov/health/article/CBC-instructions>)
14. **You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn Code. Ann. §36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.**

Attach
Photo Here



Appl. 3167-001 \$200.00
Temp. 3167-001 \$150.00
Reg. 3167-006 \$ 10.00

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_____ Exam _____ Reciprocity _____ Endorsement _____ Temporary

NAME _____
Last First Middle Maiden (if not used as your middle name)

CURRENT HOME MAILING ADDRESS: _____
CURRENT PRACTICE NAME AND ADDRESS _____

*If you have no practice address, notify the Board of your practice address within 30 days of obtaining a practice address. If you have multiple practice address, please attach an additional page listing all practice addresses.

Home Phone # (____) _____ Work Phone # (____) _____

E-Mail Address: _____

Do you wish to receive notifications, including renewal notification, from the Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. Yes _____ No _____

Social Security No. _____ - _____ - _____ Birth Date: _____ / _____ / _____

Race: _____ Gender: Female _____ Male _____ U.S. Citizen: Yes _____ No _____
All applicants must complete the Declaration of Citizenship form.

Entitled to Live and Work in the U.S. Yes _____ No _____

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (if yes, please provide proof of status.) Yes _____ No _____

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (if yes, please provide proof of status.) Yes _____ No _____

Have you ever been known by any other names other than what is listed above? Yes _____ No _____

Please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known:

EDUCATIONAL INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space. Request that an official transcript be submitted directly from the educational institution where you completed your master's degree directly to the board's administrative office.

From:	To:	Educational Institution	City, State	Degree Earned	Year Graduated
_____ Mo./Yr.	_____ Mo./Yr.	_____	_____	_____	_____
_____ Mo./Yr.	_____ Mo./Yr.	_____	_____	_____	_____
_____ Mo./Yr.	_____ Mo./Yr.	_____	_____	_____	_____
_____ Mo./Yr.	_____ Mo./Yr.	_____	_____	_____	_____

LICENSURE INFORMATION

Are you or have you ever been licensed in this profession in another state? Yes _____ No _____

Are you or have you ever been licensed in any other profession in Tennessee or another state? Yes _____ No _____

List below ALL state, countries, or provinces in which you have ever been or are currently licensed or permitted. Please request that verification of licensure be submitted directly to the Board's office from each state. Additional pages may be added if necessary.

STATE	PROFESSION	LICENSE #	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EMPLOYMENT INFORMATION

Please complete your entire healthcare employment history starting with the most current position first. Use the back of this page, if you need additional space. Dates of employment must be included.

Company/ Employer:	Address: (City, and State)	Position:	Duties:	Dates	
				From: Mo./Yr.	To: Mo./Yr.
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

COMPETENCY QUESTIONS

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer “Yes” to any question, attach an explanation on a separate sheet. **In support of your explanation, the final documents or orders from the issuing states, courts and/or agencies must be submitted along with this application.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **“Ability to practice your profession”** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned judgments, to learn and keep abreast of medical developments;
 - b. The ability to communicate those judgments and medical information to clients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
 - c. The physical capability to perform required tasks and procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.
3. **“Minor Traffic Offense”** generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.
4. **“Chemical substances”** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.
5. **“Currently”** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one’s functioning as a licensee or within the past two (2) years.
6. **“Illegal use of controlled substances”** means the use of controlled substances obtained illegally (e.g., heroin, or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:

YES **NO**

- | | | | |
|----|---|-------|-------|
| 1. | Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated because of ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice? | _____ | _____ |
| 2. | Do you currently use any chemical substances with in any way impair or limit your ability practice your profession with reasonable skill and safety? | _____ | _____ |

If so, please list:

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.]

3. At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances? _____
4. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances? Are you currently engaged in the illegal use of controlled substances? _____
5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? _____
6. Have ever held or applied for a license or certificate to practice marriage and family therapy in any state, country, or province, that had been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? _____
7. Have you ever held staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, or otherwise disciplined or voluntarily surrendered under threat of restriction or disciplinary action? _____
8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, otherwise disciplined, or voluntarily under threat of investigation or disciplinary action? _____
9. Have you ever been convicted (including a “nolo contendere” plea or guilty plea) of a felony or a misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?? _____
10. Have you ever been rejected or censured by a professional association? _____
11. In relation to the performance of your professional services in any profession:
 - a. Have you ever had a final judgment rendered against you; _____
 - b. Have you ever had settlement of any legal action rendered against you; or _____
 - c. Are there any legal actions pending against you or to which you are a party? _____
12. Have you ever held a license or certificate in any health care profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? _____
13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state. _____

Name: _____

**MARITAL AND FAMILY
COURSE WORK SUMMARY**

All courses listed on this page must also appear on the transcript sent directly from your college or university to the Board's Administrative Office.

	Course Name	*Credit Hours	
I.	Marriage & Family Studies	3 courses required	Institution
	1. _____	_____	_____
	2. _____	_____	_____
	3. _____	_____	_____
II.	Marriage & Family Therapy	3 courses required	Institution
	1. _____	_____	_____
	2. _____	_____	_____
	3. _____	_____	_____
III.	Human Development and Personality	3 courses required	Institution
	1. _____	_____	_____
	2. _____	_____	_____
	3. _____	_____	_____
IV.	Professional Ethics	1 course required	Institution
	_____	_____	_____
V.	Research	1 course required	Institution
	_____	_____	_____

*Convert all quarter credit hours to semester credit hours: # of quarter hours x .67 = # of semester hours

CLINICAL PRACTICUM/INTERNSHIP

List the location, dates, and hours at least 300 hours of supervised practicum(s)/internship in marital and family therapy.

AFFIDAVIT AND RELEASE

I, _____, of _____, being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board’s Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a licensed marital and family therapist in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a marital and family therapist .

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith without malice concerning my competence, ethics, character, and/or other qualifications, for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE

DATE

REQUEST FOR TEMPORARY LICENSURE
AS A MARITAL AND FAMILY THERAPIST

Applicant: If you desire a temporary license, have your supervisor complete this page and add \$150 to the fee requested in instruction #2 on the first page of this application. Do not send this page separately; a request for temporary license must be returned with the entire application.

Name of Applicant _____
(please print)

I, the undersigned, hereby accept responsibility for direct supervision of the above named applicant.

Name of Supervisor License # of Supervisor

Name and Address of Supervisor's Facility _____

Telephone # of Supervisor's Facility: _____

Signature of Supervisor

Subscribed and sworn to me this _____ day of _____, _____.

Notary Public

My commission expires: _____

<u>For Office Use</u> <u>Only</u> <u>Temporary License</u>
Number _____
Issued _____
Expires _____
Extended _____

(SEAL)

VERIFICATION OF SUPERVISED POST-MASTERS EXPERIENCE

PLEASE COMPLETE THIS FORM AND RETURN IT TO THE ADDRESS BELOW. ON YOUR LETTERHEAD STATIONERY DESCRIBE THE POST-MASTERS SUPERVISED CLINICAL EXPERIENCE, INCLUDING ALL LOCATIONS. **TYPE OR PRINT LEGIBLY.**

TO BE COMPLETED BY THE APPLICANT'S SUPERVISOR

APPLICANT'S NAME: _____

SUPERVISOR'S NAME: _____

SUPERVISOR'S LICENSE NUMBER: _____

SUPERVISOR'S ADDRESS: _____

THE SUPERVISOR MUST HAVE:

1. Been in clinical practice as a marital and family therapist at least five (5) years;
2. At least two (2) years experience supervising marital and family therapists;
3. Received at least 36 clock hours of supervision (by an approved supervisor) of his supervisory work by at least two (2) persons doing marital and family therapy; or
4. Completed training for supervision with an AAMFT approved supervisor.
5. **Please submit proof of qualifications.**

THE ABOVE APPLICANT HAS SUCCESSFULLY COMPLETED SUPERVISED CLINICAL TRAINING DURING THE PERIOD _____, _____ TO _____, _____, AS FOLLOWS:

1. Total hours of **CLINICAL CONTACT IN MARRIAGE AND FAMILY THERAPY** provided by the applicant during the time you supervised him/her. _____ hours
2. Total hours of **INDIVIDUAL SUPERVISION** of this work (200 are required). _____ hours

I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT AND THAT I MEET THE ABOVE SUPERVISOR QUALIFICATIONS.

SUPERVISOR'S SIGNATURE

DATE

SWORN TO BEFORE ME THIS _____ DAY OF _____, _____.

NOTARY PUBLIC

MY COMMISSION EXPIRES _____

AFFIX SEAL HERE

SEND TO: Board for PC/MFT/CPT
665 Mainstream Drive
Nashville, TN 37243

THIS PAGE MAY BE DUPLICATED IF NEEDED.