



**APPLICATION FOR NATIONAL EXAMINATION IN
MARITAL & FAMILY THERAPY**

Instructions:

1. Type all answers or print in black ink.
2. Complete all sections. If a section is not applicable, enter N/A in the space provided.
3. If additional information is needed for any questions, please attach a separate sheet, clearly identifying the questions, which the answers apply.
4. ***Attach the Board's application fee of \$220.00 to this application. All fees are non-refundable.***

Note: In addition to this application fee, the fee charged by the Professional Examination Service (PES) is \$220.00, and an additional \$75.00 is charged by PrometricTomson Learning Centers. **Do not submit the PES or Prometric fees to the Board Office.** PES and Prometric will notify you directly concerning their fees.

5. Mail this application to the Board office at the above address.

Once the Board approves your application, the Board will then authorize PES to issue you a pass to take the examination at the Prometric site of your choice. PES will notify you of test site locations and the required fee which you will submit directly to them.

6. A transcript covering all graduate work showing degree or certificates awarded must be sent directly to the Board from the academic institution. This application will not be accepted without said transcript(s)

This document is available in alternative formats to individuals with disabilities by Calling (612) 617-2220, or, through the Minnesota Relay Service at (800) 627-3529

**** Office Use Only ****

Check #: _____ Amount: \$ _____ Deposit #: _____

Rights of Subject of Data

Under Minnesota Statutes, section 13.41, subdivision 2 (1996), information you provide in this application, except for your name and address, is classified as private while you remain an applicant; that is, accessible only to you, the staff and members of the Board, the Board's counsel, and persons you designate. When you become licensed, the information in your file related to your licensure is classified as public under Minnesota Statutes, section 13.41, subdivision 4 (1996).

The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. You are not legally required to provide this information, but you cannot be licensed without doing so.

Section I General Information

Name:		
Last:	First:	MI:

If you have used names other than the above, please indicate:

Home Address:			
City:		State:	Zip Code:
Telephone Number: ()			

Name of Workplace:			
Address:			
City:		State:	Zip Code:
Telephone Number: ()			

E-Mail Address:

The information below is requested of you as part of the Board's compliance with Minnesota Statutes, Section 214.07, subdivision 1 (1996). This law states that the Board shall prepare reports in each even-numbered year containing information regarding the age, sex, and states of residency of applicants, among other things. These reports are delivered to the Commissioner of Health and are for statistical purposes only. Your name is not used in connection with this data. Your answers to the questions below do not in any way affect your candidacy for licensure, however, failure to supply this information may delay the processing of your application.

- **Social Security Number:** _____/_____/_____
- **Birthdate:** _____/_____/_____ **Sex:** _____ **Male** _____ **Female**
 Month **Day** **Year**
- **State(s) of Residency:** _____, _____
- **Minnesota Business Identification Number:** _____
(Enter N/A if you do not have such a number)

- Are you a citizen of the United States? Yes _____ No _____
- If you are not a United States citizen, or if you hold citizenship in another country or additional citizenships, what is your country of residence? _____
- As a non-resident, are you lawfully entitled to work in the United States?
Yes _____ No _____
- Are you at least 18 years of age? Yes _____ No _____
- Because of functional limitations imposed by disability, special arrangements will be necessary for me to complete the licensure examination: Yes _____* No _____

* If yes, please explain arrangements that you will need on a separate page and attach to this application.

Applicant Licensure Status

- Have you ever been denied licensure, certification, or registration in Minnesota or any other jurisdiction? _____* Yes _____ No
* (If yes, please explain and attach documentation.)
- Do you hold or have you ever held a license or certificate to practice marriage and family therapy, or other health related profession, in another state, jurisdiction, or in Minnesota? _____* Yes _____ No *If yes, please list all such licenses or certificates:

Please supply the following information regarding your Marriage and Family Therapy license:

State:	Title of License/Certificate:	License/Certificate Number:	Date Issued:	Expiration Date:

If you have previously practiced marriage and family therapy, or other health related profession in another state or jurisdiction, please provide the following, only if applicable:

Is your license(s) in good standing?
_____ Yes _____ No If no, please explain and attach documentation.

Has any license ever been revoked, suspended, or otherwise acted against for any reason?
_____ Yes _____ No If yes, please explain and attach documentation.

- (1) Number, date and disposition of any malpractice settlement or award made to the plaintiff or other claimant relating to the quality of services provided by you, and the state in which this action occurred:

Number:	Date:	Disposition of Malpractice Settlement or Award:	Place of Jurisdiction:

- (2) Number, date and disposition of any civil litigation or arbitration relating to the quality of services provided by you in which the party complaining against you prevailed or otherwise received a favorable decision or order, and the state in which this occurred (please use additional paper if needed):

Number	Date	Disposition of Civil Litigation or Arbitration:	Place of Jurisdiction:

Applicant Membership Status

- Are you a current member of any health related professional organization?

___ * Yes ___ No* If yes, please list all such memberships below:

Name of Professional Organization:	Type of Membership:	How Long Have You Been a Member?

Ethical Considerations:

- Have you ever been disciplined by any licensure, certification, or regulation Board?
___ Yes ___ No
- Have you ever been disciplined by any professional organization?
___ Yes ___ No
- If you answered yes to either of the above, answer the following **and** attach an explanation:

State:	Nature of Discipline:	Board or Organization Name:	Date Disciplined:

Please attach additional information concerning the disciplinary action taken that you feel will assist the Board in determining your candidacy for licensure.

- Have you been convicted of any violation of federal or state law?

___ * Yes ___ No * If yes, please attach an explanation.

Tax Clearance Information

Pursuant to Minnesota Statutes, Section 148B.06, subdivision 3 (1996), the Board is required to ask all applicants to provide their social security number and Minnesota Business Identification Number on all license applications. Upon request of the Commissioner of Revenue, the Board must provide to the Commissioner a list of all regulated individuals and applicants, including their names and addresses, social security numbers, and business identifications numbers.

Under the Minnesota Government Data Practices Act, you are advised of the following regarding the use of this information:

1. This information may be used to deny the issuance or renewal of your license in the event you owe the Minnesota Department of Revenue delinquent taxes in the amount of \$500.00 or more.
2. Upon receiving this information, the Board will supply it only to the Minnesota Department of Revenue. However, under the Federal Exchange of Information Agreement, the Department of Revenue may supply this information to the Internal Revenue Service.
3. Failure to supply this information may jeopardize or delay the processing of your application.

PRACTICUM AFFIDAVIT

I hereby certify that: _____
Student Name

Has completed at: _____
College or University Name

A clinical practicum in Marriage & Family Therapy of at least 300 hours of clinical client contact with individuals, couples, and families for the purpose of assessment and intervention. Of the 300 hours, no more than 150 hours was with individuals. This clinical experience was supervised on site or at the academic institution by a licensed marriage and family therapist or an American Association for Marriage and Family Therapy approved supervisor.

Faculty Member

Address

(_____) _____
Telephone Number

Date

Notary:

Subscribed and sworn to before me this ____ day of _____ 20

Signature of Notary Public

My commission expires the ____ day of _____ 20 _____

Notary Seal _____

Section II

Education Information

Begin with graduate education. Transcripts of the graduate degree(s) you are using to meet the requirements for licensure must be sent directly to the Board by the educational institution. Transcripts must be from regionally accredited institutions and show all coursework and degrees or certificates used to meet licensure requirements. **This application can not be considered without receipt of the above.**

Name of Institution:	Location (City, State):	Degree Obtained, and in What Subject Field:	Date Degree Granted Month/Year:

Which degree(s) are you using to meet the education requirements for licensure?

Please list:

Is this degree(s) from a regionally accredited educational institution?

_____ Yes _____ No

If yes, list the name of the accrediting agency: _____

- If the degree listed above is **NOT** a degree in Marriage and Family Therapy from a program accredited by COMAFT but complies with the curriculum stated in Minnesota Rules, Part 5300.0140, Subpart 2, please complete the following grid:

Please identify completed courses which meet the requirements of graduate degree training in Marriage and Family therapy, according to Minnesota Rules, Part 5300.0140, Subpart 2. If this Board has previously approved all or part of your academic work, include a copy of that grid sheet.

List the course title, course number, and credit hours, as indicated on the transcript(s) which is sent to the Board office.

	Course Title:	Course Number:	Credit Hours:
Human Development: (9 semester hours or 12 quarter hours needed)			
Marital and Family Studies: (9 semester hours or 12 quarter hours needed)			
Marital and Family Therapy: (9 semester hours or 12 quarter hours needed)			
Research Methods: (One course)			
Professional Studies: (One course)			
Clinical Practicum: (At least 300 hours, of which not more than 150 hours may be with individuals)			

AFFIDAVIT OF APPLICANT:

STATE OF: _____

COUNTY OF: _____

I, _____, hereby apply for the national examination in marital and family therapy, under the laws and regulations governing marriage and family therapy licensure. I acknowledge receipt of Minnesota Statutes, Sections 148B.01 to 148B.175 and 148B.39, and related rules, and further that I have read these regulations. I understand that I am under a continuing obligation to keep informed of any changes to the law and rules governing marriage and family therapy licensure.

I swear that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of Minnesota: that I am the person named in the transcript which will be sent directly from academic institute.

I hereby authorize all educational institutions, hospitals, medical institutions or organizations, clinics, my references, Personal physicians, employers (past and present), business and professional associates (past and present), all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files, or records including (but not limited to) transcripts, medical records, personnel files, and any information, favorable or otherwise, the Board may require for its evaluation of my professional, ethical, and physical qualifications for licensure in Minnesota.

I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing of oral information or of documents, records, or other information to the Board.

I have carefully read the questions in the in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice marriage and family therapy in Minnesota. I understand that I am required to update my application with pertinent information to cover the time period between date of application and date approved by the Board.

➤ _____
Signature of Applicant

Sworn to before me this _____ day of _____, 20 _____

Signature of Notary Public

My commission expires: _____

CERTIFICATION OF IDENTIFICATION:
Certification of Notary Public is required.

Applicant Name: _____

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. Sworn to before me by the applicant on this _____ day of _____, 20 _____.

Signature of Notary Public _____

Expiration Date: _____

Notary Seal: _____

