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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**

\_\_\_\_\_ Exam                      \_\_\_\_\_ Reciprocity                      \_\_\_\_\_ Endorsement                      \_\_\_\_\_ Temporary

**INSTRUCTIONS**

1. Complete this application, have it notarized, and mail it to the above address. **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 through 11 and do not complete pages 2, 5, and 6. Instead, enclose, or have sent, proof of the work experience, or the clinical supervision (page 3) or the A.A.M.F.T. clinical membership.
4. If you are applying by endorsement, disregard instructions 3 and 7 through 10, and do not complete pages 2, 5, and 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 attached Declaration of Citizenship form and have it notarized.
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 signator's letterhead. These letters must verify your good moral character and ethics.
11. Have your supervisor of post-masters experience complete page 6 and enclose it or have it sent to the above address.
12. If you have ever been licensed in any other states as a Marital and Family Therapist, enclose a copy of those state's statutes and rules and complete page 7. Also enclose a copy of your original licenses and renewal certificates from those states.

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

*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.*

U.S. CITIZEN: Yes \_\_\_\_\_ No \_\_\_\_\_

All applicants **must** complete the attached Declaration of Citizenship form

CURRENT HOME MAILING ADDRESS: \_\_\_\_\_

CURRENT PRACTICE ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HOME PHONE # \_\_\_\_\_

WORK PHONE # \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

Do you wish to receive notifications, including renewal notification, from the Department of Health via email? \_\_\_\_ Yes \_\_\_\_ No

List all states where you currently have or have ever had a Marital and Family Therapist license.

\_\_\_\_\_

**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	Institution
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 AND DATES OF SUPERVISED PRACTICUM/INTERNSHIP IN MARITAL AND FAMILY THERAPY**

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**COMPETENCY INFORMATION**

**PLEASE ANSWER THE FOLLOWING QUESTIONS.** If any answers to questions in this part are in the affirmative, 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 marital and family therapy”** is to be construed to include all of the following:
  - a. The cognitive capacity to make appropriate diagnosis or evaluation, and exercise reasoned judgment, to learn, and keep abreast of marital and family therapy developments;
  - b. The ability to communicate those judgments and 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. **“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.
4. **“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.
5. **“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:**

	<b>YES</b>	<b>NO</b>
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice marital and family therapy with reasonable skill and safety?	_____	_____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	_____	_____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	_____	_____

[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.]

**QUESTIONS:**

	<b>YES</b>	<b>NO</b>
2. Do you currently use chemical substances?	_____	_____
a. If yes, do they in any way impair or limit your ability to practice marital and family therapy with reasonable skill and safety?	_____	_____
3. Are you currently engaged in the illegal use of controlled substances?	_____	_____

- a. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances? \_\_\_\_\_
  
- 4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? \_\_\_\_\_
  
- 5. If you have ever held or applied for a license or certificate to practice marital and family therapy in any state, country, or province, has it or was it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? \_\_\_\_\_
  
- 6. If you have ever held staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action? \_\_\_\_\_
  
- 7. Have you ever applied for and been denied a state or federal controlled substance certificate? \_\_\_\_\_
  
- a. If you have possessed such a certificate has it ever been revoked, suspended, restricted, or otherwise disciplined, or voluntarily under threat of investigation or disciplinary action? \_\_\_\_\_
  
- 8. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic offense? \_\_\_\_\_
  
- 9. Have you ever been rejected or censured by a professional association? \_\_\_\_\_
  
- 10. 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? \_\_\_\_\_
  
- 11. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? \_\_\_\_\_

**APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC**

**AFFIDAVIT AND RELEASE**

I, \_\_\_\_\_, of \_\_\_\_\_,  
*(Applicant's Name)* *(City)* *(State)*

being duly sworn and identified as the person referred to in this application and signed photos attests to the truth of each statement made in said application. I further swear that I have read and understand the statute and the Rules and Regulations, which were enclosed in the application packet, and agree to abide by them in the practice of marital and family therapy 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 marital and family therapy.

**AUTHORIZE** release, use of 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.

**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 that provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for licensure.

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

**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**

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
**NOTARY PUBLIC** Affix Seal Here

My Commission expires \_\_\_\_\_

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.

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

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: \_\_\_\_\_

(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.

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 \_\_\_\_\_

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

AFFIX SEAL HERE

**THIS PAGE MAY BE DUPLICATED IF NEEDED.**





STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TN 37243

**DECLARATION OF CITIZENSHIP  
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE**

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) \_\_\_\_\_  
Healthcare Profession (Please Print) License number if applicable

**Please Print Legibly**

1. Name: \_\_\_\_\_  
Last First Middle Maiden\_
2. Mailing Address: \_\_\_\_\_
3. Phone Number: Home: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Office: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_-\_\_\_\_
4. I am a United States Citizen: \_\_\_Yes \_\_\_No
5. I am a foreign national not physically present in the United States \_\_\_Yes \_\_\_No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
  - a) Tennessee Driver's License, or photo ID issued by Department of Safety.
  - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
  - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
  - d) A federally issued birth certificate.
  - e) A valid, unexpired U.S. passport.
  - f) A report of birth abroad of a U.S. citizen.
  - g) A certificate of citizenship.
  - h) A certificate of naturalization.
  - i) A U.S. citizen ID card.
  - j) Any successor document to #'s a-i above.
  - k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
  - a) Permanent Residents

- b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
- c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
- d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
- e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
- g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status- "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Signature

Sworn to before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: \_\_\_\_\_

**If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.**