The Commonwealth of Massachusetts
Division of Professional Licensure
Board of Allied Mental Health and
Human Services Professions
1000 Washington Street, Suite 710
Boston, MA 02118-6100

APPLICANT INFORMATION FOR LICENSURE AS A MARRIAGE & FAMILY THERAPIST

All Applicants:

- The NON-REFUNDABLE application fee of **$117.00** must accompany the submitted application. Only a check or money order payable to "Comm. of MA" is acceptable.
- Submit pages 3-5 of the application to the address above (in addition to required documents specified below).
- Official Transcripts. **Please remember that 60 graduate semester hours are required for degrees conferred after July 1, 1999.** Degrees completed prior to July 1, 1999 must be a minimum of 45 credit hours. If the degree was less than 45 hours, a further degree or CAGS (Certificate of Advanced Graduate Study) or its equivalent is required, which shall meet the 60 semester hour requirement
- All applicants must submit **TWO** professional references on forms furnished by the Board (form provided within this application), from the two most recent supervisors.
- **The Checklist provided at the end of this application must be completed and included**.

Exam Applicants: In addition to requirements of **―All Applicants‖**, be sure that pages 6, 7 & 8 of this application are completed and submitted. The Board determines your eligibility to take the exam based on your education and pre-master's experience documentation.

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Please be advised: post-master's clinical experience documentation will not be reviewed until you have passed the examination. You are NOT required to submit evidence of post-master's clinical experience in order to be approved to sit for the examination. Following passage of the examination this documentation will be requested of you.

Once the Board deems you eligible to take the exam, you will receive email from Board staff with instructions. This notice will explain the exam registration process and associated fees. **Please be aware that the Board cannot guarantee entrance to a specific testing window.** During the registration process candidates will be allowed to choose from the two nearest upcoming testing windows. Notice of examination results are sent by the Board approximately 4-6 weeks after the close of the examination window.

EXAMINATION TESTING WINDOWS:

Third full week of each month (Saturday through Saturday).

Documenting Post-master's experience (not *applicable to clinical fellow and reciprocity applicants*):
Following passage of the examination, documentation of the required post-master's clinical experience will be requested. Be sure to have your approved supervisor(s) complete the Post-master's Clinical Experience Form to document the required hours of experience and supervision.

Clinical members/fellows of the AAMFT: In addition to the requirements of "**All Applicants**‖, you must submit official verification of your status from AAMFT and if licensed, official verification of licensure from all applicable state(s). ***Please be advised that passage of the national MFT licensure exam is required and confirmation of passage must be provided either by the state Board verification or by AMFTRB via a score transfer report***. To request a score transfer report from AMFTRB please visit the website www.amftrb.org and review the FAQ section for instructions**. *If you have not already taken the national examination, you will be automatically approved to do so.***

Reciprocity Applicants: In addition to the requirements of "**All Applicants**‖, you must submit an official license verification from the applicable state(s) where you are licensed. The Board must determine if the requirements for licensure in the state in which you are licensed are equivalent to or higher than those in Massachusetts, and therefore it is requested that a copy of the licensure requirements in effect at the time of your initial licensure be submitted as well (these may generally be obtained from the state Board that issued your license). ***Please be advised that passage of the national MFT licensure exam is required and confirmation of passage must be provided either by a state Board via the verification or by AMFTRB via a score transfer report***. To request a score transfer report from AMFTRB please visit the website www.amftrb.org and review the FAQ section for instructions**. Be advised that if it is determined that the licensure requirements met were NOT equivalent to or higher than those in Massachusetts, then you will be required to demonstrate via the application forms that you do indeed meet ALL Massachusetts licensure requirements.**

Should you have any questions regarding the application process, please contact the Board staff at (617) 701-8683 or via email amh.board@state.ma.us.

Please be aware that if you submit an application and it is determined by the Board that it is incomplete, or that you have failed to meet the regulatory requirements for licensure, the Board will provide you six months to complete your application or submit the information needed to demonstrate that you meet the regulatory requirements, which will be communicated to you in a written letter from the Board. After six months, if your application is still incomplete, or if you have still failed to demonstrate that you meet the regulatory requirements for licensure, you will be issued a letter from the Board indicating that your application has been closed or denied. If your application is closed or denied, you would need to re-apply for licensure by submitting a complete application to the Board and by paying a new application fee.

***ALL APPLICANTS** MUST COMPLETE AND INCLUDE THE CHECKLIST PROVIDED AT THE END OF THIS APPLICATION & TWO PROFESSIONAL REFERENCES.**

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Please attach recent passport type
2 X 2
head and shoulder photograph

MARRIAGE AND FAMILY THERAPIST LICENSURE APPLICATION

NON-REFUNDABLE APPLICATION FEE: $117.00
(Upon completion of all requirements an initial license fee will be assessed)

Please check only one

☐ ***EXAM Applicant*** ☐ ***CLINICAL FELLOW Applicant*** ☐ ***RECIPROCITY Applicant***

1. Name: _____
   Last First Middle Maiden

2. Mailing Address: _____
   Street Apt #./ Suite #/ Business Name

   _____
   City/Town State Zip Code

***NOTE**: The mailing address above will be a **matter of public record**. It will appear on your license and will be used for all Board correspondence. The mailing address may be a business address or post office box.*

3. Date of Birth: _____

4. Telephone No: Day_____ Evening _____

5. *Email:_____
   Do you consent to receiving information about your application from the Board via email (e.g., incomplete documents): Yes_____ No_____

****Exam candidates: Please note that if an e-mail address is provided it will be utilized by ProExam for exam registration notification****

DISCIPLINARY HISTORY

If you answer —Yes‖ to any of the following questions, please attach a full explanation.

A. Has any disciplinary action been taken against you by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes No _

B. Are you the subject of pending disciplinary action by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes No _

C. Have you voluntarily surrendered or resigned a professional license to a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes No _

D. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction? Yes____No ____

E. Have you ever been convicted of a felony or misdemeanor in the United States or any country or foreign jurisdiction, other than a traffic violation for which a fine of less than $200 was assessed? Yes____No ____

F. Have you taken a Board-approved training in Domestic and Sexual Violence? Yes___No ____

The Board is registered under the provisions of M.G.L c.6 §172 to receive Criminal Offender Record Information (CORI) for the purpose of screening current licensees and otherwise qualified prospective license applicants. CORI must be checked as part of your licensing process. No convictions contained in a CORI are automatic disqualifiers. In order to complete the CORI check process, please fill out the Criminal Offender Record Information Acknowledgment Form on Page 13 & 14.

AAMFT MEMBERSHIP STATUS
Do you have current **clinical** membership/ fellowship with the American Association of Marriage and Family Therapy (AAMFT)? Yes ____No ___(**If you answered —Yes,‖ please include verification from AAMFT)**

EDUCATION				
College or University	Degree	Major	Year	Credits (indicate semester or quarter hrs)

If you currently hold or have ever held a license in another state or jurisdiction, please complete the information below. An official, sealed letter of license verification from licensing board must be submitted.			
State	Date Issued	Expiration Date	Status

AFFIDAVIT

Pursuant to G.L. c. 62C, s. 49A, I have filed all state tax returns and paid all state taxes required under law. Yes____No _____

Pursuant to G.L. c. 119 s. 51A and G.L. c. 112, s. 1A, my signature on this application is my certification that I understand my obligation to report the abuse or neglect of children and that failure to do so may result in criminal punishment including fines and/or imprisonment.

The applicant named on this application agrees to abide by the rules and regulations for Licensed Marriage and Family Therapists and attests that all statements are truthful and are made under the pains and penalties of perjury.

_____
Applicant's Signature

_____
Date

PLEASE LIST THE COURSES AND CREDIT HOURS FOR EACH REQUIRED GROUP

Each course taken can only be used to fill one requirement.

	Course Title & Number	**Number of credits (specify semester or quarter)**
Marital and Family Therapy: **9 semester hours or 12 quarter hours required** ***Family therapy methodology; family assessment; treatment and intervention methods; overview of major clinical theories of marital and family therapy.***		
Marital and Family Studies: **9 semester hours or 12 quarter hours required** ***Family life cycle; sociology of the family; families under stress; the contemporary family; family in a social context; the cross-cultural family; and youth/adult/aging and the family; family subsystems; individual, interpersonal relationships (marital, parental, sibling).***		
Human Development: **9 semester hours or 12 quarter hours required** ***Human development; personality theory; human sexuality; psychopathology; behavior-pathology. One course in this category must be in psychopathology or its equivalent.***		
Professional Studies: **3 semester hours or 4 quarter hours required** ***Professional socialization and the role of the professional organization; legal responsibilities and liabilities; independent practice and inter-professional cooperation; ethics; family law.***		
Research: **3 semester hours or 4 quarter hours required** ***Research design; methods; statistics; research in marital and family studies and therapy.***		

PRE-MASTER'S DEGREE EXPERIENCE – STUDENT PRACTICUM AND/ OR INTERNSHIP

I.

Name of Facility: _____

Address of Facility: _____

_____

Your Title:_____Dates of Supervision_____

Name and Title of Supervisor: _____

Nature of Clinical Experience:

_____

_____

_____

_____

II.

Name of Facility: _____

Address of Facility: _____

_____

Your Title:_____Dates of Supervision_____

Name and Title of Supervisor: _____

Nature of Clinical Experience:

_____

_____

_____

_____

POST-MASTER'S DEGREE CLINICAL EXPERIENCE

Name of Facility: _____

Address of Facility: _____

_____

Your Title:_____Dates of Supervision_____

Name and Title of Supervisor: _____

Nature of Clinical Experience:

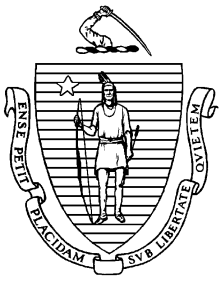
_____

_____

_____

_____

_____



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MARRIAGE AND FAMILY THERAPIST LICENSURE:
ACADEMIC PROGRAM DIRECTOR FORM
(To be filled out by Academic Program Director of graduate program)

Name of Applicant _____

Name of Program Director _____

Institution_____

Department_____

Title of Program _____

An applicant for licensure as a Marriage and Family Therapist must have completed a program of graduate study meeting the requirements outlined in 262 CMR. Please indicate with a check mark whether the graduate study the applicant completed at your institution met these requirements.

YES NO

_____ ____The program in Marriage and Family Therapy is offered in an accredited institution of higher education.

_____ ____The program has an identified Marriage and Family Therapy faculty.

_____ ____The program includes supervised practice and/or internships consistent with the requirements in 262 CMR

_____ ____The field based supervisor of the supervised internship met the requirements of an "Approved Supervisor" as defined in 262 CMR

AFFIDAVIT
I, the undersigned, do state under the penalties of perjury that the answers given above are correct. I agree to provide any additional information requested by the Board.

_____ _____
Academic Program Director's Signature Date

MARRIAGE AND FAMILY THERAPIST LICENSURE APPLICATION

POST-MASTER'S CLINICAL EXPERIENCE FORM

Name of Applicant: _____

INSTRUCTIONS: Please duplicate this form as necessary. See following page for the definition of Approved Supervisor. *PLEASE PRINT CLEARLY OR TYPE.*

MINIMUM REQUIREMENTS: **A minimum of two years full-time or equivalent part-time (3360 hours), including 200 hours of supervision from an approved supervisor, of which 100 hours must be individual supervision. This supervised clinical experience in marriage and family therapy must include a minimum of 1000 hours face-to-face contact hours of clinical experience; of those 1000 hours, a minimum 500 hours must be specifically face-to-face contact hours of clinical experience with couples and families**

Remainder of Form to be completed by Approved Supervisor

Name of Supervisor: _____
Supervisor's Title: _____
Supervisor's License Type and Number: _____
Supervisor's phone number: _____
Name/Address of Clinical Facility: _____
_____

Dates of Supervision of the Applicant:____/____/_____To: /_____/_____(month/date/year)

The applicant worked_____hours per week for_____weeks for a total of_____MFT experience hours

Number of direct, face-to-face, clinical hours completed during this period:
Individual_____Couples/Family: _____ Group: _____ Total:_____

Number of Supervision Hours provided during this period by this supervisor:
Individual:_____Group: _____

Has any disciplinary action been taken against you by any of the following: (if yes, please submit detailed explanation)

Professional Association or Organization:	Yes: ____	No: ____
Governmental Authority (e.g. Professional Licensing Board):	Yes: ____	No: ____
Third Party Insurance Carrier:	Yes: ____	No: ____
Credentialing Board:	Yes: ____	No: ____

I have read the definitions of Approved Supervisor listed in 262 CMR and/or on the next page and believe that I qualify as an Approved Supervisor. **The undersigned states that under the pains and penalties of perjury, the above statements are true and correct.**

_____
Signature of Approved Supervisor Date

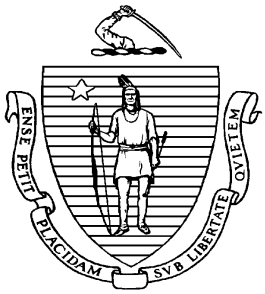
DEFINITION OF APPROVED SUPERVISOR (262 CMR)

(a) A marriage and family therapist designated as an " Approved Supervisor" by the AAMFT to supervise the clinical practice of marriage and family therapists, or

(b) a licensed marriage and family therapist, rehabilitation counselor, educational psychologist, mental health counselor, psychologist, psychiatrist, all of whom holds a masters degree in either social work, marriage and family therapy, rehabilitation counseling, educational psychology, counseling or an equivalent field, or holds a doctorate degree in psychology, or a medical degree with a sub-specialization in psychiatry, and who:

1. has had primary supervisory responsibility for two practitioners providing marriage and family therapy for a period of two years or the equivalent; or

2. holds either a teaching or supervisory position in a recognized educational institution, institute or agency which trains marriage and family therapists, provides clinical services to individuals, couples and families on a regular basis, or offers graduate degrees in marriage and family therapy or a related field.



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PROFESSIONAL REFERENCE FORM

INSTRUCTIONS: All applicants must submit a minimum of TWO professional references. Please duplicate this form as necessary and provide it to your post-master's supervisor, as well as, your most recent supervisor (if this is also your post-master's supervisor, then provide it to your next most recent supervisor). *PLEASE PRINT CLEARLY OR TYPE AND SUBMIT ORIGINAL SIGNED DOCUMENT.*

Waiver of Liability: (Must be completed by licensure applicant)

I,_____, hereby authorize _____
(applicant's name) (reference's name)
(hereinafter "the reference") to provide the Board of Registration of Allied Mental Health and Human Service Professionals with all information of any kind that the reference may, in his or her absolute discretion, deem relevant to my qualifications as an applicant. I hereby release and discharge the professional reference from all claims arising out of the provision of such information.

Applicant's signature:_____ Date: _____

Remainder of Form to be completed by Approved Supervisor

General information for references completing this form:

- **The Board assumes that you, in recommending this applicant, will be willing to interpret or to substantiate to the Board your recommendation, should the Board desire to contact you. The Board will keep all information confidential to the maximum extent permitted by law.**
- **Complete this reference form only if the applicant has signed the above waiver of liability.**

Reference's name:_____ Title: _____

Reference's license type:_____ License number/Jurisdiction: _____

Length of time the reference has known the applicant: from_____ to _____

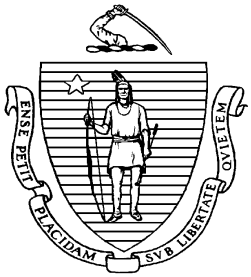
1. Extent of knowledge of applicant's professional and ethical behavior:
   ☐Thorough ☐Moderate ☐Limited

2. Based on my experience, to the best of my knowledge, the applicant is an individual of good moral character:
   ☐Yes ☐No ***(if no, please explain on a separate sheet)***

3. Quality and extent of endorsement: ☐Without reservation ☐With reservation ☐No recommendation
   (if "with reservation" or "no recommendation", please explain on a separate sheet)

_____

Signature of Reference **Date**



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Reference's license type:_____License number/Jurisdiction: _____

Length of time the reference has known the applicant: from_____to _____

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2. Based on my experience, to the best of my knowledge, the applicant is an individual of good moral character:
☐Yes ☐No ***(if no, please explain on a separate sheet)***

3. Quality and extent of endorsement: ☐Without reservation ☐With reservation ☐No recommendation
(if "with reservation" or "no recommendation", please explain on a separate sheet)

_____
Signature of Reference

Marriage and Family Therapist Application Checklist:

(All Applicants MUST include this with your completed application)

MANDATORY

My social security number is:

☐☐☐-☐☐-☐☐☐☐ Pursuant to G.L. c. 62C, § 47A, the Division of Professional Licensure is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you comply with the tax laws of the Commonwealth.

Prior to submitting an application, please make sure the following information is included and / or documented:

___**Completed application with photo.**

___**Check or Money Order payable to —Comm. of MA‖ for non-refundable application fee of $117.00.** *An Additional licensure fee of* ***$155.00*** *will be assessed when all requirements have been met.*

___**Official sealed Transcript(s) ONLY GRADUATE (Non-Baccalaureate) degrees.**

___**If a current Clinical Member of the American Association of Marriage and Family Therapy (AAMFT), official verification of status from AAMFT.**

___**If currently or previously licensed in another State or jurisdiction, official letter of verification from the State(s) or jurisdictions in a sealed envelope.**

___**Two Professional Reference forms completed by two most recent supervisors (May be submitted later if post-master's experience is not yet complete; originals only—photocopies are not accepted).**

___**Clinical Fellow and Reciprocity applicants are required to submit verification of the National MFT examination.**

___**Completed Criminal Offender Record Information Request Form, including notarization.**

COMMONWEALTH OF MASSACHUSETTS
1000 Washington Street, Suite 710
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CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT FORM

The Division of Professional Licensure by itself and on behalf of boards of registration pursuant to M.G.L. c. 13, §9 [hereinafter, "Division of Professional Licensure"] is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective license applicants and current licensees.

As a license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Services ("DCJIS"). I hereby acknowledge and provide permission to the Division of Professional Licensure to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing the Division of Professional Licensure written notice of my intent to withdraw consent to a CORI check.

FOR LICENSING PURPOSES ONLY:

I understand that the Division of Professional Licensure may conduct a subsequent CORI check within one year of the date this Form was signed by me.

By signing below, I provide my consent to an initial CORI check and a subsequent CORI check, both within one year of the date of this Form, and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

_____ _____

Signature Date

Please provide the name of the board of registration and license type for which you are applying or currently hold:

_____ _____

Board of Registration License Type

NOTE: DPL CANNOT ACCEPT THIS TWO-PAGE CORI ACKNOWLEDGMENT FORM UNLESS IT IS EITHER (1) SIGNED IN PERSON AT THE BOARD'S OFFICES IN THE PRESENCE OF A DPL EMPLOYEE WHO HAS VERIFIED THE APPLICANT'S IDENTITY THROUGH ACCEPTABLE IDENTIFICATION, OR (2) SIGNED IN THE PRESENCE OF A NOTARY PUBLIC WHO HAS LIKEWISE VERIFIED IDENTITY AND THEN MAILED OR OTHERWISE DELIVERED TO THE BOARD'S OFFICES AT THE ADDRESS SET FORTH ABOVE.

SUBJECT INFORMATION: (A red asterisk (*) denotes a required field)

_____

*Last Name *First Name Middle Name Suffix

_____

*Maiden Name (or other name(s) by which you have been known)

_____ _____

*Date of Birth Place of Birth

* Social Security Number: _____-_____-_____

Sex: _____ Height: ____ ft. ____ in. Eye Color: _____

Driver's License or ID Number: _____ State of Issue: _____

Current and Former Addresses:

_____

Street Number & Name City/Town State Zip

_____

Street Number & Name City/Town State Zip

_____

IDENTITY VERIFICATION SECTION: If this form is submitted by hand at DPL Offices, Section A must be completed. Otherwise, Section B must be completed.

SECTION A: VERIFICATION BY DPL EMPLOYEE: I hereby certify that I verified the identity of the above-referenced subject by reviewing the following form(s) of government-issued identification:[1]

☐ Passport ☐ State-issued driver's license ☐ Military identification ☐ State-issued identification card

VERIFIED BY: _____

Name of Verifying DPL Employee (Please Print)

_____

Signature of Verifying DPL Employee Date

SECTION B: VERIFICATION BY NOTARY:

On this _____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____ (name of document signer), and proved to me through satisfactory evidence of identification, which was the following:[1]

☐ Passport ☐ State-issued driver's license ☐ Military identification ☐ State-issued identification card

to be the person whose name is signed on the preceding or attached document, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose.

_____

Notary Public: Notary Commission Expires On

[1] If a subject does not have an acceptable government-issued identification, his or her identity shall be verified by other forms of documentation as determined by DCJIS. 803 CMR 2.09(2).