

**Arizona Board of Behavioral Health Examiners
Marriage and Family Therapy Licensure Application Supplement**

Part 1. EDUCATION

(Not required for applicants with an active Arizona Associate Marriage and Family Therapy license.)

The following information can be obtained by calling the institution that awarded your graduate degree.

ACCREDITATION OF GRADUATE INSTITUTION

NOTE: Complete for the highest marriage and family therapy degree you hold.

Degree received _____

YES NO Did your graduate program hold accreditation from the Commission On Accreditation for Marriage and Family Therapy (COAMFT) on the date your degree was awarded? Date of Accreditation _____

If "Yes" you do not have to complete part 3.

Part 2. OFFICIAL TRANSCRIPTS

(Not required for applicants with an active Arizona Associate Marriage and Family Therapy license.)

You must include an official transcript for each graduate program you attended. Request that the educational institution send you an official transcript. **DO NOT OPEN THE ENVELOPE CONTAINING YOUR TRANSCRIPT.** Submit all transcripts in unopened envelopes **WITH** your application. Transcripts submitted in opened envelopes will not be accepted.

Part 3. CURRICULUM

(Not required for applicants with an active Arizona Associate Marriage and Family Therapy license.)

Only graduate and post-graduate courses are accepted. Each course can only be used once to fulfill curriculum requirements. All courses listed must appear on the transcript(s) you include with your application. Each course must be either a 3-semester hour or 4-quarter hour course.

If you attended a program outside of Arizona that was not accredited by COAMFT, you must attach course descriptions for all courses you list below from the catalog or bulletin of your graduate institution.

MARRIAGE & FAMILY STUDIES (3 courses): studies of introductory systems theory, family development, family systems, including marital, sibling, and individual subsystems, special family issues, and gender and cultural issues, all with a major focus from a systems theory orientation.

Institution	Course No.	Course Title (spell out)	Dates From /To	Semester Credit Hours	Quarter Credit Hours	MFTCC use only	
						Yes/No	Initials
						/	/
						/	/
						/	/
						/	/

MARRIAGE & FAMILY THERAPY (3 courses): studies of advanced systems theory and interventions, major systemic marriage and family treatment approaches, structural, strategic, neo-analytic, group therapy, behavioral marriage and family therapy, communications, sex therapy, and psychopharmacology.

Institution	Course No.	Course Title (spell out)	Dates From /To	Semester Credit Hours	Quarter Credit Hours	MFTCC use only	
						Yes/No	Initials
						/	/
						/	/
						/	/
						/	/

HUMAN DEVELOPMENT (3 courses): Studies of normal and abnormal human development, personality theory, human sexuality, psychopathology and abnormal behavior, which may be integrated with systems theory.

Institution	Course No.	Course Title (spell out)	Dates From /To	Semester Credit Hours	Quarter Credit Hours	MFTCC use only	
						Yes/No	Initials
						/	/
						/	/
						/	/
						/	/

PROFESSIONAL STUDIES (1 course): Studies of professional ethics as a therapist including legal and ethical responsibilities and liabilities, and family law.

Institution	Course No.	Course Title (spell out)	Dates From /To	Semester Credit Hours	Quarter Credit Hours	MFTCC use only	
						Yes/No	Initials
						/	/

RESEARCH (1 course): Studies of research design, methodology, and statistics in marriage and family therapy.

Institution	Course No.	Course Title (spell out)	Dates From /To	Semester Credit Hours	Quarter Credit Hours	MFTCC use only	
						Yes/No	Initials
						/	/

SUPERVISED INTERNSHIP (2 courses): A minimum of 300 client contact hours under direct supervision is required.

Educational Institution (not the clinical practice site)	Course No.	Supervisors	Dates From/To	Semester Credit Hours	Quarter Credit Hours	MFTCC use only	
						Yes/No	Initials
						/	/
						/	/

Name _____ Social Security Number _____

NOTE: After completing this verification form, university personnel must send this verification form back to the applicant in a sealed envelope. Applicants must submit these unopened verification envelopes with their applications. **The Board will not accept unsealed envelopes.**

**SECTION 1: VERIFICATION OF PRACTICUM OR INTERNSHIP
(TO BE COMPLETED BY THE APPLICANT)**

To: _____
University (please print)

DOB: _____

SSN: _____

From: _____
Applicant's Name (please print)

(_____) _____ - _____
Telephone

Applicant's Address

I have applied to the Arizona Board of Behavioral Health Examiners for licensure as a behavioral health professional. I hereby authorize you to release the information requested below.

Applicant's Signature Date

Date

**THE APPLICANT MUST MAIL THIS FORM TO THE UNIVERSITY FOR VERIFICATION
BEFORE SUBMISSION TO THE ARIZONA BOARD OF
BEHAVIORAL HEALTH EXAMINERS**

SECTION 2: TO BE COMPLETED BY THE UNIVERSITY

NOTE: After completing this verification form, university personnel must send this verification form back to the applicant in a sealed envelope. Applicants must submit these unopened verification envelopes with their applications. **The Board will not accept unsealed envelopes.**

Total client contact hours under the direct supervision of a faculty member: _____

Total clinical supervision hours: Group: _____ Individual: _____

Name of on site supervisor: _____ Credential Held: _____

Name of Professor: _____ Credential Held: _____

Name of Professor: _____ Credential Held: _____

Form Completed By Date

Please Include University Seal

University Name and Phone Number

Name _____ Social Security Number _____

PART 4. PRACTICUM / INTERNSHIP SUPERVISOR VERIFICATION OF CREDENTIAL FORM

(Not required for supervisors licensed by Arizona State Board of Behavioral Health Examiners)

Complete Section I and mail to your practicum / internship supervisors to obtain a verification of their license, registration or certification. Your supervisor must complete Section 2 and mail to their licensing, registering or certifying agency.

SECTION 1: TO BE COMPLETED BY THE APPLICANT BEFORE SUBMITTING THE FORM TO EACH SUPERVISOR

To: _____ (Supervisor)

I have applied to the Arizona Board of Behavioral Health Examiners for licensure as a behavioral health professional. Please submit the following form to your licensing, registering or certifying agency to verify your credentials. Please return this form to my attention.

Applicant's Signature

Date

SECTION 2: TO BE COMPLETED BY THE APPLICANT'S SUPERVISOR

Mail this form and any necessary fee to your licensing, registering or certifying agency.

Name: _____ License/Registration/Certification No: _____

Address: _____ Phone Number: _____

Section 3: TO BE COMPLETED BY THE STATE IN WHICH THE INDIVIDUAL IDENTIFIED IN SECTION 2 ABOVE IS LICENSED, REGISTERED, OR CERTIFIED:

I am the person named in Section 2 who provided supervision to an applicant of the Arizona Board of Behavioral Health Examiners. I hereby authorize you to release the information requested below. **Please return the completed form to me at the address listed in Section 2 above.**

Supervisor's Signature

Date

Professional's Name (supervisor) _____

Credential Held _____

Credential Number _____

Issuance Date _____

Expiration Date _____

Current Status _____

Pending Disciplinary Actions YES NO

Number of Past Disciplinary Actions _____

Attach explanation of all disciplinary actions.

Form Completed By

Date

Please Include State Seal

Credentialing Agency Name and Phone Number

Name _____ Social Security Number _____

Part 5. VERIFICATION OF SUPERVISED WORK EXPERIENCE
(Not required for Licensed Associate Marriage and Family Therapy applicants)

NOTE: After notarization, the supervisor must send the verification form back to the applicant in a sealed envelope with the supervisor's name written across the seal. Applicants must submit these unopened supervision envelopes with their applications. **The Board will not accept unsigned, unnotarized or unsealed envelopes.** If your work experience was acquired as an independent contractor, please contact the Board for additional instructions.

SECTION A: TO BE COMPLETED BY APPLICANT

Supervisor's Name

Name of the agency where you obtained your supervised work experience

I have applied to the Arizona Board of Behavioral Health Examiners (AzBBHE) for licensure as a Marriage and Family Therapist. Please complete the following information verifying my supervised work experience, have the form notarized, and return the form to me in a sealed envelope. Please sign your name across the seal. I hereby authorize the above-named individual and agency to release the requested information to AzBBHE. **DO NOT INCLUDE DATES OR HOURS OF EMPLOYMENT PRIOR TO THE DATE MY GRADUATE DEGREE WAS AWARDED ON**

_____.

Applicant's Signature

Date

SECTION B: TO BE COMPLETED BY APPLICANT'S EMPLOYER OR SUPERVISOR

NOTE: After notarization, the supervisor must send the verification form back to the applicant in a sealed envelope with the supervisor's name written across the seal. Applicants must submit these unopened supervision envelopes with their applications. **The Board will not accept unsigned, unnotarized or unsealed envelopes.**

I certify that _____ (applicant name) was engaged in supervised work experience in the practice of marriage and family therapy as follows:

NOTE: You must list a specific end date. "Current" or "Present" will not be accepted.

Dates of supervised work experience: From _____ through _____
mm/dd/yy mm/dd/yy

(NOTE: In both places below, identify total hours worked, not hours per week.)

Total hours of **direct client contact** involving the use of psychotherapy for the purpose of assessment, diagnosis and treatment of individuals, couples, families and groups during the time period identified above: _____

Total hours of **direct client contact** with couples and families during the time period identified above _____

Total hours of **supervised work experience**: Direct client contact hours plus the hours the supervisee spent in activities directly related to the provision of the psychotherapy, such as time spent doing documentation and receiving clinical supervision, during the time period identified above: _____

You must attach a copy of the published job description for the position(s) the applicant held during the work experience identified above.

YES NO I have attached a copy of the applicant's published job description.

Name _____ Social Security Number _____

Identify your position with the entity / agency where the applicant obtained the work experience which you are verifying:

During the period of supervised work experience, the applicant was an:

employee independent contractor other

I was the applicant's: Employer Supervisor

Name: _____ Degree: _____

Title: _____ Telephone: _____

Agency: _____

Address: _____

Agency OBHL License # if applicable: _____

I hold the following professional license(s) or certification(s):

Type of Credential	Issuing State	Date Issued	Expiration Date	License # and Current Status

NOTE: You must sign and date this affidavit IN THE PRESENCE of the notary and the date you write must be the same as the date written by the notary. Affidavits with different dates will not be accepted.

I certify under penalty of perjury that all information contained in this verification, including all supporting documents, is true and correct to the best of my knowledge and belief with full knowledge that any false statements or misrepresentations made in this verification may be grounds for disciplinary action against any license I hold.

Employer/Supervisor Signature

Date

TO BE COMPETED BY NOTARY

Subscribed and sworn before me this _____ day of _____, 20____, in the State of _____ and County of _____.

Notary Public _____ My Commission Expires _____

Notary Seal

INSTRUCTIONS FOR COMPLETING THE VERIFICATION OF SUPERVISED WORK EXPERIENCE FORM

1. Your employer or supervisor must list the dates of the supervised work experience in a mm/dd/yy format. Using the words "current" or "present" is not acceptable.
2. Your employer or supervisor must verify your hours of direct client contact providing **psychotherapy only**. **Hours counted must be limited to only those hours spent providing assessment, diagnosis and treatment services.**
3. **TOTAL hours of supervised work experience verified should include all direct client contact hours AND all indirect hours RELATED to direct services, such as training, supervision hours you received and documentation. DO NOT include non-clinical hours, such as case management, administrative time or supervision hours you provided to others.**
4. **Total hours of direct client contact must be limited to only those hours spent providing assessment, diagnosis and treatment services.**

NOTE: You must list a specific end date. "Current" or "Present" will not be accepted.

Dates of supervised work experience: From _____ through _____
mm/dd/yy mm/dd/yy

(NOTE: In both places below, identify total hours worked, not hours per week.)

Total hours of **direct client contact** involving the use of psychotherapy for the purpose of assessment, diagnosis and treatment of individuals, couples, families and groups during the time period identified above: _____

Total hours of supervised work experience: Direct client contact hours plus the hours the supervisee spent in activities directly related to the provision of the psychotherapy, such as time spent doing documentation and receiving clinical supervision, during the time period identified above: _____

Part 6. VERIFICATION OF CLINICAL SUPERVISION AND ASSESSMENT

(Not required for Licensed Associate Marriage and Family Therapy applicants)

NOTE: After notarization, the supervisor must send the verification form back to the applicant in a sealed envelope with the supervisor’s name written across the seal. Applicants must submit these unopened supervision envelopes with their applications. **The Board will not accept unsigned, unnotarized or unsealed envelopes.**

SECTION A: TO BE COMPLETED BY THE APPLICANT BEFORE SUBMITTING TO EACH SUPERVISOR

To: _____ (Supervisor’s name)

I have applied to the Arizona Board of Behavioral Health Examiners (AzBBHE) for licensure as a Marriage and Family Therapist. Please complete the following information verifying the clinical supervision that I received from you, have the form notarized, and return the form to me in a sealed envelope. Please sign your name across the seal. I hereby authorize the above-named individual to release the requested information to AzBBHE. **DO NOT INCLUDE SUPERVISION HOURS PRIOR TO THE DATE MY GRADUATE DEGREE WAS AWARDED ON**

_____.

Applicant’s Signature

Date

SECTION B: TO BE COMPLETED BY THE APPLICANT’S SUPERVISOR

NOTE: After notarization, the supervisor must send the verification form back to the applicant in a sealed envelope with the supervisor’s name written across the seal. Applicants must submit these unopened supervision envelopes with their applications. **The Board will not accept unsigned, unnotarized or unsealed envelopes**

I certify that _____ (applicant name) received face-to-face clinical supervision from me as follows:

NOTE: You must list a specific end date. “Current” or “Present” will not be accepted.

Dates of clinical supervision: From _____ through _____
mm/dd/yy mm/dd/yy

Applicant’s position or title: _____

Describe below the applicant’s specific work activities:

Skills / Attributes	Outstanding	Above Avg	Average	Below Avg	Poor	Can’t evaluate
Assessment						
Diagnosis						
Individual psychotherapy skills						
Ability to make appropriate referrals						
Group psychotherapy skills						
Personal integrity						
Appropriate use of supervision						
Insight into client’s problems						
Ability to maintain appropriate boundaries						
Ability to be objective on the job						
Ethical conduct						
Concern for welfare of clients						
Sense of responsibility						
Recognition of own limits						
Ability to maintain confidentiality						

Name _____ Social Security Number _____

(NOTE: Identify total supervision hours, not supervision hours per week.)

Total hours of clinical supervision during the above dates: _____

Total hours of direct observation or review of audio or video tapes of applicant providing treatment: _____

Of the total hours of clinical supervision identified above, indicate the following:

Group supervision hours _____ Individual supervision hours _____

Hours of clinical supervision focusing on couples and families during the above dates: _____

Name: _____ Degree: _____

Title: _____ Telephone: _____ Agency: _____

Address: _____

I hold the following professional license(s) or certification(s):

NOTE to Supervisor: If you were not licensed or certified as a behavioral health professional in Arizona or any other state when you provided this supervision, you must enclose a copy of your graduate transcript and curriculum vitae with this form.

Type of Credential	Issuing State	Date Issued	Expiration Date	License # and Current Status

NOTE: You must sign and date this affidavit IN THE PRESENCE of the notary and the date you write must be the same as the date written by the notary. Affidavits with different dates will not be accepted.

I certify under penalty of perjury that all information contained in this verification, including all supporting documents, is true and correct to the best of my knowledge and belief with full knowledge that any false statements or misrepresentations made in this verification may be grounds for disciplinary action against any license I hold.

I certify that I have complied with the requirement for continuing education that addresses clinical supervision or that I hold a clinical supervisor certification as provided in A.A.C. R4-6-212(J) and I have included verification of the training.
[] YES [] NO

I certify that I have read and understand the clinical supervision requirements in A.A.C. R4-6-212 and that the clinical supervision identified above complied with those requirements. [] YES [] NO

I certify that I have maintained clinical supervision documentation in compliance with A.A.C R4-6-212(F)(4) and that I agree to provide such documentation upon request. [] YES [] NO

Supervisor Signature

Date

Printed Name of Supervisor

TO BE COMPETED BY NOTARY

Subscribed and sworn before me this _____ day of _____, 20____, in the State
of _____ and County of _____.

Notary Public _____ My Commission Expires _____

Notary Seal

**INSTRUCTIONS FOR COMPLETING THE
VERIFICATION OF CLINICAL SUPERVISION AND ASSESSMENT FORM**

1. Your clinical supervisor must verify hours he/she spent **meeting directly with you** to review and discuss clinical practice issues only. Time spent discussing non-clinical matters, such as staff meetings covering administrative issues cannot be verified.
2. ALL clinical supervision hours verified on the Clinical Supervision and Assessment form **MUST** occur during the supervised work period identified on your completed Verification of Supervised Work Experience form.
3. Your clinical supervisor can only verify clinical supervision hours he/she provided directly to you. A supervisor cannot verify clinical supervision hours provided by another supervisor.
4. The clinical supervisor must verify that he/she has maintained written documentation to validate all clinical supervision hours he/she verifies. The supervisor's clinical supervision documentation must comply with Board standards set out in A.A.C. R4-6-212(F)(4). A copy of the Board standards for clinical supervision documentation is attached for your convenience. PLEASE NOTE that the Board may request copies of clinical supervision documentation during the application process.
5. Group supervision hours may be verified for clinical supervision provided to two but no more than six supervisees. Typically, staff meetings do not qualify as clinical supervision hours because the supervisor meets with more than six supervisees, discussions are not limited to clinical practice issues ONLY, or the supervisor does not maintain clinical supervision documentation for staff meetings in accordance with the standards set out in A.A.C. R4-6-212(F)(4).
6. Individual supervision hours may be verified for clinical supervision meetings between the clinical supervisor and the applicant.
7. Any clinical supervision submitted for work experience acquired after July 1, 2006, must include at least 10 hours of clinical supervision acquired through direct observation or review of video/audio tapes by the clinical supervisor (A.A.C. R4-6-212(G)) of the applicant providing treatment and evaluation services to a client.
8. The clinical supervisor must have completed the continuing education required in A.A.C. R4-6-212(J) and must include verification of the training with the completed supervision form.

Name _____ Social Security Number _____

PART 7. SUPERVISOR VERIFICATION OF CREDENTIAL FORM

NOTE: Use this form only if you are applying as a Licensed Marriage and Family Therapist AND your clinical supervisor(s) was licensed or certified in another state.

Complete Section I and mail to your supervisors to obtain a verification of their license, registration or certification. Your supervisor must complete Section 2 and mail to their licensing, registering or certifying agency.

SECTION 1: TO BE COMPLETED BY THE APPLICANT BEFORE SUBMITTING THE FORM TO EACH SUPERVISOR

To: _____ (Supervisor)

I have applied to the Arizona Board of Behavioral Health Examiners for licensure as a behavioral health professional. Please submit the following form to your licensing, registering or certifying agency to verify your credentials. Please return this form with the supervision forms that you completed in an envelope sealed and signed across the seal.

Applicant's Signature

Date

SECTION 2: TO BE COMPLETED BY THE APPLICANT'S SUPERVISOR

Mail this form and any necessary fee to your licensing, registering or certifying agency. Upon receipt of the completed verification form from your licensing, registering or certifying agency, please submit the verification form with the supervision and work experience forms that you completed.

Name: _____ License/Registration/Certification No: _____

Address: _____ Phone Number: _____

Section 3: TO BE COMPLETED BY THE STATE IN WHICH THE INDIVIDUAL IDENTIFIED IN SECTION 2 ABOVE IS LICENSED, REGISTERED, OR CERTIFIED:

I am the person named in Section 2 who provided supervision to an applicant of the Arizona Board of Behavioral Health Examiners. I hereby authorize you to release the information requested below. **Please return the completed form to me at the address listed in Section 2 above.**

Supervisor's Signature

Date

Professional's Name (supervisor) _____

Credential Held _____

Credential Number _____

Issuance Date _____

Expiration Date _____

Current Status _____

Pending Disciplinary Actions YES NO

Number of Past Disciplinary Actions _____

Attach explanation of all disciplinary actions.

Form Completed By

Date

Please Include State Seal

Credentialing Agency Name and Phone Number

Part 8. CHECKLIST OF REQUIRED DOCUMENTS

**APPLICATIONS SUBMITTED WITHOUT ALL REQUIRED DOCUMENTATION
WILL NOT BE PROCESSED**

YOU MUST SUBMIT THE FOLLOWING DOCUMENTS WITH YOUR APPLICATION. Indicate below that your application includes all required documentation.

All Licensed Associate Marriage and Family Therapy and Licensed Marriage and Family Therapy applicants must submit the following required documentation:

- _____ Cashier’s check, certified check or money order for \$250.00 payable to the Arizona Board of Behavioral Health Examiners. **Personal checks will not be accepted and the fee is NON-REFUNDABLE.**
- _____ A copy of your fingerprint card or a completed fingerprint card obtained directly from the Board.
- _____ Parts I – III, V – VII, and IX of the General Application.
- _____ HIPDB / NPDB reports, submitted in an unopened envelope from the federal databank as required in Part VIII of the General Application. Reports must be dated within 90 days of the date you submit your application. The 90 day period begins when you hit “submit” on line.
- _____ Part 1 of the Marriage and Family Therapy Licensure Application Supplement.
(Not required for applicants who currently hold an active Arizona Associate Marriage and Family Therapist license.)
- _____ Part 2 of the Marriage and Family Therapy Licensure Application Supplement. Submit an official transcript for each graduate institution attended. Although courses from one school may appear on the transcript of another, the Board requires separate transcripts from each institution attended. All transcripts are to be sent to you in a sealed envelope. **You must submit these unopened transcripts with your application.** (Not required for applicants who currently hold an active Arizona Associate Marriage and Family Therapist license.)
- _____ Part 3 of the Marriage and Family Therapy Licensure Application Supplement.
(Not required for applicants who currently hold an active Arizona Associate Marriage and Family Therapist license.)

SUPPLEMENTARY DOCUMENTATION

- _____ Submit your exam score in an **unopened** envelope **IF** you have already taken and passed the required exam. Applicants who have not taken and passed the required exam must receive approval to test from the Marriage and Family Therapy Credentialing Committee. Approval to test cannot be given until the Marriage and Family Therapy Credentialing Committee approves your application.
- _____ Submit a completed Part IV of the General Application for every active and non-active credential listed in Part III of the General Application.

Licensed Marriage and Family Therapy applicants must submit the following required documentation:

- _____ Parts 4 and 5 of the Marriage and Family Therapy Licensure Application Supplement.
- _____ Submit Part 6 of the Marriage and Family Therapy Licensure Application Supplement **ONLY** if your supervisor is licensed as a behavioral health professional in another state and is not licensed as a Licensed Marriage and Family Therapist in Arizona.