APPLICATION FOR LICENSURE AS A ASSOCIATE MARRIAGE & FAMILY THERAPIST

GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS, AND MARRIAGE & FAMILY THERAPISTS
237 Coliseum Drive
Macon, Georgia 31217
Phone (478) 207-2440
www.sos.state.ga.us/plb/counselors

Please read the instructions carefully and be familiar with the laws and rules governing the practice of Marriage & Family Therapy in the State of Georgia. Visit the Board's web site for information.

****Important****
The Board cannot process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board. Please review this application before you submit it to ensure that all information and documentation is complete and correct. Incomplete applications result in delayed processing. Incomplete applications are void after one year.

Application Checklist

The following checklist is an important part of your application. Please use this checklist to ensure that you submit a COMPLETE application.

The **NON-REFUNDABLE APPLICATION FEE** made payable to Georgia Professional Counselors, Social Workers, and Marriage & Family Therapists must be included with the application. (Please see Fee Schedule at the Board's website)

PLEASE ACCESS THE BOARD RULES WHICH INCLUDES LICENSURE REQUIREMENTS FROM OUR WEBSITE AT WWW.SOS.STATE.GA.US/PLB/COUNSELORS

- ❑ **NOTARIZED APPLICATION:** THE APPLICATION MUST BE MAILED TO THE BOARD'S OFFICE AT THE ADDRESS LISTED ABOVE, ALONG WITH YOUR **FEE**. ALL QUESTIONS MUST BE ANSWERED. ANY QUESTION ANSWERED "YES", REQUIRES FURTHER DOCUMENTATION TO BE SUBMITTED. REQUEST OFFICIAL COURT DOCUMENTS BE SUBMITTED TO THE BOARD AND PROVIDE AN EXPLANATION IF YOU HAVE HAD ANY CRIMINAL CONVICTIONS OR CHARGES, OR SANCTIONS BY ANOTHER STATE LICENSING BOARD. THE BOARD, AT THEIR NEXT SCHEDULED MEETING, WILL REVIEW THE APPLICATION WITH REQUIRED DOCUMENTATION. APPROVAL OF LICENSURE IS AT THE BOARD'S DISCRETION.
- ❑ **NATIONAL BOARD SCORES:** IF YOU HAVE NOT TAKEN THE MFT EXAM THRU PES, YOU WILL RECEIVE THE EXAM PACKET INFORMATION AFTER BOARD APPROVAL. ALL APPLICANTS ARE REQUIRED TO PASS THE MARRIAGE & FAMILY THERAPY EXAMINATION/PES EXAM. IF YOU HAVE TAKEN THE MFT EXAM, PLEASE CONTACT THE NATIONAL BOARD ADMINISTRATIVE OFFICES AT (212) 367-4389 AND HAVE THEM CERTIFY YOUR SCORES TO GEORGIA.

- **DEGREE TRANSCRIPT:** ALL APPLICANTS FOR LICENSURE MUST HAVE EARNED A MASTER'S DEGREE IN MARRIAGE & FAMILY THERAPY, COUNSELING, SOCIAL WORK, MEDICINE, APPLIED PSYCHOLOGY, PSYCHIATRIC NURSING, PASTORAL COUNSELING, APPLIED CHILD AND FAMILY DEVELOPMENT, APPLIED SOCIOLOGY, OR FROM ANY PROGRAM ACCREDITED BY THE COMMISSION ON ACCREDITATION FOR MARRIAGE AND FAMILY THERAPY EDUCATION. SUCH DEGREE SHALL BE FROM AN EDUCATIONAL INSTITUTION ACCREDITED BY A REGIONAL BODY RECOGNIZED BY THE COUNCIL ON POST SECONDARY ACCREDITATION. AN **OFFICIAL** COLLEGE TRANSCRIPT CERTIFYING THE GRADES, DEGREE CONFERRED AND THE DATE AWARDED MUST BE RECEIVED IN THIS OFFICE DIRECTLY FROM THE REGISTRAR OF THE COLLEGE/SCHOOL.

- **NAME CHANGES:** IF YOUR NAME HAS CHANGED SINCE YOU ATTENDED SCHOOL, PLEASE MAKE A NOTE ON THE APPLICATION ADVISING OF YOUR FORMER NAME(S) SO WE CAN MATCH-UP THE DOCUMENTS WITH YOUR APPLICATION.

- **FORM A/INTERNSHIP VERIFICATION:** THE INSTRUCTOR OF RECORD AT THE COLLEGE OR UNIVERSITY OR THE SITE SUPERVISOR MAY BE VERIFIED BY THE SCHOOL AS PART OF THE MASTER'S DEGREE PROGRAM WHICH INCLUDES A GRADUATE LEVEL COURSE OVER 12 CONSECUTIVE MONTHS, UNDER SUPERVISION, MINIMUM OF 500 HOURS MFT CLINICAL CONTACT.

- **FORM B/PRACTICUM/INTERNSHIP VERIFICATION:** PRACTICUM/INTERNSHIP MUST MEET MINIMUM REQUIREMENTS SET OUT IN BOARD RULE 135-5-.06. COMPLETE A SEPARATE FORM FOR EACH PRACTICUM/INTERNSHIP LISTED ON YOUR APPLICATION.

- **CONTRACT AFFIDAVIT:** YOU MUST COMPLETE AND SUBMIT ALL 4 PAGES OF THIS FORM IN ITS ENTIRETY. THE PURPOSE OF THE CONTRACT AFFIDAVIT IS TO DEFINE THE EMPLOYMENT RELATIONSHIP FOR THE PURPOSE OF ACQUIRING THE REQUIRED POSTMASTER'S EXPERIENCE UNDER SUPERVISION THAT WILL BE APPLICABLE FOR LICENSURE. INDEPENDENT PRIVATE PRACTICE IS NOT ACCEPTABLE AS "EMPLOYMENT" FOR THE PURPOSES OF OBTAINING DIRECTED EXPERIENCE UNDER SUPERVISION.

- **OTHER STATE LICENSURE CERTIFICATION:** IF YOU ARE OR HAVE EVER BEEN LICENSED IN ANOTHER STATE(S), PLEASE HAVE THAT/THOSE STATE(S) OFFICIALLY CERTIFY THAT LICENSE DIRECTLY TO THE BOARD'S OFFICE.

- **ENDORSEMENT:** MARRIAGE & FAMILY THERAPIST LICENSURE BY ENDORSEMENT IS CONSIDERED ON A STATE-BY-STATE BASIS. AS OF PRESENT DATE THE FOLLOWING STATES' REQUIREMENTS ARE DEEMED SUBSTANTIALLY EQUAL TO THOSE OF GA MFT REQUIREMENTS:

  1. ALABAMA **2.** MISSISSISSIPPI **3.** TENNESSEE **4.** UTAH **5.** TEXAS

- **REFERENCES:** PLEASE SUBMIT REFERENCES FROM TWO (2) TEACHERS OR SUPERVISORS WHO ARE FAMILIAR WITH THEIR EXPERIENCE IN PROFESSIONAL COUNSELING.

- **IMPORTANT:** APPLICANTS, PLEASE NOTE WHEN ACCESSING YOUR APPLICATION STATUS ON OUR WEBSITE THROUGH THE LINK "CHECK THE STATUS OF AN APPLICATION", THAT CHECKLIST ITEMS MOVED OVER TO THE COMPLETED COLUMN ONLY MEANS THAT THOSE DOCUMENTS HAVE BEEN RECEIVED. PLEASE ALLOW SEVERAL DAYS FROM THE SUBMISSION OF ANY FORMS, DOCUMENTS ETC TO BE PROCESSED BEFORE ACCESSING THE WEB LINK FOR A STATUS UPDATE.

- ONLY THE GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS AND MARRIAGE & FAMILY THERAPIST HAS THE AUTHORITY TO APPROVE OR DENY AN APPLICATION FOR LICENSURE. <u>EVERY APPLICATION FILE MUST BE PRESENTED TO THE BOARD FOR REVIEW.</u>

FOR BOARD USE ONLY
Amount Submitted ____________
Date ____________
Receipt # ____________

FOR BOARD USE ONLY
Certificate Number ____________
Date Issued ____________
Applicant No. ____________

GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS AND MARRIAGE & FAMILY THERAPIST

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APPLICATION FOR LICENSURE AS A ASSOCIATE MARRIAGE & FAMILY THERAPIST

Application Fee $100 (NON-REFUNDABLE)

(Checks returned for insufficient funds will be assessed a $40.00 service charge pursuant to O.C.G.A. §16-9-20).

Applications valid for (1) one year

Additional License Types (currently or previously issued by any Georgia Professional Licensing Board):

____

Method Obtained by: Applicant is applying for above referenced license by:

( ) Examination

( ) Endorsement (state-by-state basis – Board will determine if state of licensure has requirements that meet or exceed those of Georgia)

( ) Examination Waiver (**only** if you have already taken the MFT exam thru PES)

Name ____
First Middle Last

Name as shown on exam records or transcripts (If different than above):

____
First Middle Last

____________________ ____________
Social Security Number **Date of Birth**

Physical Address ____
Number and Street Apt. No City/State Zip

(*P.O. Box not acceptable * If you are granted a license, your name, mailing address and license number are public information and your mailing address will appear on the internet. Your physical address is required, if different than the mailing address. You must immediately notify the Board in writing of an address change).*

Mailing Address (If Different): ____
(P.O. Box Acceptable) Number and Street Apt. No City/State Zip

____________________ ____________________ ____________________
Telephone Number (Day) Telephone Number (Evening) E-Mail Address*

(* Acknowledgement of your application will be sent by e-mail. Also, if any additional information is needed, e-mail is the most efficient way for the Board staff to contact you so that your application can be processed in the most efficient manner. Please notify the Board of any e-mail address change. YOUR E-MAIL ADDRESS WILL NOT BE SHARED WITH ANY THIRD PARTY).

PART II - PROFESSIONAL BACKGROUND

ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS. IF "YES," TO 1 THROUGH 9, ATTACH A DETAILED LETTER OF EXPLANATION.

❒ Yes ❒ No 1. Are you unable to practice safely as a result of use of alcohol or other drugs?

❒ Yes ❒ No 2. Have you been denied professional licensure or renewal because of a license disciplinary proceeding?

❒ Yes ❒ No 3. Have you ever had a license to practice social work, counseling, marriage and family therapy, or any other profession revoked, suspended or annulled or otherwise sanctioned, including by private order, by any board or agency in Georgia or any other state, territory, or country?

❒ Yes ❒ No 4. Have you been subject to disciplinary action or had your membership revoked by any professional organization?

❒ Yes ❒ No 5. Have you knowingly failed to renew a license during an investigation of a disciplinary matter against you?

❒ Yes ❒ No 6. To the best of your knowledge, is there any disciplinary action or investigation pending against you by any licensing board, agency, or professional organization?

❒ Yes ❒ No 7. Have you ever been convicted of any criminal offense?

❒ Yes ❒ No 8. Have you ever been arrested, charged, or sentenced for the commission of a felony, misdemeanor (other than minor traffic or parking violations) or any crime of moral turpitude, including the entry of a plea of nolo contender or a plea entered pursuant to the provisions of the "Georgia First Offenders Act"? You must respond "yes" if you plead and completed probation as a First Offender. If yes, provide certified copies of the court disposition.

❒ Yes ❒ No 9. Have you been the defendant in a malpractice suit and either entered into a settlement agreement or paid court awarded expenses?

❒ Yes ❒ No 10. Do you now hold or have you ever held a license as a social worker in any jurisdiction? If "yes," complete the following:
Jurisdiction ____________________ License No.______________
Date Issued____________________ Expiration ______________

❒ Yes ❒ No 11. Have you previously applied to the Board for the same license for which you are currently applying?
If "yes," name under which application was submitted: ____________________

❒ Yes ❒ No 12. Have you ever served on active duty in the Armed Forces, the Reserves or the National Guard during wartime or during any conflict when military personnel were committed by the President? If "Yes," you may be eligible for Veterans' Preference Points to be added to your examination score. Submit your DD214 Form to the Board office.

Part III - GRADUATE EDUCATION

- For licensure as an Associate Marriage and Family Therapists, you must have satisfied one of three (3) educational requirements. See Board Rule 135-5-.05(b).
- Direct the Registrar of your institution(s) to send an official copy of your transcript directly to the Board office.

A - EDUCATIONAL REQUIREMENTS

CHECK THE APPLICABLE EDUCATIONAL REQUIREMENTS YOU MEET:

❒ 1. I earned a master's degree from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). The program, at the time the degree was awarded, was fully approved by COAMFTE.
Date degree program was fully approved by COAMFTE:____________________
❒ Letter of Verification **MUST BE** attached.

❒ 2. I earned a master's degree from a program in Marriage and Family Therapy, as specified in Board rules, from a recognized educational institution and will COMPLETE PART III - C.

❒ 3. I completed a program, including an earned master's degree and additional post-master's coursework, as specified in Board Rules. All coursework, including the master's degree and all post-graduate coursework, was earned from a recognized educational institution and will COMPLETE PART III - C.

B - MASTER'S DEGREE
Official Title of Program [As Listed on Transcript]:
Date Awarded:
Name of Institution:
Address: ______________________________ Street City State Zip

C - MFT COURSEWORK

- **Under Number 1** – If your masters degree was earned from a fully accredited COAMFTE approved program, you may go directly to part IV

If you meet the educational requirements listed in Number 2 or 3 above, complete this section.

- **Under Number 2** — To qualify for licensure, at a minimum your master's degree program must have included all of the following courses. See Board Rule 135-5-.05(a)(4).
- **Under Number 3** — You must have an earned master's degree and have completed additional post-graduate coursework in marriage and family therapy. Such coursework must have included, at a minimum, ALL of the following courses. See Board Rule 135-5-.05(a)(5).

Course Title and Number	Institution
THREE (3) COURSES IN MARRIAGE AND FAMILY STUDIES	
A "Marriage and Family Studies Course" includes the study of the theory and practice of the principles, concepts, or history of marriage and family life, family systems, family relations and family development. Board Rule 135-5-.05(a)(6).	
1.	
2.	
3.	
THREE (3) GRADUATE LEVEL COURSES IN MARRIAGE AND FAMILY THERAPY	
A "Marriage and Family Therapy Course" includes the study of the theory and practice of various treatment modalities in marriage and family therapy. Board Rule 135-5-.05(a)(7).	
1.	
2.	
3.	
THREE (3) COURSES IN HUMAN DEVELOPMENT	
"Human development courses" encompass the study of all aspects of individual development across the life span. Such courses include, but are not limited to, theories of individual development, theories of learning, theories of personality development, theories of normal and abnormal behavior, human sexuality, and psychopathology. Board Rule 135-5-.05(a)(8).	
1.	
2.	
3.	

<table>
<tr><td colspan="4">ONE (1) COURSE IN MARRIAGE AND FAMILY THERAPY ETHICS</td></tr>
<tr><td colspan="4">A course in “Marriage and Family Ethics” includes, but is not limited to: state and federal laws, Rules of the Georgia Composite Board of PC, SW & MFT, professional ethics, legal responsibilities and liabilities, professional socialization, professional organization, interprofessional cooperation, licensure legislation and independent practice. Board Rule 135-5-.05(a)(9).</td></tr>
<tr><td colspan="2">1.</td><td colspan="2"></td></tr>
<tr><td colspan="4">ONE (1) COURSE IN RESEARCH</td></tr>
<tr><td colspan="4">A course in “Research” includes, but is not limited to, research design, methods, and statistics, but not credit received for thesis or dissertation. Board Rule 135-5-.05(a)(10).</td></tr>
<tr><td colspan="2">1.</td><td colspan="2"></td></tr>
<tr><td colspan="4">A ONE-YEAR PRACTICUM/INTERNSHIP UNDER SUPERVISION IN MARRIAGE AND FAMILY THERAPY</td></tr>
<tr><td colspan="2">1.</td><td colspan="2"></td></tr>
<tr><td>Date Began:</td><td>Date Ended:</td><td>Total # Hours Clinical Experience:</td><td>Total # Hours of Supervision:</td></tr>
<tr><td colspan="2">NAME OF SUPERVISOR:</td><td>MFT License #</td><td>State:</td></tr>
<tr><td colspan="4">❒ Board-Approved Supervisor ❒ AAMFT-Approved Supervisor ❒ Not an Approved Supervisor</td></tr>
</table>

<table>
<tr><td>PART IV - POST-MASTER’S DIRECTED EXPERIENCE UNDER SUPERVISION</td></tr>
<tr><td>INSTRUCTIONS:
■ An applicant for licensure as an Associate Marriage and Family Therapist must submit to the Board the Post-Master’s Experience Under Direction and Supervision Contract Affidavit.</td></tr>
<tr><td>DATE ALL EDUCATIONAL REQUIREMENTS WERE COMPLETED: ______________________________</td></tr>
<tr><td>DATE MFT EXAMINATION TAKEN AND PASSED (IF APPLICABLE): _____________________________</td></tr>
<tr><td>❒ I have completed and am submitting as part of this application the Post-Master’s Directed Experience Under Supervision Contract Affidavit.</td></tr>
<tr><td>❒ I acknowledge that if I change work settings, contract terms, or supervisors, I must request and receive approval from the Board by completing a new Contract and submitting it to the Board for approval.</td></tr>
</table>

APPLICANT SIGNATURE & AFFIDAVIT

YOU MUST SIGN THIS AFFIDAVIT IN THE PRESENCE OF A NOTARY

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage & Family Therapists, and I agree to abide by these laws and rules, as amended from time to time.

By signing this application, electronically or otherwise, I hereby swear and affirm one of the following to be true and accurate pursuant to O.C.G.A. § 50-36-1:

1) _______ I am a United States citizen 18 years of age or older. Please submit a copy of your current Secure and Verifiable Document(s) such as driver's license, passport, or other document as indicated on pages 8 & 9 of this application.

2) _______ I am not a United States citizen, but I am a legal permanent resident of the United States 18 years of age or older, or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act 18 years of age or older with an alien number issued by the Department of Homeland Security or other federal immigration agency. Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number (See pages 8 & 9 of this application).

In making the above attestation, I understand that any failure to make full and accurate disclosures may result in disciplinary action by the Georgia Composite Board of Professional Counselors, Social Workers and Marriage & Family Therapists and/or criminal prosecution.

_______________________________________ _______________________

Signature of Applicant Date

Sworn to and subscribed before me this
___________ day of ____________________ 20_______

_______________________________________ (Notary Seal)

Notary Public Signature

My Commission Expires: _________________________

NOTE to NOTARY: Application must be signed with Proper ID.

APPLICANT: PLEASE CHECK THE FORM OF IDENTIFICATION BELOW THAT YOU POSSESS. RETURN THIS FORM ALONG WITH A COPY OF YOUR APPROPRIATE DOCUMENTATION.

____

(Printed Name of Applicant)

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2
Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA") provides that "not later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

_____ A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3);8 CFR § 274a.2]

_____An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

_____A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

_____A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A.§50-36-2(b)(3); 22 CFR § 41.2]

_____A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3);8 CFR § 274a.2]

_____A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]

GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS, AND MARRIAGE AND FAMILY THERAPISTS
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MARRIAGE AND FAMILY THERAPY PRACTICUM/INTERNSHIP VERIFICATION

FORM A

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print clearly. For additional forms, please photocopy. This is a 2-sided form.
- Practicum/Internship must meet the requirements set out in Board Rule 135-5-.06 [Graduate level course over 12 consecutive months, under supervision, minimum 500 hours MFT clinical contact.]
- **Applicant** – Complete Part I.
- **On-Site Coordinator of Practicum/Internship** - Complete Part II.

PART I - TO BE COMPLETED BY APPLICANT

Name:

Address: ____
Street City State Zip

√ Check applicable and complete information below:
❐ Practicum/Internship which was **part of my degree program** OR
❐ Practicum/Internship **before or after the master's degree**.

√ Check Type of Practicum/Internship: ❐ MFT ❐PC ❐SW

Institution: Degree:

Course Title & Number: Supervisor:

Practicum/Internship Site:

Address:

Position/Title:

Description of Responsibilities:

DATES:	FROM: Month/Year	TO: Month/Year
DURATION:	TOTAL YEARS:	TOTAL MONTHS:
HOURS OF ON-SITE EXPERIENCE		
Individuals:	Group:	Couples/Families:

OATH

I attest that the above information is a true and accurate representation of my Practicum/Internship.

____________________ ____
Date Signature of Applicant

Subscribed to and sworn before me____
Printed Name

this ____day of ____________,________

____
Notary Public
My Commission Expires: ______________ NOTARY SEAL

FORM A-PART II - TO BE COMPLETED BY THE ON-SITE COORDINATOR

INSTRUCTIONS:

- Please review the applicant's description of his/her Practicum/Internship experience. If you have any additional information that would assist the Board in making a decision on licensure for this applicant, please provide that information below.
- Complete A or B below, as applicable.

ADDITIONAL INFORMATION:

A - ACTUAL ON-SITE COORDINATOR

ATTESTATION:

I attest that I served as the On-Site Coordinator for the Practicum/Internship described above and that this description is a true and accurate representation of this applicant's experience.

Date | Signature of On-Site Coordinator

Printed Name

Name of Site:

Address:
Street | City | State | Zip

Work Phone: ( ) | Home Phone: ( ) | Fax: ( )

B - CURRENT ON-SITE COORDINATOR

ATTESTATION:

I attest that the person who coordinated this applicant's Practicum/Internship cannot be located and that I am the current On-Site Coordinator and can verify this applicant's experience based upon a review of the available records. After a diligent and thorough search of available records, I attest that the Practicum/Internship described above is a true and accurate representation of this applicant's experience.

Date | Signature of Current On-Site Coordinator

Printed Name

Name of Site:

Address:
Street | City | State | Zip

Work Phone: ( ) | Home Phone: ( ) | Fax: ( )

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MARRIAGE AND FAMILY THERAPY VERIFICATION OF PRACTICUM/INTERNSHIP SUPERVISION
FORM B

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print clearly.
- Practicum/Internship must meet minimum requirements set out in Board Rule 135-5-.06.
- **Applicant** – Complete Part I. For additional forms, please photocopy. Complete a separate form for each Practicum/Internship listed on you're application.
- **Practicum/Internship Supervisor** - Complete Part II. After you have completed this form and it has been notarized, enclose it in a sealed envelope, sign your name over the flap and return it to the applicant.

PART I - TO BE COMPLETED BY APPLICANT

PRINT Name:____ Social Security #:_______/_______/_______

PART II - TO BE COMPLETED BY THE PRACTICUM/INTERNSHIP SUPERVISOR

Name of Supervisor:

Type of License: ❐MFT ❐LPC ❐CSW ❐PSYCHOLOGIST ❐ PSYCHIATRIST

License # ____________________ State:____________ Date Issued: ________________ Expiration Date:______________

CERTIFICATION:
I hereby certify that I supervised the Internship/Practicum of the above-named applicant who practiced:
❐ Marriage and Family Therapy ❐ Professional Counseling ❐ Social Work

Practicum/Internship Site:

Address:
Street City State Zip

FROM: Month/Year	TO: Month/Year	TOTAL MONTHS:

SUPERVISION: This applicant received the following supervision from me:

INDIVIDUAL:_________________ Hours/Week _________________ GROUP: _______________ Hours/Week_________

- I certify that at the time of the documented supervision I met one of the following criteria:

❐ AAMFT Approved Supervisor ❐ AAMFT Supervisor In Training ❐ GA Board Approved Supervisor

DESCRIPTION OF PRACTICE SUPERVISED:

OATH

I attest that the supervision described above is a true and accurate representation of this Practicum/Internship experience and supervision.

____

Date Signature of Internship/Practicum Supervisor

Subscribed to and sworn before me
this ____day of ____________,________

____
Printed Name

____
Notary Public
My Commission Expires:______________ NOTARY SEAL

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MARRIAGE AND FAMILY THERAPIST
PRACTICUM/INTERNSHIP - MISSING OR DECEASED SUPERVISOR AFFIDAVIT
FORM C

INSTRUCTIONS: Please type or print clearly. **NO FAXED FORMS ACCEPTED**

APPLICANTS:

- Make every effort to locate the supervisor(s)/instructor(s) of record as necessary to document the required Practicum/Internship Experience.
- You may show your diligence with returned mail, copies of letters, verifications from your academic institution, etc.
- If, however, after a diligent search you are unable to locate the supervisor(s), you may attest to undocumented supervision of practicum/internship by taking the Oath below.
- The Board may require additional information upon review.

OATH

Under penalty of perjury as provided in the Official Code of Georgia Annotated, I hereby aver and swear that I was unsuccessful, after I made a diligent effort, to locate the supervisor below.

Name of Supervisor: ______________________________

who served as my Practicum/Internship Supervisor in the practice of Marriage and Family Therapy

during the period of : ______________________ to ______________________
Month/Year Month/Year

and during that period he/she was licensed as a:
- ❒ Marriage and Family Therapist
- ❒ Professional Counselor
- ❒ Clinical Social Worker
- ❒ Psychologist
- ❒ Psychiatrist

License Number: ________________ In the State of: ______________________

During that period he/she was:
- ❒ AAMFT Approved Supervisor or Supervisor in Training
- ❒ Georgia Board Approved Supervisor

I have attached copies of letters and/or returned mail that demonstrate my attempt(s) to reach this supervisor.

______________________________ ______________________________
Printed Name of Applicant Signature of Applicant

Sworn to and subscribed before me this ______________
Date

_________ day of _______________, _______.

____
Notary Public
My Commission Expires: Notary Seal

GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS
237 Coliseum Drive   Macon, Georgia 31217-3858
(478) 207-2440 (Telephone) * www.sos.state.ga.us/plb/counselors

APPLICATION FOR ASSOCIATE MARRIAGE AND FAMILY THEREAPIST PERSONAL REFERENCE FORM

FORM D

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print legibly.
- Applicants must have references from **two (2) teachers or supervisors** who are familiar with their experience in Marriage and Family Therapy.
- **APPLICANT** - Complete Part I, give this form to your references with an envelope addressed to yourself. Retrieve the completed form from your reference for inclusion with your application.
- **REFERENCE** - Complete Part II, enclose this form in the envelope provided to you by the applicant, seal the envelope, sign your name across the envelope flap and return it to the applicant.
  The Board assumes that in recommending this applicant, references will interpret or substantiate to the Board your recommendation if the Board needs to contact you at a later date.

PART I - APPLICANT

Name:

PART II - REFERENCE

Name:

Address:____

Day Phone: (   )

Other Phone: (   )

Relationship to Applicant: ❐ Teacher ❐ Supervisor

Dates of Teaching/Supervisory Relationship: FROM: Month/Day/Year TO: Month/Day/Year

PROFESSIONAL POSITION WHEN TEACHING OR SUPERVISING APPLICANT:
Title:____
Agency/Institution:____
Address:____

RECOMMENDATION: I ❐ Recommend ❐ Do Not Recommend the Applicant for licensure.

ADDITIONAL COMMENTS:
[Please write any comments that would assist the Board in making a decision on this Applicant for licensure.]

____
Date Signature of Reference

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APPLICATION FOR ASSOCIATE MARRIAGE AND FAMILY THEREAPIST PERSONAL REFERENCE FORM

FORM D

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  The Board assumes that in recommending this applicant, references will interpret or substantiate to the Board your recommendation if the Board needs to contact you at a later date.

PART I - APPLICANT

Name:

PART II - REFERENCE

Name:

Address:____

Day Phone: (   )

Other Phone: (   )

Relationship to Applicant: ❒ Teacher ❒ Supervisor

Dates of Teaching/Supervisory Relationship: FROM: Month/Day/Year TO: Month/Day/Year

PROFESSIONAL POSITION WHEN TEACHING OR SUPERVISING APPLICANT:
Title:____
Agency/Institution:____
Address:____

RECOMMENDATION: I ❒ Recommend ❒ Do Not Recommend the Applicant for licensure.

ADDITIONAL COMMENTS:
[Please write any comments that would assist the Board in making a decision on this Applicant for licensure.]

____
Date Signature of Reference

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POST-MASTER'S EXPERIENCE UNDER DIRECTION AND SUPERVISION

CONTRACT AFFIDAVIT

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- The purpose of this Contract Affidavit is to define the employment relationship for the purpose of acquiring the required post-master's experience under the direction and supervision that will be applicable for licensure pursuant to O.C.G.A. § 43-10A et. seq.
- For the specific definitions of terms pertaining to specific licenses, see the Rules of the Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists (Chapter 135-5).
- In addition to the above, all contractual parties are required to adhere to all local, state and federal laws and regulations pertaining to all aspects of this contractual agreement whether written or implied. This includes, but is not limited to, the payment of local, state and federal taxes, minimum wage guidelines, assessment and collection of fees, insurance reimbursement claims, etc.
- Independent private practice or practice under O.C.G.A. § 43-10A-7, sections (9), (10), (13), (14), (15), (16) or (17) is **not** acceptable as "employment" for the purposes of obtaining directed experience under supervision.
- **NOTE: You must complete a separate Contract Affidavit for each directed experience site and /or supervisor.**
- **YOU MUST COMPLETE AND SUBMIT ALL 4 PAGES OF THIS FORM IN ITS ENTIRETY.**

PART I — APPLICANT

* * * TO BE COMPLETED BY THE APPLICANT * * *

NAME:
Last First Other[Middle/Maiden]

ADDRESS:
Street City State Zip

HOME TELEPHONE: ( ) OFFICE TELEPHONE: ( )

SOCIAL SECURITY NUMBER:
[Optional: For Identification, Law Enforcement, Statistical and Administrative Purposes]

LICENSE APPLIED FOR: ❒ LAPC ❒ LPC ❒ LMSW ❒ LCSW ❒ LAMFT ❒LMFT

EDUCATION

DEGREE EARNED: ❒ Master's ❒ Master's Specialist ❒ Doctorate: ❒ Ph.D. ❒ Ed.D.

PRACTICUM/INTERNSHIP

Did you complete a Practicum/Internship as part of your degree program? ❒ Yes ❒ No

If "Yes," Name of Site: ____
Start Date: ______________________________ End Date: ______________________________
Name of Practicum/Internship Supervisor who was Instructor of Record for the course:
____________________ LICENSED AS: ❒ LPC ❒ LCSW ❒ LMFT ❒ Psychologist ❒Psychiatrist
At the time of your practicum was your supervisor one of the following?
❒ AAMFT Approved Supervisor or Supervisor in Training ❒ GA Board Approved Supervisor

VERIFICATION

I attest that I have read and understand O.C.G.A. Title 43, Chapter 10A, and Chapter 135 of the Board's Rules and I agree to comply completely with all laws of the State of Georgia and the Rules of the Composite Board governing the practice of any specialty licensed by the Board. Furthermore, I understand that I may not practice without appropriate direction and supervision until licensed by the Board, nor engage in independent private practice or practice under O.C.G.A. § 43-10A-7 (9), (10), (11), (14), (15), (16) or (17) while obtaining the required experience for licensure.

______________ ______________________________________
Date Signature of Applicant

PART II - DIRECTED EXPERIENCE
* * * TO BE COMPLETED BY THE DIRECTOR * * *

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- The purpose of DIRECTION is to provide ongoing administrative oversight by an employer or superior in the practitioner's area of specialty.
- The Director is responsible for assuring the quality of the services provided and ensuring that qualified clinical supervision or intervention occurs in situations that require expertise beyond that of the employee.
- The Director must be located on-site and is specifically responsible for ensuring regularly-scheduled reviews of employee compliance with the Rules of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists (Chapter 135) and all relevant federal, state, and local laws and regulations.
- **NOTE: Director and applicant (employee) must describe the content of the training experience and complete Part IV, Plan for Direction Section, on page 4.**

DIRECTOR

NAME:

TITLE/POSITION:
IF APPLICABLE: ❒ LPC ❒ LCSW ❒ LMFT ❒ Psychologist ❒ Psychiatrist
Date License Issued: Expires: State: Highest Earned Degree:

HOME TELEPHONE: ( ) | OFFICE TELEPHONE: ( )

EMPLOYMENT SITE

NAME OF EMPLOYMENT SITE:

ADDRESS:____
Street City State Zip

OTHER PROFESSIONAL STAFF AT EMPLOYMENT SITE (ATTACH A SEPARATE SHEET, IF NECESSARY):

1. ____
Name Degree License (If Applicable) Job Title

2. ____
Name Degree License (If Applicable) Job Title

3. ____
Name Degree License (If Applicable) Job Title

4. ____
Name Degree License (If Applicable) Job Title

5. ____
Name Degree License (If Applicable) Job Title

AFFIDAVIT AND SIGNATURES

I attest that I have read and understand O.C.G.A. Title 43, Chapter 10A and the Rules of the Board and I agree to comply completely with all laws of the State of Georgia and Rules of the Composite Board governing the practice of any specialty licensed by the Board. Furthermore, I understand that this individual may not practice without appropriate direction and supervision until licensed by the Board, nor engage in independent private practice, or practice under O.C.G.A. § 43-10A-7, Sections (9), (10), (11), (13), (14), (15), (16), or (17) while obtaining the required experience for licensure.

I do hereby affirm under penalty of perjury that all statements made and information contained above are true and correct to the best of my knowledge and belief. Further, I hereby authorize the release of any information relating to information contained in this form that may be necessary to verify the accuracy of the information contained herein.

____
Signature of Applicant (Employee) Printed Name Date

____
Signature of Director Printed Name Date

Subscribed and sworn before me this _____
day of ___________________, __________.

____
My Commission Expires:________________ **NOTARY SEAL**

PART III — SUPERVISION

* * * TO BE COMPLETED BY THE SUPERVISOR * * *

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- "SUPERVISION" is the direct clinical review, for the purposes of training or teaching, by a supervisor of interaction with a client/s in order to promote the development of clinical skills. It may include, but is not limited to, the review of case presentations, audiotapes, videotapes, and direct observation.
- The supervisor assumes complete clinical responsibility for all clients.
- The supervisor **does not** have to be located on-site.
- IMPORTANT: The requirements to be eligible to serve as a supervisor differ for Professional Counseling, Social Work and Marriage and Family Therapy. The number of hours and type (individual and/or group) of supervision is also specific to each license. See Chapter 135-5, Rules of the Composite Board of Professional Counselors, Social Workers and Marriage and Therapists for the precise requirements.
- NOTE: SUPERVISOR and APPLICANT (Employee) must complete PART V, Plan for Supervision, on page 4.

SUPERVISOR

NAME OF SUPERVISOR:

TITLE/POSITION:
IF APPLICABLE: ❒ LPC ❒ LCSW ❒ LMFT ❒ Psychologist ❒ Psychiatrist
Date License Issued: Expires: State: Highest Earned Degree:

HOME TELEPHONE: ( )	OFFICE TELEPHONE: ( )

SUPERVISOR'S EMPLOYMENT SITE:

ADDRESS: ____
Street City State Zip

Do you have any current or prior relationship with the applicant/employee? ❒ No ❒ Yes If "Yes," please explain:

MFT SUPERVISORS ONLY:

1. Do you intend to supervise this applicant for licensure as a Marriage and Family Therapist or Associate Marriage and Family Therapist? ❒ Yes ❒ No
2. If "Yes," have you obtained one of the following required designations?
   ❒ GA Board Approved MFT Supervisor ❒AAMFT Approved Supervisor
   Supervisor's Name: ____

☞ *See Board Rule 135-5-.06 for specific information.*

AFFIDAVIT AND SIGNATURES

I attest that I have read and understand my responsibilities as a supervisor under O.C.G.A. § 43, Chapter 10A and the Rules of the Board and that I will assure complete compliance with all laws of the State of Georgia and the Rules of the Composite Board governing the practice of any specialty licensed by the Board. In addition, I assume full responsibility for all aspects of the clinical services provided by this individual. Furthermore, I have reviewed this Contract Affidavit and will ensure that this individual will not practice without appropriate direction, nor engage in independent private practice, or practice under O.C.G.A. §43-10A-7, Sections (9), (10), (11), (13), (14), (15), (16), or (17) while obtaining the required experience for licensure.

I do hereby affirm under penalty of perjury that all statements made and information contained above are true and correct to the best of my knowledge and belief. Further, I hereby authorize the release of any information relating to information contained in this form that may be necessary to verify the accuracy of the information contained herein.

____
Signature of Applicant (Employee) Printed Name Date

____
Signature of Supervisor Printed Name Date

Subscribed and sworn before me this _____
day of ___________________, 20__________.

____

My Commission Expires: ________________ **NOTARY SEAL**

PART IV — TRAINING EXPERIENCE AND PLAN FOR DIRECTION

INSTRUCTIONS:

- To be completed by the director and applicant (employee). Use additional sheets, if necessary.
- Describe in detail below the content of the training experience and the specific plan for "Direction."
- The plan must include, but is not limited to: 1) A description of the nature of the services being provided to the public; 2) the wages, salaries or other monetary considerations; and 3) a description of and declaration that both the direction and supervision occur on a regular basis.

PLAN FOR DIRECTION:

Signature of Director	Date	Signature of Applicant (Employee)

PART V — PLAN FOR SUPERVISION

INSTRUCTIONS:

- To be completed by the director and applicant (employee). Use additional sheets, if necessary.
- Describe the specific "Supervision Plan" for this applicant (supervisee).
- "Supervision" means the direct, i.e., face-to-face, clinical review for the purpose of training, teaching, and promoting the development of clinical skill by a supervisor of a supervisee's interaction with a client/s. Supervision may include, but is not limited to, the review of case presentations, audiotapes, videotapes, and direct observations.
- **CONTRACT/AFFIDAVIT MUST SPECIFY THE NUMBER OF HOURS PER WEEK TO MEET THE 30 MINIMUM HOURS PER YEAR.**

PLAN FOR SUPERVISION

Signature of Supervisor	Date	Signature of Applicant (Employee)