



APPLICATION FOR LICENSURE AS A MARRIAGE & FAMILY THERAPIST

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

237 Coliseum Drive, Macon, Georgia 31217-3858

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 and you must reapply.

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 AND PHOTO:** 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. If you have taken the MFT exam thru PES, you would apply for license by exam waiver. If you have not taken the MFT exam thru PES, you would apply for license by exam. If you have an Associate Marriage & Family Therapy license, your MFT application will be combined with your AMFT file and you will not need to submit another exam score.
- 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. If you have an Associate Marriage & Family Therapy license in Georgia, you will not need to submit another transcript unless you have obtained a higher degree.

- NAME CHANGE:** 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. If you have an Associate Marriage & Family Therapy license in Georgia, you will not need to submit Internship Verification again.
- 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.
- FORM D-DIRECT CLINICAL EXPERIENCE VERIFICATION:** Complete a separate form for each experience listed on your application. Documented experience must meet the minimum requirements set out in Board Rule 135-5-.06. The Director of Clinical experience must complete Part II. Direction means the ongoing administrative oversight by an employer or supervisor of a special practitioner's work.
- FORM E-SUPERVISION OF DIRECT CLINICAL EXPERIENCE VERIFICATION:** Complete a separate form for each Supervisor listed on your application. The number of hours and type of supervision required for licensure as an MFT depends upon the graduate degree that you hold. See Board Rule 135-5-.06.
- 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. The Board will determine if the issuing state's licensure requirements meet or exceed those of Georgia. You must provide a copy of the issuing states' requirements for licensure to the Georgia Board for review. As of present date, the following states' requirements are deemed substantially equal to those of GA MFT requirements:
1. ALABAMA 2. MISSISSIPPI 3. TENNESSEE 4. UTAH 5. TEXAS
- REFERENCES:** Please submit references from two (2) teachers or supervisors who are familiar with their experience in Marriage & Family Therapy.
- 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 following your submission of documents for their processing before you check the status link.
- Only the Georgia Composite Board of Professional Counselors, Social Workers and Marriage & Family Therapist have the authority to approve or deny an application for licensure. Every application file must be presented to the board for review.

PLEASE DO NOT SUBMIT THESE INSTRUCTION PAGES WITH YOUR APPLICATION AND SUPPORTING DOCUMENTS

FOR BOARD USE ONLY

Amount Submitted _____

Date _____

Receipt # _____



FOR BOARD USE ONLY

Certificate Number _____

Date Issued _____

Applicant No. _____

GEORGIA STATE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS AND MARRIAGE & FAMILY THERAPISTS

237 Coliseum Drive • Macon, Georgia 31217-3858 • (478) 207-2440

www.sos.state.ga.us/plb/counselors

APPLICATION FOR LICENSURE AS A MARRIAGE AND 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 a Georgia Professional Licensing Board): _____

Method Obtained by:

Applicant is applying for above referenced license by:

Examination

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

Endorsement (Considered on a State by State basis – the Board will determine if the licensure requirements of the issuing state meet or exceed those of Georgia-Provide a copy of the issuing states licensure requirements) As of present date, the following states' requirements are deemed substantially equal to those of GA MFT requirements:

1. ALABAMA 2. MISSISSIPPI 3. TENNESSEE 4. UTAH 5. TEXAS

Name _____
First Middle Last

Name as shown on exam records or transcripts (If Different): _____
First Middle Last

_____/_____/_____
Social Security Number Date of Birth

THIS INFORMATION IS AUTHORIZED TO BE OBTAINED AND DISCLOSED TO STATE AND FEDERAL AGENCIES PURSUANT TO O.C.G.A. §§ 19-11-1 & 20-3-295, U.S.C.A §§ 551, 20 & 1001)

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 EXPLANATION AND SUPPORTING COURT OR OTHER RELATED DOCUMENTS ON THE DISPOSITION, AND CURRENT STATUS OF THE ISSUE.

- Yes No 1. Are you unable to practice safely as a result of the 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 contendere 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. DUI and DWI are not minor traffic offenses.
- 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 professional counselor, social worker or marriage and family therapist in any jurisdiction? If "yes," complete the following:
Jurisdiction _____ License No. _____
Date Issued _____ Expiration _____
- Yes No 11. Have you previously applied 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.

III - GRADUATE EDUCATION

INSTRUCTIONS:

- If you are applying for Associate Licensure, please complete the application for Associate Licensure.
- If your degree is in Marriage and Family Therapy from a COAMFTE accredited program (whether applying for full or associate licensure), complete Part III – A of the application.
- If your degree is in MFT (not a COAMFTE program), Counseling, Social Work or an allied profession, complete Part III - B of the Application.
- List any additional post degree courses you want considered as part of this Application.
- Direct the Registrar of your institution(s) to send an official copy of your transcript directly to the Board office.

QUALIFYING DEGREE

Doctorate: Specify

Date Awarded:

Masters: Specify

Date Awarded:

Name of Institution:

Street Address of Institution:

Is the program accredited by the Commission on Accreditation for MFT Education (COAMFTE)? Yes No

POST DEGREE COURSEWORK TO BE CONSIDERED

COURSE TITLE AND NUMBER	EDUCATIONAL OR TRAINING INSTITUTE

PART III - A – MFT COURSEWORK

Course Title and Number	Institution
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THREE (3) GRADUATE LEVEL COURSES IN MARRIAGE AND FAMILY STUDIES

A "Marriage and Family Studies Course" includes the study of the principles, concepts, or history of marriage and family life, family systems, family relations and family development. Board Rule Chapter 135-5-.05(a)4.

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 Chapter 135-5-.05(a)5.

1.	
2.	
3.	

THREE (3) COURSES IN HUMAN DEVELOPMENT

"Human Development Courses" encompass the study of all aspects of human 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 Chapter 135-5-.05(a)3.

1.	
2.	
3.	

ONE (1) COURSE IN MARRIAGE AND FAMILY THERAPY ETHICS

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, inter-professional cooperation, licensure legislation and independent practice. Board Rule Chapter 135-5-.05(a)6.

1.	
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ONE (1) COURSE IN RESEARCH

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 Chapter 135-5-.05(a)(7).

1.

A ONE-YEAR PRACTICUM/INTERNSHIP UNDER SUPERVISION IN MARRIAGE AND FAMILY THERAPY

1.

Date Began:	Date Ended:	Total # Hours Clinical Experience:	Total # Hours of Supervision:
Name of Supervisor:		MFT License #	State:

Georgia Board-Approved Supervisor AAMFT-Approved Supervisor or Supervisor in Training Not an Approved Supervisor

2.

Date Began:	Date Ended:	Total # Hours Clinical Experience:	Total # Hours of Supervision:
Name of Supervisor:		MFT License #	State:

Georgia Board-Approved Supervisor AAMFT-Approved Supervisor or Supervisor in Training Not an Approved Supervisor

PART III – B – MFT, COUNSELING, SOCIAL WORK, OR ALLIED PROFESSIONAL DEGREE COURSEWORK

RELATED PROFESSIONAL DEGREES

Check Applicable : MFT Professional Counseling Social Work Medicine
 Psychiatric Nursing Psychology Pastoral Counseling
 Other: Specify

TWO (2) GRADUATE LEVEL COURSES IN MARRIAGE AND FAMILY STUDIES – LIST COURSE TITLE, NUMBER AND INSTITUTION

1.

2.

TWO (2) GRADUATE LEVEL COURSES IN MARRIAGE AND FAMILY THERAPY – LIST COURSE TITLE, NUMBER AND INSTITUTION

1.

2.

TWO (2) GRADUATE LEVEL COURSES IN CLINICAL CONTENT SUCH AS THE ETIOLOGY, DYNAMICS, EVALUATION, ASSESSMENT, OR TREATMENT OF EMOTIONAL OR BEHAVIORAL PROBLEMS

1.

2.

ONE (1) GRADUATE LEVEL COURSE IN PROFESSIONAL ETHICS

1.

PRACTICUM/INTERNSHIP EXPERIENCE FOR ALLIED PROFESSIONS

INSTRUCTIONS

- Applicants for licensure as an MFT **may** apply up to one (1) year of Practicum/Internship experience toward the experience requirements for licensure.
- List, in chronological order, each practicum/internship which you want the Board to consider toward the experience requirements
- Complete the appropriate verification forms.

Yes No I am applying my Practicum and/or Internship toward the experience requirements. If "Yes" complete below.

A - PRACTICUM/INTERNSHIP COMPLETED AS PART OF A DEGREE PROGRAM

(1) COURSE TITLE AND NUMBER:

PROGRAM:	DEGREE:
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NAME OF SITE:

NAME OF ON-SITE SUPERVISOR:

STARTING DATE:	ENDING DATE:	TOTAL HOURS ON-SITE EXPERIENCE:
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Georgia Board Approved Supervisor AAMFT Supervisor or Supervisor in Training Not Approved Supervisor

(2) COURSE TITLE AND NUMBER:

PROGRAM:	DEGREE:
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NAME OF SITE:

NAME OF ON-SITE SUPERVISOR:

STARTING DATE:	ENDING DATE:	TOTAL HOURS ON-SITE EXPERIENCE:
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Georgia Board Approved Supervisor AAMFT Supervisor or Supervisor in Training Not Approved Supervisor

(3) COURSE TITLE AND NUMBER:

PROGRAM:	DEGREE:
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NAME OF SITE:

NAME OF ON-SITE SUPERVISOR:

STARTING DATE:	ENDING DATE:	TOTAL HOURS ON-SITE EXPERIENCE:
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Georgia Board Approved Supervisor AAMFT Supervisor or Supervisor in Training Not Approved Supervisor

B - PRACTICUM AND/OR INTERNSHIP(S) COMPLETED OTHER THAN PART OF A DEGREE PROGRAM

(1) COURSE TITLE AND NUMBER:

INSTITUTION NAME & ADDRESS:

NAME OF SITE:

NAME OF ON-SITE SUPERVISOR:

STARTING DATE:	ENDING DATE:	TOTAL HOURS ON-SITE EXPERIENCE:
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Georgia Board Approved Supervisor AAMFT Supervisor or Supervisor in Training Not Approved Supervisor

PART IV – POST MASTERS DIRECT CLINICAL EXPERIENCE

INSTRUCTIONS:

- Yes No I am applying my Practicum and/or Internship toward the experience requirements.
- The number of years of experience that are required for licensure as an MFT **depends upon the graduate degree you hold and whether you have completed a practicum and or internship.**
- List in chronological order your post-master’s experience that you want to use to satisfy the experience requirements.
- Use additional sheets if necessary.
- Submit a separate Form D, Parts I and II- MFT Direct Clinical Experience Verification for each site listed below.

(1) Starting Date:	Ending Date:	Total On-Site Experience: YEARS:	MONTHS:
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Name of Site:

Address:

Street	City	State	Zip
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Name of Director:	Your Position Title:
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My Experience Was As: MFT PC SW

(2) Starting Date:	Ending Date:	Total On-Site Experience: YEARS:	MONTHS:
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Name of Site:

Address:

Street	City	State	Zip
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Name of Director:	Your Position Title:
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My Experience Was As: MFT PC SW

(3) Starting Date:	Ending Date:	Total On-Site Experience: YEARS:	MONTHS:
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Name of Site:

Address:

Street	City	State	Zip
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Name of Director:	Your Position Title:
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My Experience Was As: MFT PC SW

PART V- SUPERVISION OF POST MASTERS DIRECT CLINICAL EXPERIENCE

INSTRUCTIONS:

- You must have obtained 200 hours of MFT supervision concurrent with your documented experience. At least 100 of the 200 hours must have been provided by an AAMFT approved supervisor, an AAMFT supervisor-in-training, or a Board approved supervisor. A minimum of 50 of these 100 hours must have been in individual supervision and a maximum of 50 may have been in group supervision.
- **If you are using 100 hours from your approved practicum, be sure that you have completed Form B.**
- Complete the following for each supervisor whose supervision you are using to fulfill this requirement.
- Submit a separate Form E - MFT Supervision of Direct Clinical Experience Verification for each supervisor listed below.
- Enclose the form from each supervisor with your application in a signed, sealed envelope.

(1) Supervisor’s Name:

Credentials: MFT PC CSW Psychologist Psychiatrist GA Board-Approved MFT Supervisor **or**
 AAMFT-Approved Supervisor Supervisor-in-Training

License Title & #:	State:	Issue Date:	Expiration Date:
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Supervision Was In The Practice of: <input type="checkbox"/> PC <input type="checkbox"/> SW <input type="checkbox"/> MFT			
Date Started:		Date Ended:	
Duration: ____ Years ____ Months		Hours: _____ Group _____ Individual	
(2) Supervisor's Name:			
Credentials: <input type="checkbox"/> MFT <input type="checkbox"/> PC <input type="checkbox"/> CSW <input type="checkbox"/> Psychologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> GA Board-Approved MFT Supervisor or <input type="checkbox"/> AAMFT-Approved Supervisor <input type="checkbox"/> Supervisor-in-Training			
License Title & #:	State:	Issue Date:	Expiration Date:
Supervision Was In The Practice of: <input type="checkbox"/> PC <input type="checkbox"/> SW <input type="checkbox"/> MFT			
Date Started:		Date Ended:	
Duration: ____ Years ____ Months		Hours: _____ Group _____ Individual	
(3) Supervisor's Name:			
Credentials: <input type="checkbox"/> MFT <input type="checkbox"/> PC <input type="checkbox"/> CSW <input type="checkbox"/> Psychologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> GA Board-Approved MFT Supervisor or <input type="checkbox"/> AAMFT-Approved Supervisor <input type="checkbox"/> Supervisor-in-Training			
License Title & #:	State:	Issue Date:	Expiration Date:
Supervision Was In The Practice of: <input type="checkbox"/> PC <input type="checkbox"/> SW <input type="checkbox"/> MFT			
Date Started:		Date Ended:	
Duration: ____ Years ____ Months		Hours: _____ Group _____ Individual	
(4) Supervisor's Name:			
Credentials: <input type="checkbox"/> MFT <input type="checkbox"/> PC <input type="checkbox"/> CSW <input type="checkbox"/> Psychologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> GA Board-Approved MFT Supervisor or <input type="checkbox"/> AAMFT-Approved Supervisor <input type="checkbox"/> Supervisor-in-Training			
License Title & #:	State:	Issue Date:	Expiration Date:
Supervision Was In The Practice of: <input type="checkbox"/> PC <input type="checkbox"/> SW <input type="checkbox"/> MFT			
Date Started:		Date Ended:	
Duration: ____ Years ____ Months		Hours: _____ Group _____ Individual	
PART VI – APPLICANTS FOR LICENSURE BY ENDORSEMENT/RECIPROCITY			
INSTRUCTIONS:			
<ul style="list-style-type: none"> ■ The Board may license without examination any Marriage and Family Therapist currently licensed in another jurisdiction <u>so long as that jurisdiction's requirements are substantially equal to those of Georgia.</u> ■ Complete this part if you are applying for licensure by endorsement. 			
<input type="checkbox"/> I currently hold License # _____ from the State of _____ issued on _____			
<input type="checkbox"/> I have provided verification of this license to the Board by completing Form N and requesting that the above-referenced state return that Form to the Board office.			
<input type="checkbox"/> Included with your Form N a copy of the law and rules of the state in which you are currently licensed.			

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

Printed Name

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)]

MARRIAGE AND FAMILY THERAPY
 PRACTICUM/INTERNSHIP VERIFICATION
FORM A

INSTRUCTIONS:

- Please type or print clearly. For additional forms, please photocopy.
- 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 box and complete information below:

- Practicum/Internship which was **part of my degree program** OR
- Practicum/Internship **after the master's degree.**

✓ Check Type of Practicum/Internship: MFT PC SW

Institution:

Degree Awarded:

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:

TOTAL 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 _____

this ____ day of _____, _____ Printed Name

_____ 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: ()

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

INSTRUCTIONS:

- 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 your 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

Name: _____ Social Security #: _____

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

Name of Supervisor: _____

Type of License: MFT PC 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: _____ TO: _____ TOTAL MONTHS: _____
Month/Year Month/Year

SUPERVISION:

This Applicant received the following weekly supervision from me:
INDIVIDUAL: _____ Hours/Week GROUP: _____ Hours/Week

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

AAMFT Approved Supervisor AAMFT Supervisor-in-Training Georgia 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 _____, 20____ Printed Name

Notary Public

My Commission Expires: _____

NOTARY SEAL

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

INSTRUCTIONS: Please type or print clearly.

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, and 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:

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:

(check one) AAMFT Approved Supervisor or Supervisor in Training GA Board Approved Supervisor

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

Date

Signature of Applicant

Sworn to and subscribed before me this
_____ day of _____, 20____.

Printed Name

Notary Public

My Commission Expires:

Notary Seal

**MARRIAGE AND FAMILY THERAPY
 VERIFICATION OF DIRECT POST GRADUATE CLINICAL EXPERIENCE
 FORM D**

INSTRUCTIONS:

- Please type or print clearly. For additional forms, please photocopy.
- Complete a separate form for each experience listed on your Application.
- Documented experience must meet the minimum requirements set out in Board Rule 135-5-.06.
- **Applicant** – Complete Part I.
- **Director of Clinical Experience** - Complete Part II.

PART I - TO BE COMPLETED BY APPLICANT

Name: _____ Social Security #: _____

Address: _____
 Street _____ City _____ State _____ Zip _____

Employer: _____

Address: _____
 Street _____ City _____ State _____ Zip _____

Position/Title: _____

Description of Responsibilities: _____

The Clinical Experience was in the practice of: MFT PC SW

DATES OF EXPERIENCE:	FROM: _____ Month/Year	TO: _____ Month/Year
----------------------	---------------------------	-------------------------

DURATION OF EXPERIENCE:	TOTAL YEARS: _____	TOTAL MONTHS: _____
-------------------------	--------------------	---------------------

**HOURS OF CLINICAL EXPERIENCE IN A TYPICAL WEEK
 [Do not indicate a range of hours — e.g. 5 to 10]**

CLINICAL ACTIVITY (Weekly)	TYPE OF CLIENT	
	Individual	Couple/Family
A) Client contact as therapist or co-therapist	# of Hours: _____	# of Hours: _____
B) Case staffing or Case Consultation	# of Hours: _____	# of Hours: _____
C) Clinical Supervision (As a supervisee)	# of Hours: _____	# of Hours: _____

ATTESTATION

I attest that the above information is a true and accurate representation of my Direct Clinical Experience.

_____ Date _____ Signature of Applicant

_____ Printed Name

FORM D - PART II - TO BE COMPLETED BY THE DIRECTOR OF CLINICAL EXPERIENCE

INSTRUCTIONS:

- "Direction" means the ongoing administrative oversight by an employer or supervisor of a special practitioner's work. Direction may be provided by any person acceptable to the standards committee for that specialty in which the practitioner is working. The Director shall be responsible for assuring the quality of the services rendered by the practitioner and shall ensure that qualified supervision or intervention occurs in situations that require expertise beyond that of the practitioner.
- An "Employer" is a person who employs the services of others; one for whom employees work, who has the right to control and direct the person who performs services, and who pays their wagers or salaries or other monetary consideration for their services.
- Please review the Applicant's description of his/her Directed Clinical 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 and **sign before a Notary Public.**

ADDITIONAL INFORMATION:

A - ACTUAL DIRECTOR

OATH:

I attest that I provided the direction, as prescribed by law, of the Direct Clinical Experience described on this Application and that this description is a true and accurate representation of this Applicant's experience.

_____ Date _____ Signature of Director
 _____ Printed Name

Name of Site:

Address: _____ Street _____ City _____ State _____ Zip _____

Work Phone: () _____ Home Phone: () _____ Fax: () _____

B - CURRENT DIRECTOR

OATH:

I attest that the person who provided this Applicant's direction cannot be located, that I am the current Director 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 description above of this experience is a true and accurate representation of this Applicant's experience.

_____ Date _____ Signature of Current Director

Name of Site:

Address: _____ Street _____ City _____ State _____ Zip _____

Work Phone: () _____ Home Phone: () _____ Fax: () _____

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

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

MARRIAGE AND FAMILY THERAPY
VERIFICATION OF SUPERVISION OF DIRECT POST GRADUATE CLINICAL EXPERIENCE
FORM E

INSTRUCTIONS:

- Please type or print clearly. For additional forms, please photocopy.
- Complete a separate form for each Supervisor listed on your Application.
- The number of hours and type of supervision required for licensure as an MFT depends upon the graduate degree that you hold. Seen Board Rule 135-5-.06.
- **Applicant** – Complete Part I.
- **Supervisor of Direct Clinical Experience** - Complete Part II.

PART I - TO BE COMPLETED BY APPLICANT

Name: _____ Social Security #: _____

Address: _____
Street _____ City _____ State _____ Zip _____

Employer: _____

Address: _____
Street _____ City _____ State _____ Zip _____

Name of Supervisor: _____

The Supervision was in the practice of: MFT PC SW

DATES OF SUPERVISION:

FROM: _____
Month/Year

TO: _____
Month/Year

DURATION OF SUPERVISION:

TOTAL YEARS: _____

TOTAL MONTHS: _____

DESCRIBE THE PRACTICE:

DESCRIBE THE SUPERVISION:

ATTESTATION

I attest that the above information is a true and accurate representation of my practice and supervision.

Date

Signature of Applicant

Printed Name

FORM E - PART II - TO BE COMPLETED BY THE SUPERVISOR OF CLINICAL EXPERIENCE

INSTRUCTIONS:

- "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 client(s). Supervision may include, without being limited to, the review of case presentations, audio tapes, video tapes, and direct observations.
- Please review the Applicant's description of his/her practice and supervision. 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.

Name of Supervisor:

Address:

Street

City

State

Zip

Type of License: MFT PC CSW PSYCHOLOGIST PSYCHIATRIST

License # State: Date Issued: Expiration Date: Years of Practice:

ADDITIONAL INFORMATION:

**SUPERVISION
THIS APPLICANT RECEIVED THE FOLLOWING SUPERVISION FROM ME:**

I supervised the above-named Applicant in the practice of:

- Marriage and Family Therapy Professional Counseling Social Work

DATES OF SUPERVISION:

FROM:

Month/Year

TO:

Month/Year

DURATION OF SUPERVISION:

TOTAL MONTHS:

TOTAL YEARS:

INDIVIDUAL: _____ Hours/Week

GROUP: _____ Hours/Week

TOTAL HOURS:

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

- AAMFT-Approved Supervisor Term Expires On: _____
 In Supervision of Supervision Date Supervision of Supervision Began: _____
 Georgia Board Approved MFT Supervisor Date Approved: _____

OATH

I attest that I served as this Applicant's supervisor as prescribed by law, and the description of the supervision provided in this Application is a true and accurate representation of my supervision with this Applicant.

I RECOMMEND DO NOT RECOMMEND this Applicant for licensure.

 Date
 Subscribed to and sworn before me
 this ____ day of _____, _____

 Signature of Supervisor

 Notary Public
 My Commission Expires: _____

NOTARY SEAL

APPLICATION FOR MARRIAGE AND FAMILY THERAPIST
PERSONAL REFERENCE FORM
FORM G

INSTRUCTIONS:

- 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

MARRIAGE & FAMILY THERAPIST - VERIFICATION OF LICENSURE
FORM N

INSTRUCTIONS:

- Please type or print legibly.
- **Applicant** - Complete Part I. Mail a form to the Board or Agency of each state or jurisdiction by which you are currently licensed or certified as a Professional Counselor, Social Worker (any level) or Marriage and Family Therapist. Request the Licensure Board or Regulatory Agency to send the Georgia Board a copy of its current licensure laws and rules. Refer to List of Approved/Disapproved States for Endorsement.
- **State Licensure Board or Regulatory Agency** - Complete Part II.

PART I - APPLICANT

Full Name:

Address:

Date of Birth:

Social Security #:

GEORGIA LICENSE APPLIED FOR - CHECK ONLY ONE: Marriage and Family Therapist
 Professional Counselor Clinical Social Worker Master Social Worker

Jurisdiction:

License Number:

Title of License:

Date Issued:

Expiration Date:

TO WHOM IT MAY CONCERN

I, the undersigned applicant, am applying for a license with the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists. I hereby consent to the release of any information, favorable or otherwise, which you may have concerning my license or practice. Please return the completed form directly to the Georgia Board at the above address.

Date

Signature of Applicant

PART II - LICENSURE BOARD OR REGULATORY AGENCY CERTIFICATION

I, _____, Board Chair or Designated Official

of the _____
Name of Board or Regulatory Agency

certify that the information provided above by this applicant does does not conform with that in our record.

If "does not", please explain: _____

According to our record, the applicant has has not been disciplined by this or any other Board, state agency, or professional organization. **If the applicant has been disciplined, please explain and attach a copy of the Order or Decree:**

Date

Signature of Board Chair/Designated Official

Title of Board

Street Address

BOARD SEAL

City/State/Zip Code