

## APPLICATION FOR MN LMFT GUEST LICENSURE

**STOP:** You may only apply for MN MFT Guest Licensure if you hold a *current* LMFT license in good standing in another US jurisdiction (LMFT, LCMFT, etc.). Applicants for licensure, license holders currently subject to a disciplinary or corrective action licensure order, or those with an expired license, are NOT eligible to apply for MN guest licensure. If you are not sure if you are eligible to apply for a MN guest license, please contact the Board before applying ([mft.board@state.mn.us](mailto:mft.board@state.mn.us)) as application fees are non-refundable.

\*Please read [Minn. Stat. 148B.331](#) before filing this application & the "[Statutes & Rules](#)" governing the practice of MFT in Minnesota.

1. Submit **\$182.00** (\$150 application fee + \$32.00 criminal background check fee) by check or money order payable to the MN Board of MFT.
2. **IMPORTANT:** Minnesota law requires that all license applicants **must** complete a fingerprint-based criminal background check ([Minn. Stat. § 214.075](#)). After submission of your application, the Criminal Background Check (CBC) Program will EMAIL you a packet containing all required instructions. You should receive this EMAIL within 5 *business days* after you submit this application to the MN Board of MFT. Please see website [www.mn.gov/boards/cbc](http://www.mn.gov/boards/cbc) for more details.
3. **Additional Documents Required – All Applicants:**
  - **License Verification(s)** (Section III Licensure Status) - The licensing board in the state(s) in which you hold or have held **any** other health-related license must submit license verification directly to the Board; verification by US Mail or electronic verification accepted ([mft.board@state.mn.us](mailto:mft.board@state.mn.us)).
4. Mail application and required fee to: **MN Board of MFT, 335 Randolph Avenue, Suite 260, St. Paul, MN 55102. Keep a copy of all documents submitted to the Board.**

**Rights of Subject of Data:** Information you provide as an applicant, except for your name and address, is classified as private while you remain an applicant; that is, accessible only to you, the staff and members of the Board, the Board's counsel, and persons you designate. When you become licensed, the information in your file related to your licensure is classified as public. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. You are not legally required to provide this information, but you cannot be licensed without doing so.

*This document is available in alternative formats to individuals with disabilities by calling (612) 617-2220, or, through the Minnesota Relay Service at (800) 627-3529.*

Office Use Only: Check#: \_\_\_\_\_ Amount: \$ \_\_\_\_\_ Deposit #: \_\_\_\_\_

# APPLICATION FOR MN MFT GUEST LICENSURE

## Section I – Applicant Information

<b>LEGAL NAME:</b>	Last	First	Middle
<b>LIST ALL PRIOR/MAIDEN/PRACTICE NAMES:</b>			
<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Non-Binary <input type="checkbox"/> Other <input type="checkbox"/> Prefer to not respond			
<b>Race/Ethnicity:</b> <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Prefer to not Respond			
<b>Date of birth (required):</b> ____ / ____ / ____ Month    Day    Year		<b>Social Security Number (required):</b> ____ - ____ - ____ -----	
<b>PRIMARY BUSINESS OR AGENCY NAME:</b>			
<small>(Required; provided to public upon request; if not currently in the workforce related to MFT practice, write "NOT WORKING")</small>			
<b>BUSINESS ADDRESS:</b> (Street Address) (City) (State) (Zip code)			
<small>(Required; provided to public upon request; if not currently in the workforce related to MFT practice, write "NOT WORKING")</small>			
<b>MAILING ADDRESS:</b> (Street Address) (City) (State) (Zip code)			
If same as business address write "SAME" <small>(For Board use only; correspondence mailed to this address)</small>			
<b>EMAIL: (Please print clearly)</b>			
<b>TELEPHONE: (At least one number is required)</b>			
Business:		Home:	
		Cell:	
<b>Designated phone number for release to Public:</b>		<b>Business</b>	<b>Home</b>
			<b>Cell</b>

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## Section II - Ethical Qualifications

If you answer “Yes” to any question, you **must include** a signed, written explanation and provide any relevant documents. Answering “Yes” to certain questions may require special screening or review procedures by the Board. **Failure to disclose** requested information or a **false answer** to any question may result in denial of your application or other Board action.

Y	N	1. <b>Criminal Conduct</b> – Have you been charged with and/or convicted of any misdemeanor, gross misdemeanor, or felony crime including, but not limited to, any crime related to the use of alcohol or drugs?
Y	N	2. <b>Agency or Board Action</b> – Have you been notified that a complaint has been filed against you, that you are under investigation, that you have been disciplined and/or that you have been denied a license or registration by a state or federal agency or regulatory board?
Y	N	3. <b>Professional Association Action</b> – Have you been notified that a complaint has been filed against you, that you are under investigation, that you have been disciplined and/or that you have been denied a license or registration by a state or federal professional association?
Y	N	4. <b>Loss of License or Registration</b> – Have you had any license or registration revoked, suspended or otherwise had action taken against it, or have you voluntarily surrendered any license or registration to avoid possible revocation, suspension or other action by a state or federal agency, regulatory board or professional association?
Y	N	5. <b>Termination</b> – Have you been terminated, resigned in lieu of termination, or been subjected to disciplinary action by your employer, in any paid or unpaid job, due to any conduct that may be grounds for disciplinary action by a state or federal agency or regulatory board?
Y	N	6. <b>Malpractice</b> – Are you aware of any malpractice actions pending against you or of any malpractice settlements or judgements against you?
Y	N	7. <b>Post-Secondary Action</b> – Have you been subjected to disciplinary action by a post-secondary educational institution, withdrawn from a post-secondary educational institution, or been investigated by a post-secondary educational institution because of alleged misconduct of any kind?
Y	N	8. <b>Mental &amp; Physical Health</b> – Have you been diagnosed and/or treated for any mental, physical or cognitive condition that may affect your current ability to practice with reasonable skill and safety?
Y	N	9. <b>Substance Use</b> – Have you been diagnosed and/or treated for any substance use disorder that may affect your current ability to practice with reasonable skill and safety?
Y	N	10. Are you aware of any other fact or circumstance, not already reported in this application, which affects your ability to practice marriage and family therapy with reasonable skill and safety?

### Section III - Licensure Status

You must hold a current LMFT license to apply for guest licensure. List all health-related licenses you hold or have held (current or expired):

State	Name of License/ Certificate/Registration	License/Reg/Cert Number	Date of Initial Issuance	Expiration Date

Applicant must have the licensing board in the state(s) in which you hold or have held any other health-related license provide license verification to the Board by US Mail or electronic verification accepted.

### Section IV – General and Cooperation Affidavit



- I attest that I meet the following guest licensure requirements: (1) I hold a license in good standing to practice marriage and family therapy in another US state; (2) I have a graduate degree from a regionally accredited institution in marriage and family therapy or a related field; (3) I am of good moral character; and (4) I have no pending complaints or active disciplinary or corrective actions in any US state.
- I understand I am applying for a guest license to practice marriage and family therapy in the State of Minnesota and agree to abide by the laws of the State of Minnesota and the administrative rules adopted by the Board concerning the practice of marriage and family therapy.
- I understand the guest license, when granted, is a one-year, nonrenewable license that allows me to provide marriage and family therapy in Minnesota for no more than **FIVE (5) CONSECUTIVE MONTHS** commencing on first date of marriage and family therapy practice in Minnesota.
- That the information submitted in this application may be used as the basis for further investigation by the Board and, under some circumstances, the information could become available to other agencies or persons authorized by law to have access.
- I agree that I will cooperate with any necessary investigation of inquiry initiated by the Board, according to Minn. Stat. 148B.372, and that failure to answer a question truthfully may be grounds for disciplinary action against my license pursuant to Minn. Stat. 148B.37.
- All information and answers given in this application are true and correct.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

- Make sure your application is complete, signed and the proper fee is enclosed (\$182.00 – payable to MN Board of MFT). Incomplete applications, including applications without signature or fee, will be returned.**
- Keep a copy of all documents submitted to the Board. Mail completed application and payment to:**  
**MN Board of MFT**  
**335 Randolph Ave, Suite 260**  
**St. Paul, MN 55102**