



Minnesota Board of Marriage and Family Therapy

2829 University Avenue SE, Suite 400

Minneapolis, MN 55414-3222

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Email: mft.board@state.mn.us Website: www.bmft.state.mn.us

Hearing Impaired-Minnesota Relay Service: 1-800-627-3529

APPLICATION FOR NATIONAL EXAMINATION IN MARITAL & FAMILY THERAPY

Initial Application for individuals seeking MFT licensure

Instructions:

1. Type all answers or print in black ink.
2. Complete all sections. If a section is not applicable, enter N/A in the space provided.
3. The Practicum Affidavit, page 6, is to be completed by a graduate program practicum supervisor or a practicum site supervisor. Notarization of this page is required. This application will not be processed without required affidavit.
4. **ENGLISH LANGUAGE LEARNER SPECIAL TESTING ARRANGEMENT:** If you wish to request additional testing time due to ELL status, you must also complete the ELL Special Testing Arrangement application and submit it to the Board. The ELL application is available on the Board's website on the "Forms" page (www.bmft.state.mn.us).
5. Applicant's signature and notarization of pages 9 and 10 is required.
6. If additional response information is required for any question, please attach a separate sheet of paper. Clearly identify the question to which the answer applies.
7. **Attach the Board's application fee of \$110.00 to this application. Make check payable to MN Board of MFT. All fees are non-refundable.**
8. Mail this application to: MN Board of MFT, 2829 University Ave SE, Suite 400, Minneapolis, MN 55414. Keep a copy of all documents submitted to the Board.
9. A transcript covering all graduate work used to meet educational requirements for licensure must be sent directly to the Board from the academic institution(s). This application will not be processed without required transcript(s).

Important: Upon application approval, you will receive an electronic invitation (by email) from the Board to register for the national examination at a day and time of your choice. The national exam is administered by Professional Testing Corporation (PTC). PTC charges all individuals registering for the exam a **\$350.00** testing fee.

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 #: _____

Rights of Subject of Data: Information you provide in this application, 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.

Tax Clearance Information (Minn. Stat. 270C.72): The Board is required to provide to the MN Department of Revenue your social security number. Upon request of the Commissioner of Revenue, the Board must provide to the Commissioner a list of all regulated individuals and applicants, including their names and addresses, social security numbers, and business identifications numbers. (1) This information may be used to deny the issuance or renewal of your license in the event you owe the Minnesota Department of Revenue delinquent taxes in the amount of \$500.00 or more. (2) Upon receiving this information, the Board will supply it only to the Minnesota Department of Revenue. However, under the Federal Exchange of Information Agreement, the Department of Revenue may supply this information to the Internal Revenue Service. (3) Failure to supply this information may prevent or delay the processing of your application.

Tennessee Warning (Minn. Stat. 13.04): Data collected under “Applicant Licensure Status” and “Ethical Qualifications” is confidential/non-public and may be used for investigative purposes. The Board is seeking data from you which may be considered private or confidential under the Minnesota Government Data Practices Act, Minn. Stat. 13.01 et seq. Minn. Stat. 13.04, subd. 2 requires the Board to notify you of the following four matters before you are asked to supply such information about yourself: (1) This data is being collected to determine whether you meet the requirements for licensure as well as whether you have violated any statutes or rules the Board is empowered to enforce; (2) You are not legally required to complete and return this application, but failure to do so may result in the denial of this application; (3) If you supply the data requested and it shows a violation of any of the statutes or rules enforced by the Board, you may be subject to disciplinary or other action by the Board. If you refuse to supply the data requested, your application may be denied. In addition, falsification or omission of information may be used by the Board as a basis for disciplinary action; and (4) The data which you supply will be accessible to Board staff. The data you supply may also be released to other persons and/or governmental entities that have statutory authority to review the data, investigate specific conduct, and/or take appropriate legal action. If the Board institutes a formal disciplinary action against you, the information you supply could become public.

APPLICATION FOR NATIONAL EXAMINATION IN MARITAL & FAMILY THERAPY

Applicant Information

NAME:	Last	First	Middle
LIST ALL PRIOR OR FORMER NAMES:			
PUBLIC ADDRESS: (Street Address)		(City)	(State) (Zip code)
MAILING ADDRESS: (Street Address) If same as public address, check here <input type="checkbox"/>		(City)	(State) (Zip code)
*PRIMARY BUSINESS OR AGENCY NAME:			
BUSINESS ADDRESS: (Street Address)		(City)	(State) (Zip code)
EMAIL (please print clearly/for Board use only):			
TELEPHONE: (At least one number is required.)			
Business:		Home:	Cell:
Designated phone number for release to Public: <input type="checkbox"/> Business <input type="checkbox"/> Home <input type="checkbox"/> Cell			

***Important:** Applicants must provide a primary business address at time of initial application and all subsequent license renewals. Your primary business address is public. If you are not currently in the workforce related to mental health practice, write "Not Working" in the primary business address section above. See Minn. Stat. 214.073.

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

- Social Security Number: _____/_____/_____
- Sex: Male _____ Female _____
- Birthdate: _____/_____/_____
Month Date Year
- State of Residency: _____
- Minnesota Business Identification Number: _____
(Enter N/A if you do not have such a number.)
- Are you at least 18 years of age? _____ Yes _____ No
- Are you a citizen of the United States? _____ Yes _____ No* (*If no, attach copy of documentation verifying right to work status in U.S.)

Applicant Licensure Status

- Do you hold or have you ever held a license, certificate or registration to practice marriage and family therapy, or any other health-related profession, in Minnesota or any other jurisdiction?

_____ Yes* _____ No (*If yes, please list all such licenses or certificates below.)

State:	Title of License/ Certificate/Registration	Lic/Reg/Cert Number:	Date Issued:	Expiration Date:

- (a) Is the license(s) in good standing or, if expired, was it in good standing at time of expiration?
_____ Yes _____ No* (*If no, attach written explanation and relevant documentation.)
- (b) Has any license ever been revoked, suspended, or otherwise acted against for any reason?
_____ Yes* _____ No (*If yes, attach written explanation and relevant documentation.)

Applicant Membership Status

- Are you a current member of any health-related professional organization?
_____ Yes* _____ No (* If yes, please list all such memberships below.)

Name of Professional Organization:	Type of Membership:	How Long Have You Been a Member?

Ethical Qualifications

- Have you been convicted, pled guilty or pled no contest to a misdemeanor, gross misdemeanor or felony violation of federal or state law?

_____ Yes* _____ No (* If yes, attach written explanation and any relevant documentation.)

- Have you ever been found to be in violation of a professional organization's code of ethics, or of a state board's rules, regulations or statutes?

_____ Yes* _____ No (*If yes, attach written explanation and any relevant documentation.)

- Have you ever been investigated, sanctioned or disciplined by any professional organization or state board in Minnesota or any other jurisdiction?

_____ Yes* _____ No (*If yes, attach written explanation and any relevant documentation.)

- Have you voluntarily surrendered any professional license, registration or certification issued by a professional organization or state board, or allowed a license, registration or certification to lapse, while a complaint was pending against you with the professional organization or state board?

_____ Yes* _____ No (*If yes, attach written explanation and any relevant documentation.)

- Have you ever had an application denied or been denied membership, licensure, certification, or registration by a professional organization or state board in Minnesota or any other jurisdiction?

_____ Yes* _____ No (*If yes, attach written explanation and any relevant documentation.)

- 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?

_____ Yes* _____ No (* If yes, attach written explanation and any relevant documentation.)

- Have you ever been named as a party to civil litigation, arbitration, mediation or a malpractice action relating in any way to your profession?

_____ Yes* _____ No (*If yes, attach written explanation, provide the date, award and jurisdiction in which the settlement or award occurred, and provide any relevant documentation.)

- Are you currently unable to practice with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals or any other materials, or as a result of any mental, physical or psychological condition?

_____ Yes* _____ No (*If yes, attach written explanation and any relevant documentation.)

- Do you participate in any program, other than the State of MN's Health Professional Services Program (HPSP), designed to monitor or assist you in the management of a chemical dependency, physical, psychological or other impairment?

_____ Yes* _____ No (* If yes, attach written explanation and any relevant documentation.)

- Do you currently have any other condition or impairment, not reported in any question in this application, which in any way affects, or if left untreated might affect, your ability to practice marriage and family therapy with reasonable skill and safety to clients?

_____ Yes* _____ No (*If yes, attach written explanation and any relevant documentation.)

PRACTICUM AFFIDAVIT

(To be completed by graduate program practicum supervisor or practicum site supervisor.)

I hereby certify that: _____
Student Name

Has completed at: _____
College or University Name

A clinical practicum in Marriage & Family Therapy of at least 300 hours of clinical client contact with individuals, couples, and families for the purpose of assessment and intervention. Of the 300 hours, no more than 150 hours was with individuals. This clinical experience was supervised on site or at the academic institution by a licensed marriage and family therapist or an American Association for Marriage and Family Therapy approved supervisor.

Name of Graduate Program Practicum Supervisor Or Practicum Site Supervisor (Print)

Signature

Address

(_____) _____
Telephone Number

Date

Notary:

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

Signature of Notary Public

My commission expires: _____

Notary Seal:

Education Information

List all graduate education used to meet the educational requirements for licensure listed in Minn. Stat. 148B.33. Transcripts of the graduate degree(s) you are using to meet the requirements for licensure **must be sent directly to the Board by the graduate institution.** Transcripts must be from regionally accredited institutions and show all coursework and degrees or certificates used to meet licensure requirements. ***This application cannot be considered without receipt of the required transcripts.***

Name of Institution:	Location (City, State):	Degree Obtained, and in What Subject Field:	Date Degree Granted Month/Year:

Which degree(s) are you using to meet the education requirements for licensure?

Please list: _____

Is this degree(s) from a regionally accredited educational institution?

_____ Yes _____ No

If yes, list the name of the accrediting agency: _____

- **If the degree listed above is *NOT* a degree in Marriage and Family Therapy from a program accredited by COAMFTE, but complies with the curriculum stated in Minnesota Rules, Part 5300.0140, Subpart 2, please complete the grid on page 8 of the application.**

Please identify completed courses which meet the requirements of graduate degree training in Marriage and Family Therapy, according to Minnesota Rules, Part 5300.0140, Subpart 2.

List the course title, course number, and credit hours, **as indicated on the transcript(s) sent to the Board.**

	Course Title:	Course Number:	Credit Hours:
Human Development: (9 semester hours or 12 quarter hours needed)			
Marital and Family Studies: (9 semester hours or 12 quarter hours needed)			
Marital and Family Therapy: (9 semester hours or 12 quarter hours needed)			
Research Methods: (One course)			
Professional Studies: (One course)			
Clinical Practicum: (At least 300 hours, of which not more than 150 hours may be with individuals)			

AFFIDAVIT OF APPLICANT:

STATE OF (where notarized): _____

COUNTY OF (where notarized): _____

I, _____ **(print applicant name)**, hereby apply for the national examination in marital and family therapy, under the laws and regulations governing marriage and family therapy licensure. I acknowledge review of Minnesota Statutes, Sections 148B.01 to 148B.1751 and 148B.29 to 148B.39 and related rules, and further that I have read these regulations. I understand that I am under a continuing obligation to keep informed of any changes to the law and rules governing marriage and family therapy licensure.

I swear that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of Minnesota; and that I am the person named in the transcript which will be sent directly from academic institute.

I hereby authorize all educational institutions, hospitals, medical institutions or organizations, clinics, my references, personal physicians, employers (past and present), business and professional associates (past and present), all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files, or records including (but not limited to) transcripts, medical records, personnel files, and any information, favorable or otherwise, the Board may require for its evaluation of my professional, ethical, and physical qualifications for licensure in Minnesota. This authorization shall remain valid until issuance of licensure by this licensing Board.

I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing of oral information or of documents, records, or other information to the Board.

I have carefully read the questions in the in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice marriage and family therapy in Minnesota. I understand that I am required to update my application with pertinent information to cover the time period between date of application and date approved by the Board.

➤ _____
Signature of Applicant

Sworn to before me this _____ day of _____, 20 _____

Signature of Notary Public

My commission expires: _____

Notary Seal

CERTIFICATION OF IDENTIFICATION TO BE COMPLETED BY NOTARY PUBLIC

Certification of Notary Public is required.

Applicant Name: _____

Applicant Signature: _____

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

Sworn to before me by the applicant on this _____ day of _____, 20 _____.

Signature of Notary Public _____

My commission expires: _____

Notary Seal:

