MINNESOTA
BOARD OF MARRIAGE
AND FAMILY THERAPY

335 Randolph Avenue, Suite 260
St. Paul, MN 55102
Main Telephone: 612-617-2220
Hearing/Speech Relay: 1-800-627-3529
mft.board@state.mn.us
mn.gov/boards/marriage-and-family

APPLICATION FOR NATIONAL EXAMINATION IN MARITAL AND FAMILY THERAPY

Initial Application for individuals seeking MFT licensure

Instructions:

1. Application fee **$145.00** ($110 application fee + $35.00 criminal background check fee).

   IMPORTANT: Minnesota law now requires that all initial applicants ***must*** complete a fingerprint-based criminal background check (Minn. Stat. § 214.075). After your application with proper fees is received, 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. If you have questions after receiving the CBC email, please see the website www.mn.gov/boards/cbc for more information.

2. Type all answers or print in black ink.

3. Complete all sections. If a section is not applicable, enter N/A in the space provided.

4. **Practicum Affidavit**, page 5, is to be completed by the graduate program practicum supervisor or the practicum site supervisor **having the LMFT credential**. This application will not be processed without required affidavit.

5. **An official 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).

6. **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 office. There is not a fee for additional testing time. The ELL application is available on the Board's website under the "Forms" tab (https://mn.gov/boards/marriage-and-family/).

7. Applicant's photo, signature and notarization of page 8 is required.

8. 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.

9. Mail this application to: MN Board of MFT, 335 Randolph Avenue, Suite 260, St. Paul, MN 55102. **Keep a copy of all documents submitted to the Board**.

Important: Upon completion of the required CBC and application approval, you will receive an electronic invitation (by email) from the Board to register for the AMFTRB National Examination in MFT 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 **$365.00** 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.

Tennessen Warning (Minn. Stat. 13.04): Data collected under "Ethical Qualifications" is confidential/non-public and may be used for investigative purposes. The Board is seeking data from you that may be considered private or confidential under the Minnesota Government Data Practices Act, Minn. Stat. 13.01 et seq. The Board must 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 that 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.

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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	(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: **Business** **Home** **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 #:_____

Gender: (For use by Board staff in properly addressing correspondence to applicant)

Female ____ Male ____ Non-Binary ____ Prefer to not answer ____ Custom (please provide) _____

Date of birth (required): _____/_____/_____
Month Day Year

Social Security Number (required): _____ - _____ - _____

MN Tax Identification number (if applicable): _____

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. **Criminal Conduct** – 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. **Agency or Board Action** – 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. **Professional Association Action** – 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. **Loss of License or Registration** – 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. **Termination** – 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. **Malpractice** – Are you aware of any malpractice actions pending against you or of any malpractice settlements or judgements against you?
Y N	7. **Post-Secondary Action** – 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. **Mental & Physical Health** – 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. **Substance Use** – 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?

Applicant Licensure Status

List all health-related licenses you hold or have held (current or expired). If none, check here: ☐

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

Education Information

List all graduate education used to meet the educational requirements for licensure listed in Minn. Stat. 148B.33 and Minnesota Rule 5300.0140. 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:	Degree Award Date (from transcript):

Is qualifying degree(s) from a COAMFTE-accredited program?

_____ No* _____ Yes; If yes, list degree/graduate institution: _____

***If the degree listed above is *NOT* a degree in Marriage and Family Therapy from a COAMFTE-accredited program, it must comply with the curriculum stated in Minnesota Rules, Part 5300.0140, Subpart 2, and applicant must complete the grid on page 7 of the application.**

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PRACTICUM AFFIDAVIT

To be completed by graduate program practicum supervisor or practicum site supervisor **who holds the required LMFT credential.**

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, at least 150 hours were clinical client contact with couples and families. 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 (Please Print)

_____
Print Name Signature

LMFT License Number: _____ State of License Issuance: _____

Telephone Number: (_____)_____

Email Address: _____

Date Signed: _____

If you hold a qualifying degree from a COAMFTE-accredited MFT program you do NOT need to complete page 7. Skip to page 8.

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: (3 semester hours or 4 quarter hours needed)			
Professional Studies: (3 semester hours or 4 quarter hours needed)			
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 file the initial application for LMFT licensure, the Application for 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.29 to 148B.392 and related rules (Minnesota Administrative Rule 5300), 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 have carefully read the questions 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 between date of application and date approved by the Board.

- **_____**

  Signature of Applicant

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:

Paste a recent photo, front-view
Passport-type photo in this square