

## APPLICATION FOR LMFT LICENSURE BY RECIPROCITY

**STOP:** You may only file this Application for LMFT Licensure by Reciprocity if you hold a *current* LMFT license. Individuals holding another license or credential (LAMFT, trainee, intern) or an expired LMFT license are not eligible to proceed as a reciprocity candidate and should contact the Board for instructions on the proper application to file.

\*Passage of the [AMFTRB National Examination in MFT](#) is required of all Minnesota LMFTs. If you were licensed as an LMFT in a jurisdiction or at a time where passage of the National Exam in MFT was not required, you will be required to pass the National Examination prior to granting of your MN LMFT license. This includes California LMFTs who completed the CA exam.

\*Passage of the [MN MFT Exam](#) is required of all Minnesota LMFTs. Upon completion of required CBC and application approval, applicant will be notified by email of scheduling of the **in-person, written state examination**. All applicants are required to travel to MN to complete this exam prior to issuing the MN LMFT license. Upon passage of the MN MFT Exam, applicant will be required to submit prorated annual LMFT licensing fee (\$175.00) based upon month of licensure.

\*Please read [Minnesota Rule 5300.0250](#) before filing this application and review the "[Statutes & Rules](#)" on the Board's website.

1. Submit **\$252.00** (\$220 application fee + \$32.00 criminal background check fee) by check or money order payable to the MN Board of MFT.

**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 are 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. Please see website [www.mn.gov/boards/cbc](http://www.mn.gov/boards/cbc) for more details.

2. Type all answers or print in black ink. Complete all sections. If a section is not applicable, enter N/A.
3. Applicant's signature, photo, and notarization of page 6 is required.
4. **Additional Documents Required – All Applicants:**
  - **An official transcript** covering all graduate work used to meet educational requirements for initial licensure must be sent directly to the Board from the academic institution(s). It may be sent electronically ([mft.board@state.mn.us](mailto:mft.board@state.mn.us)) or by US Mail.
  - **Documentation of passage of the AMFTRB National Examination in MFT** – If exam date and score is not reflected on license verification document, applicant must submit an AMFTRB score report verifying exam passage.
  - **License Verification(s)** (Section IV Applicant 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. The applicant should provide the verification form (page 7) to the appropriate licensing board(s) for completion and the form may be submitted to the MN Board of MFT by email or US Mail; the Board will also accept electronic license verification directly from a licensing board.

*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 #: \_\_\_\_\_

**5. Additional Documents Required for Applicants holding LMFT license less than five (5) years:**

- **Non-COAMFTE Graduate Degree** – If your qualifying degree (Section III Education Information) was **not** a COAMFTE-accredited degree, you must complete the **Coursework Grid** (page 8) and have your graduate program complete the **Practicum Affidavit** (page 9) documenting your degree meets MN requirements for LMFT licensure. COAMFTE accreditation may be verified at [www.coamfte.org](http://www.coamfte.org).
- **Postgraduate Supervised Experience** – Include with this application a copy of your initial application for LMFT licensure, specifically the section(s) documenting all **postgraduate clinical and supervision hours logged**, or other documentation of hours logged for LMFT licensure. This is required to determine whether applicant meets MN standards for LMFT licensure. See [Minn. Rule 5300.0250, subpart 1](#).

6. If additional response information is required, attach a separate sheet of paper and clearly identify the question.

7. Mail this (1) application, (2) required fee, and (3) required / additional documents 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.

**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 “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. 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 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 LMFT LICENSURE BY RECIPROCITY**

**Section I - Applicant Information**

<b>LEGAL NAME:</b>		Last	First	Middle
<b>LIST ALL PRIOR/MAIDEN/PRACTICE NAMES:</b>				
<b>PASSAGE OF AMFTRB NATIONAL EXAMINATION IN MFT:</b>		Month	Year	
<small>(Documentation of exam passage must be submitted to the Board; if you have never taken this exam, write "No exam")</small>				
<b>Gender:</b>				
Male	Female	Transgender	Non-Binary	Other
<b>Prefer to not respond</b>				
<b>Race/Ethnicity:</b>				
Asian	American Indian/Alaskan Native		Black/African American	
Hispanic/Latino	Native Hawaiian/Pacific Islander		Other	White
<b>Prefer to not Respond</b>				
<b>Date of birth (required):</b>		<b>Social Security Number (required):</b>		
/	/	-	-	
<b>Month</b>	<b>Day</b>	<b>Year</b>		
<b>PUBLIC ADDRESS: (Street Address)</b>		(City)	(State)	(Zip code)
<small>(Required; provided to public upon request)</small>				
<b>MAILING ADDRESS: (Street Address)</b>		(City)	(State)	(Zip code)
<small>If same as public address write "SAME" (For Board use only; correspondence mailed to this address)</small>				
<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: (Street Address)</b>		(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>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>

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

## 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 - Education Information**

List all GRADUATE education used to meet the educational requirements for initial LMFT licensure. Transcripts of the graduate education/degree must be sent directly to the Board by the graduate institution. Transcripts must be from regionally accredited institutions and document required coursework and degrees.

Name of Graduate Institution:	Location (City, State):	Degree Obtained and Field of Study:	Degree Granted (Month/Year)

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

NO. If LMFT license was issued less than five (5) years ago, you **must complete** Coursework Grid (page 8) and Practicum Affidavit (page 9).

YES. List COAMFTE-accredited degree / graduate institution: \_\_\_\_\_

**Section IV - Applicant Licensure Status**

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

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. The applicant should provide the verification form (page 7) to the appropriate licensing board(s) for completion and the form may be submitted to the MN Board of MFT by email or US Mail; the Board will also accept electronic license verification directly from a licensing board.

**AFFIDAVIT OF APPLICANT:**

STATE OF (where notarized): \_\_\_\_\_

COUNTY OF (where notarized): \_\_\_\_\_

I, \_\_\_\_\_ **(print applicant name)**, hereby apply for the LMFT license, under the laws and regulations governing marriage and family therapy licensure in Minnesota. 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 institution and license verification sent directly from other licensing jurisdiction.

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**

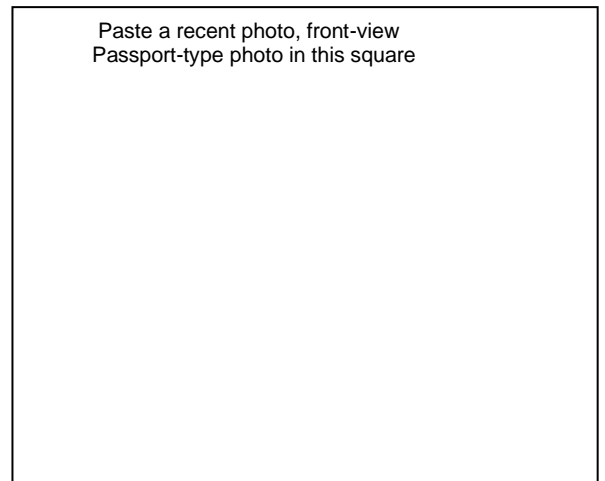
**I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, 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:**



**Verification of Licensure in Other Jurisdiction**

**DIRECTIONS TO RECIPROCITY APPLICANT:** Complete Part I and forward to the State board or office where you hold or have held a health-related license. **Make copies as needed** for verification from more than one licensing jurisdiction.

**PART I-TO BE COMPLETED BY THE RECIPROCITY APPLICANT**

Name of Applicant	State of License Issuance	License No.	Date Issued	Expiration Date

I was granted a license as described above and request that verification of that license be submitted to the Minnesota State Board of Marriage and Family Therapy. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Minnesota Board. Your prompt attention is requested.

\_\_\_\_\_  
LMFT Reciprocity Applicant Signature

\_\_\_\_\_  
Date

**PART II-TO BE COMPLETED BY STATE LICENSURE BOARD** (Mail or email completed form to address printed at top of page.)

Name of Licensee	Licensure Type	License No.	Date Issued	Expiration Date
Exam Taken ___ AMFTRB ___ Other (specify) _____		Exam Date		Exam Score
Disciplinary or Public Actions: ___ Yes* ___ No If "Yes," attach copies of public orders.		State MFT Practice Act and Administrative Rule/Code Citation:		
<b>Licensee's reported hours of direct clinical client contact and supervision required for licensure:</b> Total hours of all direct clinical client contact (individual and couple/family therapy): _____ Total hours of direct clinical contact to couples and families: _____ Total hours of all supervision (individual and group supervision): _____ Total hours of individual supervision: _____ Is LMFT licensure required for an individual to serve as a supervisor for purposes of licensure: Yes _____ No _____ If No, what license credential may a supervisor hold? _____				

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Affix Board Seal or  
Stamp Here**

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Telephone #

**STOP:** This Coursework Grid is only required if (1) reciprocity applicant’s qualifying graduate degree was **NOT** COAMFTE-accredited AND (2) applicant’s LMFT license was issued less than five (5) years ago.

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*. A course may be used only once when completing the grid.

	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)			



**STOP:** This Practicum Affidavit is only required if (1) reciprocity applicant's qualifying graduate degree was **NOT** COAMFTE-accredited AND (2) applicant's LMFT license was issued less than five (5) years ago.

## 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)

\_\_\_\_\_  
Signature

LMFT License Number: \_\_\_\_\_ State of License Issuance: \_\_\_\_\_

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Date Signed: \_\_\_\_\_