



State of Utah
DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING

160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741
Telephone (801) 530-6628
www.dopl.utah.gov

- MARRIAGE AND FAMILY THERAPIST (\$120.00 Non Refundable Application Fee)
 MARRIAGE AND FAMILY THERAPIST BY ENDORSEMENT (\$120.00 Non Refundable Application Fee)

(Note: Microsoft Word users can fill in the blanks, print the form and save it for their records)

Please list your full legal name as it appears on your driver's license, Social Security Card, etc.				
Last Name:		First Name:		Middle Name:
Social Security Number: - -			Maiden Name:	
I certify under penalty of perjury that:				
<input type="checkbox"/> I am a citizen of the United States and I have a valid US Driver License or US State ID. License/State ID Number: _____ State: __				
<input type="checkbox"/> I am a citizen of the United States currently living outside the United States and do not have a valid US Drivers License or US State ID. Please attach a legible copy of your valid passport or other documentation to verify you are a legal citizen of the United States.				
<input type="checkbox"/> I am a non-citizen of the United States, who is lawfully present in the United States and I have a valid US Drivers License or US State ID. License/State ID Number: _____ State: __				
<input type="checkbox"/> I am a non-citizen of the United States, who is lawfully present in the United States and I do not have a valid US Drivers License or US State ID. Please attach a legible copy of your current and valid government issued document showing evidence of authorization to work in the United States.				
<input type="checkbox"/> I am a foreign national not physically present in the United States.				
Mailing Address:				
City:			State:	ZIP:
<input type="checkbox"/> Male	Date of Birth:	Phone #:	E-Mail:	
<input type="checkbox"/> Female				
List all other licenses, registrations, or certifications issued by any state which you now hold or have ever held in any profession. <i>(Use additional sheets if necessary.)</i>				
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: _____
Date License/Certificate Approved/Denied: ___/___/___ by _____
Reason for Denial/Other Comments: _____

Bureau Manager Review: QQ Yes answers or Education or Exam Approve Deny

AFFIDAVIT and RELEASE AUTHORIZATION FOR APPLICANT

1. I certify that am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, forgery, misrepresentation, omission of material fact; is truthful, correct, and complete; discloses all material facts regarding the applicant; and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, institutions, organization, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division of Occupational and Professional Licensing to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which you are applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

Name: _____ Signature: _____ Date: _____

EDUCATION REQUIREMENTS *(Use additional sheets if necessary.)*

Name of School:		Dates Attended:		To:
Location:		Degree Received:		Date of Graduation:
Mailing Address:		City:	State:	ZIP:
Name of School:		Dates Attended:		To:
Location:		Degree Received:		Date of Graduation:
Mailing Address:		City:	State:	ZIP:
Name of School:		Dates Attended:		To:
Location:		Degree Received:		Date of Graduation:
Mailing Address:		City:	State:	ZIP:

EXAMINATION REQUIREMENT:

Examination of Marital and Family Therapy – Date(s) Passed:

ACCREDITATION:

Is your earned marriage and family therapy degree from a COAMFTE accredited institution?

Yes No If “NO,” complete the “EDUCATIONAL COURSE REQUIREMENTS” section of this application and submit course descriptions.

EDUCATIONAL COURSE REQUIREMENTS

To be completed by **all applicants who have not graduated from a COAMFTE accredited curriculum** in marriage and family therapy. You can expedite the review process by providing a copy of the graduate catalog course description and/or syllabus of any identified courses. Use each course only once. *(Use additional sheets if necessary.)*

Theoretical Foundations of Marital and Family Therapy: <i>(minimum 6 semester or 9 quarter hours)</i>			Total:
Course Title:	Course No:	University:	
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:	
Course Title:	Course No:	University:	
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:	
Course Title:	Course No:	University:	
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:	
Assessment and Treatment in Marriage and Family Therapy: <i>(minimum 9 semester or 12 quarter hours)</i>			Total:
Course Title:	Course No:	University:	
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:	
Course Title:	Course No:	University:	

Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:
Course Title:	Course No:	University:
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:
Human Development & Family Studies: <i>(minimum 6 semester or 9 quarter hours)</i>		Total:
Course Title:	Course No:	University:
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:
Course Title:	Course No:	University:
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:
Course Title:	Course No:	University:
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:
Professional Ethics: <i>(minimum 3 semester or 4½ quarter hours)</i>		Total:
Course Title:	Course No:	University:
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:
Course Title:	Course No:	University:
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:
Course Title:	Course No:	University:
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:
Research Methodology and Data Analysis: <i>(minimum 3 semester or 4½ quarter hours)</i>		Total:
Course Title:	Course No:	University:
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:
Course Title:	Course No:	University:
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:
Supervised Clinical Practicum <i>(minimum 500 hours of clinical practice which must include 250 hours with couples or families physically present in the therapy room AND 100 hours of face-to-face supervision for a total of 600 hours)</i>		Total:
Course Title:	Course No:	University:
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:
Course Title:	Course No:	University:
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:
Course Title:	Course No:	University:
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:
Electives in Marriage and Family Therapy: <i>(minimum 3 semester or 4½ quarter hours)</i>		Total:
Course Title:	Course No:	University:
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:
Course Title:	Course No:	University:
Year:	Credits: <input type="checkbox"/> Semester <input type="checkbox"/> Quarter	Credits Received:


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QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer the questions. Do not leave any question blank.

(Note: If you have formally expunged a criminal record you do not need to disclose that criminal history.)

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Have you ever been denied the right to sit for a licensure examination?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Are you currently under investigation or is any disciplinary action pending against you now by any licensing agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Have you ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending against you by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?
<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Have you been named as a defendant in a malpractice suit?
<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions or conditions imposed by any malpractice carrier?
<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	15. If you are licensed in the occupation/profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?
<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Have you ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?
<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug use or abuse within the past five (5) years?
<input type="checkbox"/> Yes <input type="checkbox"/> No	18. Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?
<input type="checkbox"/> Yes <input type="checkbox"/> No	19. Are you currently using or have you recently (<i>within 90 days</i>) used any drugs (<i>including recreational drugs</i>) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?
<input type="checkbox"/> Yes <input type="checkbox"/> No	20. Do you currently have any criminal action pending?
<input type="checkbox"/> Yes <input type="checkbox"/> No	21. Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.
<input type="checkbox"/> Yes <input type="checkbox"/> No	22. Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	23. Have you, in the past ten (10) years, been allowed to plea guilty or no contest to any criminal charge that was later dismissed (<i>i.e. plea-in-abeyance or deferred sentence</i>)?

<input type="checkbox"/> Yes <input type="checkbox"/> No	24. Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction or on probation/parole in any jurisdiction?
	<p>If you answered “yes” to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered “yes” to Questions 20, 21, 22, 23, or 24 you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).</p> <p>If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.</p> <p>If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.</p> <p>A “Yes” answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.</p>

REQUEST FOR VERIFICATION OF LICENSE

(Use this form to verify licensure from another state, if applicable.)

TO BE COMPLETED BY THE APPLICANT:

Complete the first section of the form and submit it to a state in which you are **currently** licensed as a Marriage and Family Therapist. Request that the verifying state complete the form and mail it directly to DOPL or return it to you for submission with your application.

Last Name:	First Name:	Middle Name:
Maiden Name:	Social Security Number: - -	
Mailing Address:	City:	State: ZIP:
Date of Birth:	E-Mail:	Date of Graduation:
I am requesting licensure in the State of Utah as a Marriage and Family Therapist		
I am/have been licensed in your state under the name:		License Nr in your state is/was:
I have enclosed the necessary license verification fee in the amount of \$		
Signature of Applicant:		

TO BE COMPLETED BY THE VERIFYING AGENCY:

Please furnish the information requested, sign and verify the document, and mail it directly to DOPL, or place the completed form in a sealed envelope and provide it to the applicant in person or by mail. The applicant will include the sealed verification of licensure with his/her Utah application. Thank you.

Name of Verifying State: _____

Name of Licensee *(as it appears in verifying state's records)*: _____

Classification of License Issued: _____

License Number: _____ Current Status: _____

Original Date of Licensure: ___/___/___ Expiration Date: ___/___/___

Continuously Licensed:

Yes No, please explain: _____

Licensed By:

Exam, Type: _____ Date: ___/___/___

Endorsement: from what state? _____

Waiver: _____

Examination Scores: _____

Education Required for Licensure: _____

Disciplinary Action or Pending Disciplinary Action:

No Yes, please provide certified copies of all Petitions, Orders, etc.

Signature: _____

Title: _____

Agency: _____

Date: ___/___/___

(SEAL)

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VERIFICATION OF ACTIVE PRACTICE AS A MARRIAGE AND FAMILY THERAPIST (For Endorsement Only)

TO BE COMPLETED BY AN EMPLOYER, HUMAN RESOURCE PERSONNEL or THIRD PARTY REFERENCE:

Name of Applicant: _____

License Number: _____ State of Licensure: _____

Name of Person Verifying Employment: _____

Relationship to Applicant: _____

Name of Employer: _____

Employer Address: _____

Employer Phone Number: _____

Describe the applicant's employment setting: (*private practice, governmental entity, nonprofit and charitable corporation, school, college, university, licensed health facility or other*)

Dates applicant was employed in this setting: from ___/___/___ to ___/___/___

How many hours did the applicant work per week? _____

What was the applicant's schedule? full-time part-time

If applicable, is the applicant still employed with agency? Yes No

If applicable, if no, is the applicant re-hirable? Yes No

This document is proof that the applicant has been actively engaged in legal practice as a licensed marriage and family therapist and has completed not less than 4,000 hours of experience which includes not less than 1,000 hours of mental health therapy.

Name: _____ Title: _____

Signature: _____

Date of Signature: ___/___/___

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VERIFICATION OF SUPERVISED EXPERIENCE

TO BE COMPLETED BY EACH SUPERVISOR OF THE REQUIRED SUPERVISED EXPERIENCE HOURS:

Applicant Name: _____

Supervisor's Name: _____

Supervisor's License Issued: State: _____ Profession: _____ Year: _____

Facility Name where experience took place: _____

Facility Street Address: _____

City: _____ State: _____ Zip: _____

Inclusive Dates of Supervised Experience: from ___/___/___ to ___/___/___

Type of Experience	Hours
Hours of Face-to-Face Individual or Group Supervision (<i>minimum 100 hours</i>): <i>This must include at least one hour of face to face supervision for every ten hours of client contact by the supervisee.</i>	
Hours of Mental Health Therapy (<i>minimum 1,000 hours</i>): <i>Does the required 1,000 hours of Mental Health Therapy include 500 hours of Mental Health Therapy in couple or family therapy with two or more clients present?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Hours of Marriage and Family Therapy Training: <i>This may include preparing for cases, writing case notes, completing paperwork, continuing education, in-service training, consultation, and other professional activities.</i>	
Grand Total of Hours (<i>minimum 4,000 hours</i>):	

The hours worked and supervised are reported on the basis of:

- Supervisor's appointment calendars or records
- Supervisor's best recollection

Nature of Applicant's Duties: _____

I do hereby certify that the applicant for licensure as a marriage and family therapist has:

(*Check only one line.*)

- successfully completed the above supervised experience; or
- has not successfully completed the above supervised experience.

I further certify that the applicant:

- is qualified and competent to practice mental health therapy as a licensed marriage and family therapist.
- is not qualified and competent to practice mental health therapy as a marriage and family therapist.

If applicant is not qualified, please explain the nature of the problem and recommendations for remediation. (*Attach additional pages as needed.*)

(Continued on the next page.)

I do hereby certify that I have been licensed as an MFT in good standing for not less than two years and that I meet one of the following requirements to be a marriage and family therapist training supervisor: *(check all that apply)*

- currently approved by AAMFT as a marriage and family therapist supervisor;
- have successfully completed a supervision course in a Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) accredited marriage and family therapy (MFT) program at an accredited university; or
- have successfully completed 20 hours of instruction sponsored by AAMFT or the Utah Association for Marriage and Family Therapists (UAMFT) as follows:
 - four hours of review of models of MFT and supervision;
 - eight hours of MFT supervision processes and practice;
 - four hours of research on effective outcomes and processes of supervision; and
 - four hours of AAMFT Code of Ethics, state rules and case studies related to MFT supervision.

I further certify that I am professionally responsible for the acts and practices of the applicant that were a part of the required supervised experience.

Signature of Supervisor: _____

Date of Signature: ____/____/____

MARRIAGE AND FAMILY THERAPIST

Application Checklist: <i>(Applications with incomplete attachments may be denied.)</i>	
<u>For all applicants:</u>	
<input type="checkbox"/>	Submit a complete application form including all applicable supporting documents. Failure to submit a complete application and supply all necessary information will delay processing and may result in denial of licensure.
<input type="checkbox"/>	Complete and submit the Qualifying Questionnaire
<input type="checkbox"/>	Submit a \$120.00 non-refundable application-processing fee for an MFT license
If you are applying for licensure as a <u>Marriage and Family Therapist</u>, complete the following in addition to submitting a completed application:	
<input type="checkbox"/>	Submit official transcript(s) documenting completion of a master's or doctorate degree in marriage and family therapy from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE).
<input type="checkbox"/>	OR
<input type="checkbox"/>	Submit official transcript(s) evidencing completion of a master's or doctorate degree in marriage and family therapy from an institution which is accredited by a professional accrediting body approved by the Council for Higher Education Accreditation of the American Council on Education (CHEA) and completion of the specific courses as shown in the Educational Course Requirements in this application.
<input type="checkbox"/>	Submit official documentation of your passing score on the Examination of Marital and Family Therapy (EMFT).
<input type="checkbox"/>	Submit a completed "Verification of Supervised Experience" form <i>(attached to this application)</i> from each of your supervisors documenting a total of 4,000 hours of supervised experience — 1,000 hours of which are in mental health therapy
If you are applying for licensure as a <u>Marriage and Family Therapist by endorsement</u> <i>(current licensure in another state)</i> complete the following in addition to submitting a completed application:	
<input type="checkbox"/>	Using the "Request for Verification of License" form <i>(attached to this application)</i> , obtain verification of licensure from a state in which you are currently licensed. Request that the verifying state complete the form and mail them directly to DOPL or return them to you for submission with your application.
<input type="checkbox"/>	Using the "Verification of Active Practice" form <i>(attached to this application)</i> document that you have been actively engaged in the lawful practice of marriage and family therapy for not less than 4,000 hours of which not less than 1,000 hours are in mental health therapy.

1. **Social Security Number:** Your social security number is classified as a private record under the Utah Government Records Access and Management Act. If an SSN is not provided, the application is incomplete and may be denied.
2. **Address of Record:** The address you provide on this application will be your address of record. You are responsible to directly notify DOPL of any change to your address of record.
3. **Laws and Rules:** You are required to understand Utah laws and rules pertaining to your practice. The laws and rules applicable to your professional practice are available on the Internet at www.dopl.utah.gov.
4. **Code of Ethics:** MFT licensees are required to abide by the Code of Ethics of the American Association for Marriage and Family Therapy (AAMFT): www.aamft.org.
5. **School Transcripts:** Have the school send the transcript directly to DOPL or you may also have the school send the transcript to you for inclusion with your application so long as it is in a sealed envelope, bearing the school's stamp/seal on the envelope flap. If you submitted your transcript(s) and/or other course descriptions as part of your application for Utah licensure as a Associate Marriage and Family Therapist, you do not need to resubmit them with your application for Utah licensure as a Marriage and Family Therapist.
6. **Supervised Marriage and Family Therapy Experience:** Upon completion of the required education, 4,000 hours of supervised marriage and family therapy and mental health therapy experience is required for licensure. The 4,000 hours of supervised marriage and family therapy experience includes a minimum of 1,000 hours of supervised experience in mental health therapy -- 500 of which must be in conjoint, couple, or family therapy sessions. You must document 100 hours of face-to-face individual supervision. Additionally, the "Verification of Supervised Experience" form must be submitted upon completion of the required supervised experience. Request that each supervisor complete the form and submit it to you for submission with your application.

7. **Requirements for a Marriage and Family Therapist Supervisor:** To qualify as a Associate Marriage and Family Therapist Supervisor, an individual must be licensed in good standing for not fewer than two years and:
- a. be currently approved by AAMFT as a marriage and family therapist supervisor

OR

- b. comply with the requirements in R156-60b-302 (d) of the Marriage and Family Therapy Act Rules available at www.dopl.utah.gov
8. **Acceptable Forms of Payment:** Licensure fees can be paid by check or money order, made payable to “DOPL.” Cash and debit/credit cards (*American Express, MasterCard, and Visa*) are also accepted in person at DOPL’s main office – but not over the telephone.
9. **Mail Complete Application to:**

By U.S. Mail	Division of Occupational & Professional Licensing P.O. Box 146741 Salt Lake City, Utah 84114-6741
By Express Mail or In Person	Division of Occupational & Professional Licensing 1 st Floor Lobby 160 E 300 S Salt Lake City UT 84111-2305

10. **Telephone Numbers:** (801) 530-6628
(866) 275-3675 – Toll-free in Utah