



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

- ASSOCIATE MARRIAGE AND FAMILY THERAPIST (\$85.00 Non Refundable Application Fee)
- ASSOCIATE MARRIAGE AND FAMILY THERAPIST EXTERN (\$85.00 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 <u>full legal name</u> 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:

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:	

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?



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).

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.

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.

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.

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**ASSOCIATE MARRIAGE AND FAMILY THERAPIST
ASSOCIATE MARRIAGE AND FAMILY THERAPIST EXTERN
Application Checklist**

Applications with incomplete attachments may be denied.

(Do not submit this checklist with your application it is for your information.)

<input type="checkbox"/>	Complete and submit the Qualifying Questionnaire
<input type="checkbox"/>	<p>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).</p> <p style="text-align: center;">OR</p> <p>Submit official transcript(s) documenting completion of a master’s or doctorate degree in marriage and family therapy from an institution that 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 portion of this application. Submit course descriptions and/or syllabi to verify the content of course work.</p>
<input type="checkbox"/>	Submit an \$85.00 non-refundable application-processing fee for an Associate MFT license.

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 following laws and rules 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.
6. **Externship:** A person who applies for licensure who has the MFT degree required but who is found to be deficient in specific courses as required in Utah Administrative Code Section R156-60b-302(a) may be issued an externship license if approved by DOPL. An extern license expires upon issuance of the license applied for or three years from the date of issuance, whichever comes first. **This license is not renewable.** If a person does not complete the education requirement and obtain normal licensure within the three-year time period, he/she will be required to discontinue practice until completing the education and being granted a license. The 4,000 hours of experience needed to obtain the MFT license cannot be gathered while licensed as an extern.
7. **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.
8. **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

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