



Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services
Board of Marriage and Family Therapy

PO Box 30670
Lansing MI 48909
(517) 335-0918

www.michigan.gov/healthlicense

**MARRIAGE AND FAMILY THERAPY
EDUCATIONAL LIMITED APPLICATION PACKET**

INCLUDED IN THIS PACKET:

1. Mailing Information & Content.....Page 1-2

2. Licensure Instructions.....Page 3

3. Application.....Pages 4-7

4. Supervisor's Evaluation of Applicant's 1000 Hours of Direct Client Contact.....Pages 8-9

5. Supervisor's Evaluation of Applicant's 300 Hours of Direct Client Contact.....Pages 10-11

6. Printing Instructions.....Page 12

7. Application Checklist.....Page 13

8. Top Things Applicants Should Know.....Page 14

9. Glossary/Definition of Terms.....Page 15

10. Frequently Asked Questions.....Page 16

11. Websites & Links.....Page 17



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MARRIAGE AND FAMILY THERAPY EDUCATIONAL LIMITED INSTRUCTIONS

* Please read application instructions carefully and answer all questions completely.
Failure to do so may cause a delay in your application process.*

1. You must complete and submit the application for licensure with the appropriate fee, as well as arrange for supporting documents to be sent to the Michigan Board of Marriage and Family Therapy.
2. Applicants for a Michigan health professional license or registration are required to submit fingerprints and undergo a Criminal Background Check (CBC). Fingerprints must be taken using the Customer ID number and instructions provided in the Application Confirmation letter that will be sent when your license application and fee are processed. Do not have your fingerprints taken prior to receiving your Customer ID number.
3. Arrange for an official transcript of your master's or higher-level degree to be sent to this office directly from your educational institution. The transcript must show the degree earned and the date conferred as well as all course work required for licensure.
4. Submit course descriptions or syllabi for the course work you list on your application. Graduates of master's or doctoral degree programs accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) do not have to submit the course descriptions or syllabi.
5. Complete Section I of the Supervisor's Evaluation of Applicant's 300 Hours of Direct Client Contact form, forward it to your supervisor for completion of Section II, and have your supervisor submit it directly to the Board office. Graduates of master's or doctoral degree programs accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) do not have to verify the completion of 300 hours of direct client contact.

Please Note:

- An application submitted with the appropriate fee is valid for two years from the date it is received. If an applicant fails to complete the requirements for licensure within the two year period following the date of application, the application will become invalid.

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| |
|--------------------|
| FOR BOARD USE ONLY |
| License Number: |
| Issue Date: |

APPLICATION FOR EXAMINATION

I am applying for the following:

Marriage and Family Therapist Educational Limited License Fee: \$85.00 [71-7101-05]

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. DO NOT SEND CASH. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

1. Demographic Information

| | | | |
|---|--------|------------------|---|
| First Name: | | Middle Name: | Last Name: |
| U.S. Social Security #: | | Birth Date: | |
| Street Address: | | Apt/Bldg #: | |
| City: | State: | Zip Code: | |
| Country: | | | |
| Phone Number: | | Email Address: | |
| Have you ever held a health professional license in any profession in Michigan? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Was your health professional license issued after 2008? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Health Professional Permanent I.D./License Number: | | Expiration Date: | |
| Have you ever been known under any other name? If yes, list name(s): | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Will documents be received under any other name? If yes, list name(s): | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever filed an application for this type of license in Michigan? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Full Name:

2. Personal Data Questions

1. Have you ever been convicted of a felony?

 Yes No

If yes, please explain

2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?

 Yes No

If yes, please explain

3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?

 Yes No

If yes, please explain

4. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?

 Yes No

If yes, please explain

5. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 in any consecutive 5 year period?

 Yes No

If yes, please explain

6. Have you ever been fined, denied, revoked, suspended, reprimanded, placed on probation, otherwise disciplined, or the subject of a final adverse action by a licensure, registration, disciplinary or certification board as a holder of or applicant for, a license or registration regulated by this state, another state or territory of the United States, the United States military, the federal government, or another country?

 Yes No

If yes, please explain

7. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care staff privileges involuntarily modified?

 Yes No

If yes, please explain

8. Have you ever been treated for substance abuse in the past 2 years?

 Yes No

If yes, please explain

Note: If you answered "yes" to any of the questions in Section 2 (questions 1-8), you must provide a detailed explanation with copies of all available official and/or court documents related to your explanation along with your application. If you do not provide the explanation, your application will be deemed incomplete and processing will be delayed.

Full Name:

Have you taken a National examination for another U.S Jurisdiction? name and date taken (month & year) Yes No

Have you taken a State Constructed examination for another U.S. Jurisdiction? Please list state and date taken (month & year) Yes No

3. Professional Education

Is this program COAMFTE accredited? Yes No

| Name of Institution | Address of Institution | Graduation Date | Certificate/Diploma/ Degree Granted |
|---------------------|------------------------|-----------------|-------------------------------------|
| | | | |
| | | | |
| | | | |

List course work that includes study in the following required areas. Credit for any course work can be counted only once. All courses must be graduate level courses. You must submit course syllabi for all courses listed.

| Name and Address of College | Course # | Course Title | List # of Hours (indicate semester or quarter hours) |
|---|----------|--------------|--|
| FAMILY STUDIES - 3 courses required. Must total 6 semester or 9 quarter hours | | | |
| | | | |
| | | | |
| FAMILY THERAPY METHODOLOGY - 3 courses required. Must total 6 semester or 9 quarter hours | | | |
| | | | |
| | | | |
| HUMAN DEVELOPMENT- PERSONALITY THEORY, OR PSYCHOPATHOLOGY- 3 courses required must total 6 semester or 9 quarter hours. | | | |
| | | | |
| | | | |
| ETHICS, LAW AND STANDARDS OF PROFESSIONAL PRACTICE. Must total 2 semester or 3 quarter hours. | | | |
| | | | |
| | | | |
| RESEARCH. Must total 2 semester or 3 quarter hours. | | | |
| | | | |
| | | | |

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Full Name: _____

4. License(s) in Other State(s) and/or Province(s)

Do you hold or have you held a permanent license or registration in any state or Canadian province, for the type of license for which you are applying? Yes No

Please list each state or province, the license or registration number, the date issued, the number of years you held the license, and how the license was obtained (either examination or endorsement). **DO NOT LIST TEMPORARY LICENSES.** (Attach additional sheets, if necessary.)

| State/Country | Permanent License/ Registration Number | Date of Issue | Number of Years Licensed | Expiration Date | How Obtained (Exam or Endorsement) |
|---------------|---|---------------|-----------------------------|--------------------|---------------------------------------|
| | | | | | |
| | | | | | |
| | | | | | |

5. CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police, law enforcement, or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant _____ Date _____

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**SUPERVISOR'S EVALUATION OF APPLICANT'S
 1000 HOURS OF DIRECT CLIENT CONTACT**

Authority: Public Act 368 of 1978, as amended.
 If this form is not completed, certification will not be issued.

EXPERIENCE REQUIREMENTS

Following the completion of the education required for licensure, you must have obtained a minimum of 1,000 direct client contact hours in supervised marriage and family therapy experience. At least 500 of these hours must be completed with families, couples, or other subsystems of families physically present in the therapy room. A licensed marriage and family therapist must provide the supervision.

200 hours must be completed with a supervisor present, 100 hours of this supervision must be individual supervision with no more than one other supervisee present. The remaining hours may be group supervision with no more than six supervisees present.

SECTION I - APPLICANT INFORMATION

Instructions: Complete Section I. Type or print your name exactly as it appears on your application. Print this form and then for completion of Section II, send this form to your supervisor. This certification must be submitted directly to the Michigan Board of Marriage and Family Therapy by your supervisor.

| | | |
|-----------------|----------------|-------------|
| First Name: | Middle Name: | Last Name: |
| Street Address: | | Apt/Bldg #: |
| City: | State: | Zip Code: |
| SSN: | Date of Birth: | Email: |

Signature _____

Date _____

Upon completion of Section I, print, sign, and date the form then send the form to your supervisor for completion of Section II. **This certification must be submitted directly to the Michigan Board of Marriage and Family Therapy by your supervisor.**

Full Name: _____

SECTION II - SUPERVISOR'S EVALUATION

Please complete the following information. Return this completed certification directly to Department of Licensing and Regulatory Affairs, Michigan Board of Marriage and Family Therapy, PO Box 30670, Lansing, MI 48909.

Name of Supervisor: _____

Name of Agency or Clinic: _____

Street Address: _____

| | | |
|-------------|--------------|-----------------|
| City: _____ | State: _____ | Zip Code: _____ |
|-------------|--------------|-----------------|

Were you a licensed Marriage and Family Therapist during the time you supervised the Applicant? Yes No

License Number _____

Issued by which State? _____

Applicant worked under my supervision from _____ to _____

Month Year Month Year

Under my supervision, the applicant has completed a total of _____ hours of direct client contact in supervised marriage and family therapy experience.

OF THE TOTAL DIRECT CLIENT CONTACT HOURS STATE ABOVE:

a. _____ hours of direct contact were completed with families, couples, or other subsystems of families physically present in the therapy room.

I have provided the applicant a total of _____ face to face hours of supervision during the dates indicated above.

OF THE TOTAL HOURS OF FACE TO FACE SUPERVISION STATED ABOVE:

a. The applicant has received _____ hours of supervision in which no more than one other supervisee was present.

b. The applicant has received _____ hours of supervision in which no more than no more than six supervisees were present.

Supervisor's Signature _____ Date of Signature _____

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

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**SUPERVISOR'S EVALUATION OF APPLICANT'S
 300 HOURS OF DIRECT CLIENT CONTACT**

Authority: Public Act 368 of 1978, as amended.
 If this form is not completed, certification will not be issued.

EXPERIENCE REQUIREMENTS

You must provide verification from your supervisor of the completion of 300 hours of direct client contact, at least half of which must occurred in a setting where families, couples, or subsystems of families were physically present in the therapy room. You must also have completed 60 hours of supervised clinical experience over at least eight consecutive months in either A CLINICAL PRACTICUM DURING GRADUATE EDUCATION OR IN A POSTGRADUATE MARRIAGE AND FAMILY THERAPY INSTITUTE ACCEPTABLE TO THE BOARD.

A practicum supervisor must be one of the following: a licensed marriage and family therapist; a licensed master's social worker; a licensed professional counselor; a physician practicing in a mental health setting; a fully licensed psychologist; or an AAMFT approved supervisor or supervisor-in-training.

SECTION I - APPLICANT INFORMATION

Instructions: Complete Section I. Type or print your name exactly as it appears on your application. Print this form and then for completion of Section II, send this form to your supervisor. This certification must be submitted directly to the Michigan Board of Marriage and Family Therapy by your supervisor.

| | |
|---|--|
| I AM APPLYING FOR THE FOLLOWING: | |
| Note: This form is required if you are applying for a limited license OR for a full licensure and you have not held a limited license | |
| <input type="checkbox"/> Full License | <input type="checkbox"/> Limited License |

| | | |
|-----------------|----------------|-------------|
| First Name: | Middle Name: | Last Name: |
| Street Address: | | Apt/Bldg #: |
| City: | State: | Zip Code: |
| SSN: | Date of Birth: | Email: |

Signature _____

Date _____

Upon completion of Section I, print, sign, and date the form then send the form to your supervisor for completion of Section II. **This certification must be submitted directly to the Michigan Board of Marriage and Family Therapy by your supervisor.**

Full Name: _____

SECTION II - SUPERVISOR'S EVALUATION

Please complete the following information. Return this completed certification directly to Department of Licensing and Regulatory Affairs, Michigan Board of Marriage and Family Therapy, PO Box 30670, Lansing, MI 48909.

| | | |
|---|--------|--------------------|
| Name of Supervisor: | | |
| Name of Agency or Clinic: | | |
| Street Address: | | |
| City: | State: | Zip Code: |
| Which of the following were you at the time of supervision (Check One): | | |
| <input type="checkbox"/> a licensed marriage and family therapist <input type="checkbox"/> a licensed master's social worker | | |
| <input type="checkbox"/> a licensed professional counselor <input type="checkbox"/> a physician practicing in a mental health setting | | |
| <input type="checkbox"/> a fully licensed psychologist <input type="checkbox"/> an approved supervisor or supervisor-in-training through the AAMFT | | |
| Please provide your license number for the profession you checked | | |
| License Number _____ | | |
| Issued by which State? _____ | | |
| Applicant worked under my supervision from _____ to _____ | | |
| Month | Year | Month Year |
| Applicant's experience was obtained in a <input type="checkbox"/> Clinical practicum during graduate education OR in a <input type="checkbox"/> postgraduate marriage and family therapy institute. | | |
| Name of organization or institute where experience was obtained: _____ | | |
| The applicant has completed _____ hours of direct client contact. | | |
| Of the total directed client contact hours, the applicant has completed _____ hours of in a setting where families, couples, or subsystems of families were physically present in the therapy room. | | |
| The applicant has completed _____ hours of supervision of clinical experience over _____ consecutive months. | | |
| Supervisor's Signature _____ | | Date of Sign _____ |

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Please print out the Application (Pages 4-7), the Supervisor's Evaluation of Applicant's 1000 Hours of Direct Client Contact form (pages 8-9) and the Supervisor's Evaluation of Applicant's 300 Hours of Direct Client Contact (pages 10-11). Sign and date your application, and submit the application along with any supporting documentation and with your check or money order made payable to the "State of Michigan" to:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services
Board of Marriage and Family Therapy
PO Box 30670
Lansing MI 48909

APPLICATION CHECKLIST

Application Fee: Submit a check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN**.

1. Demographic Information: Social Security Number: Please list only a United States Social Security number.

Name: List your full name: first, middle and last name. If your name changes after you apply, you must submit a name change to the Bureau of Health Care Services in writing along with legal documentation within 30 days.

Birth Date: Provide the month, day and year of your birth.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, and country. This will be your permanent address with the Bureau of Health Care Services. If your address changes, you must notify us in writing within 30 days.

Phone: Enter a telephone number where you can be reached in case we have questions about your application.

E-mail: Enter your e-mail address. E-mail is a quick way our office can communicate with you about your application.

Other Name(s): Indicate whether you have been known by any other names.

2. Personal Data Questions: All applicants must answer the same personal data questions. If you answer "yes" to any questions in this section, you must submit a detailed explanation with your application. If you do not provide this information, your application will be deemed incomplete and processing will be delayed.

3. Professional Education: List your current or completed professional school. Indicate degree/certificate/diploma earned. List graduation and/or anticipated graduation date.

4. License in Other State(s) and/or Province(s): List all states/provinces where you have held an marriage and family therapist license or registration. Indicate method of licensure - examination or endorsement.

5. Certification: You must sign and date your application for it to be valid. By signing the application you are indicating that you have read and understood the certification section.

TOP THINGS APPLICANTS SHOULD KNOW

1. **NOTE:** If you have ever been licensed in another state and you have a current disciplinary sanction on that license (even if the license is inactive), you are not eligible for licensure in Michigan according to the Public Health Code, PA 368, as amended, Section 333.16174 (2). Sanctions include probation, limitation, suspension, revocation, or fine. Upon resolution of the sanction and verification that the license is active with no disciplinary action in effect, you can proceed with the filing of an application for a Michigan license or registration.
2. Read the entire application before submitting it and **DO NOT** send the checklist to the Board of Marriage and Family Therapy office.
3. Applications and mail are processed as quickly as possible in date-received order.
4. Please allow time to process your application before you call or email our office to check on the status. Applications may take up to 2 weeks to reach our office. Applications with fees are first processed through our central mailroom then through our payment processing office.
5. Mail, including mail sent overnight, is first received by our central mailroom prior to reaching the Board.
6. Supporting documentation will not be accepted if faxed into our office.
7. **SPECIAL ACCOMMODATIONS:** If you require special testing accommodations because of a disability, you must submit a letter that indicates what your disability is and what type of accommodations you are requesting. We also require that you send us a letter from a licensed health care provider that clearly states your diagnosis and includes copies of all supporting test findings and/or evaluations. In addition, you should send us documentation from your educational program that describes the accommodations provided to you during your education. These documents need to be submitted with your application, if not earlier, to: Licensing and Regulatory Affairs, Bureau of Health Care Services, Board of Marriage and Family Therapy, ATTN: ADA Request, PO Box 30670, Lansing, MI 48909.
8. **REFUND POLICY:** If you wish to withdraw your application, you must notify the Board of Marriage and Family Therapy in writing to request a partial refund.
9. If your name and/or address changes please notify the Board of Marriage and Family Therapy in writing within 30 days. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website at www.michigan.gov/healthlicense and fax it to (517) 335-2044 ATTN: Applications Section or mail the form to: Licensing and Regulatory Affairs, Bureau of Health Care Services, Board of Marriage and Family Therapy, Application Section, PO Box 30670, Lansing, MI 48909. Telephone calls are **NOT** accepted for these changes. After your license is issued, you can change your address online at www.michigan.gov/elicense.

GLOSSARY/DEFINITION OF TERMS

| | |
|----------------|--|
| ENDORSEMENT | Application made by an individual who holds an active license in another state with licensure requirements substantially equivalent to Michigan requirements. |
| EXAMINATION | Application made by an individual who must take and pass an examination in order to become licensed in Michigan. |
| LAPSED LICENSE | A lapsed license is a license that is no longer active. A license becomes inactive when it is not renewed upon the expiration date printed on the license. |
| RECIPROCITY | Process by which an individual could possibly become licensed in Michigan through a reciprocity agreement with another state board. Michigan does not have a reciprocity agreement with any other state. |
| REINSTATEMENT | The process in which a disciplinary, suspended or revoked license has not lapsed is reactivated by the Board. |
| RELICENSURE | The application process in which a licensee must apply to reactivate a lapsed or lapsed suspended license. |
| RENEWAL | Process to maintain active licensure status at the end of each renewal cycle. |

FREQUENTLY ASKED QUESTIONS

Q. How long will it take to process my application?

Applications and mail are processed as quickly as possible in date-received order. Applications with fees are first processed through our central mailroom then through our payment processing office.

Q. What do I do if I forgot to include my payment with my application?

Please submit the fee along with a copy of your application and a letter indicating that you failed to submit the required payment with your previous application. Mail to: Licensing and Regulatory Affairs, Bureau of Health Care Services, Board of Marriage and Family Therapy, PO Box 30670, Lansing, MI 48909.

Q. How do I check on the status of my application?

Within approximately three weeks of mailing your application to our office, you should receive an Application Confirmation letter containing your customer number. You may use your customer number to check the status of your application at www.michigan.gov/appstatus.

Q. If I have been convicted of a felony or misdemeanor will it stop me from being licensed?

We ask that you submit your application, fee and information regarding the occurrence. The Board will review your file and make a decision at that time. Please keep in mind that we do take into consideration the type of conviction, the age that you were when the incident occurred and the time that has elapsed since the conviction.

Q. How long is my license valid?

The initial license is good for a partial licensure cycle and will expire on the upcoming January 31 renewal date. Each subsequent license will cover a full two-year cycle.

WEBSITES AND LINKS

WEBSITES:

| | |
|---|--|
| Michigan Department of Licensing and Regulatory Affairs | www.michigan.gov/lara |
| Bureau of Health Care Services | www.michigan.gov/bhcs |
| Health Professions Licensing Division | www.michigan.gov/healthlicense |
| Michigan Board of Marriage and Family Therapy Rules | www.michigan.gov/healthlicense |
| Michigan Public Health Code | www.michigan.gov/healthlicense |
| Application Status | www.michigan.gov/appstatus |
| Verify a Health Professional License | www.michigan.gov/verifylicense |
| Renewal Website | www.michigan.gov/elicense |

LINKS:

| | |
|----------|--|
| Identogo | www.identogo.com |
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