KENTUCKY BOARD OF LICENSURE FOR MARRIAGE AND FAMILY THERAPISTS

P.O. Box 1360, Frankfort, KY 40602 ~ 500 Mero Street 2 SC 32, Frankfort, KY 40601
Phone (502) 782-8809 ~ http://mft.ky.gov

APPLICATION FOR LICENSE REACTIVATION

In accordance with KRS 335.340 the Board may reactivate your license **within three years of your license expiration date**. Reactivation may be requested with the completion and submission of this form, a fee of $100.00 plus $150.00 annual renewal fee for each year since that date, and evidence of completion of the annual requirement of qualifying continuing education hours as set forth in 201 KAR 060 including annual ethics training; effective July 2016, completion of six (6) hours of training in the field of suicide assessment, treatment and management every six years; and three (3) hours of training in the field of domestic violence. The fee should be paid by check or money order made payable to the **Kentucky State Treasurer or online by credit card.** List on page two of this form the continuing education hours obtained, including course name, beginning and ending dates. **Attach documentation to support the continuing education hours you have listed.**

COMPLETE THE FOLLOWING (print or type):

l. Mailing Address:

Name:_____
Last First Middle

_____
Street City State Zip

2. E-Mail Address:_____ Social Security Number _____

3. Home Phone (____) _____ Business Phone (____) _____

4. License Number_____ Expiration Date: _____

5. Present Business Address:

Name: _____

_____
Street City State Zip

6. Have you been convicted of a felony or misdemeanor since the last renewal of your license? ☐ No ☐ Yes

If yes, what offense and give details _____
_____
_____

7. Has your License to be a Marriage and Family Therapist or any other professional credential in Kentucky or any other state been subject to disciplinary action? ☐ No ☐ Yes If yes, give details,

_____
_____
_____

(Please complete reverse side)

Incomplete forms will be returned. It is your responsibility to maintain all documentation. Documentation to support the continuing education hours you have listed must be attached.

Program/Seminar Title	Dates Attended Month/Day/Year	Hours Earned

_____ ***Effective July 1, 2016****, I verify with my initials that I have completed six (6) hours of training in the field of suicide assessment, treatment and management, every six (6) years, as required by 201 KAR 32:060 Section 1(4).*

As required by 201 KAR 32:060 Section 1(5), all persons seeking licensure in Kentucky who have not completed the required domestic violence training must complete three (3) hours of training in the field of domestic violence within three years of Kentucky licensure approval.

CERTIFICATION AFFIDAVIT

I, the licensee named in the above, do certify under penalty of law that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should investigation at any time disclose any such misrepresentation or falsification, my license could be subject to disciplinary action by the Kentucky Board of Licensure of Marriage and Family Therapists.

Date_____ **Applicant's Signature**_____
(Sign your name - Do not print or type)

Do Not Write Below This Line--For Board and Office Use Only

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REACTIVATION REVIEW - FOR BOARD MEMBER USE ONLY

Application: **Date** _____

Approved Approved Provisionally Deferred Denied

Committee Signatures _____ _____ _____

Comments:_____

Resubmitted: Date: _____

Approved Approved Provisionally Deferred Denied

Committee Signatures _____ _____ _____

Comments:_____