



## Kentucky Board of Licensure for Marriage & Family Therapists

Public Protection Cabinet – Department of Professional Licensing

P.O. Box 1360, Frankfort, Kentucky 40602

500 Mero Street, Second Floor, Frankfort, Kentucky 40601 (Overnight Delivery Only)

Phone: (502) 782.8809 | Fax: (502) 564.4818 | [mft.ky.gov](http://mft.ky.gov) | [mft@ky.gov](mailto:mft@ky.gov)

### APPLICATION FOR PERMIT AS A MARRIAGE & FAMILY THERAPIST ASSOCIATE

#### INSTRUCTIONS

1. This form must be typed or printed legibly and completed in its entirety.
2. This application and Supervision Plan for Clinical Experience must be submitted with the application fee of fifty dollars (\$50.00), and an initial licensure fee of twenty-five dollars (\$25.00). These fees are non-refundable. All fees must be paid by check or money order made payable to the Kentucky State Treasurer. DO NOT SEND CASH.
3. An official transcript must be received by the Board from the educational institution prior to review.
4. Attach continuation sheets if more space is needed to provide information.
5. Refer to KRS 335.332 and 201 KAR 32:026.
6. This completed form may be submitted to the Kentucky Board of Licensure for Marriage and Family Therapists either by mail to P.O. Box 1360, Frankfort, KY 40602, or by hand delivery during business hours or overnight mail to 500 Mero St, Second Floor, Frankfort, KY 40601.

#### SECTION 1: PERSONAL BACKGROUND

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Prior Names Used: \_\_\_\_\_ SSN (Last 4): \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ County of Residence: \_\_\_\_\_

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

#### GENERAL QUESTIONS

- |                                                                                                                                                                                                 |     |    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Have you ever been credentialed as a Marriage and Family Therapist Associate in any other state?                                                                                             | YES | NO |
| If yes, what state? _____                                                                                                                                                                       |     |    |
| Is the permit active at this time?                                                                                                                                                              | YES | NO |
| Title of credential: _____                                                                                                                                                                      |     |    |
| 2. Have you ever been credentialed as a Licensed Marriage and Family Therapist in any other state?                                                                                              | YES | NO |
| If yes, what state? _____                                                                                                                                                                       |     |    |
| Is the license active at this time?                                                                                                                                                             | YES | NO |
| Title of credential: _____                                                                                                                                                                      |     |    |
| 3. Have any credentials obtained in Kentucky or any other state ever been disciplined?                                                                                                          | YES | NO |
| If yes, give details: _____                                                                                                                                                                     |     |    |
| 4. Have you ever been discharged or forced to resign for misconduct or unsatisfactory service from any position, from any professional training program, or from the program of any university? | YES | NO |
| If yes, give details: _____                                                                                                                                                                     |     |    |

- |                                                                                                                                   |     |    |
|-----------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 5. Have you ever been convicted of a felony or misdemeanor? If yes, what offense?<br>(Submit court documents resolving case)      | YES | NO |
| 6. Do you hold membership in the American Association for Marriage and Family Therapy?                                            | YES | NO |
| 7. Have you ever been sanctioned by AAMFT or by any other professional association for ethical misconduct? (Submit documentation) | YES | NO |

## SECTION 2 – PART A – EDUCATION

### ***Undergraduate***

|                       |                                   |                     |             |
|-----------------------|-----------------------------------|---------------------|-------------|
| School Name/Location: | Dates Attended (Mo./Yr to Mo./Yr) | Graduation (Mo./Yr) | Credit Hrs. |
| _____                 | _____                             | _____               | _____       |

Degree 1: \_\_\_\_\_ Degree 2: \_\_\_\_\_

Degree 3: \_\_\_\_\_ Degree 4: \_\_\_\_\_

|                       |                                   |                     |             |
|-----------------------|-----------------------------------|---------------------|-------------|
| School Name/Location: | Dates Attended (Mo./Yr to Mo./Yr) | Graduation (Mo./Yr) | Credit Hrs. |
| _____                 | _____                             | _____               | _____       |

Degree 1: \_\_\_\_\_ Degree 2: \_\_\_\_\_

Degree 3: \_\_\_\_\_ Degree 4: \_\_\_\_\_

### ***Graduate***

|                       |                                   |                     |             |
|-----------------------|-----------------------------------|---------------------|-------------|
| School Name/Location: | Dates Attended (Mo./Yr to Mo./Yr) | Graduation (Mo./Yr) | Credit Hrs. |
| _____                 | _____                             | _____               | _____       |

Degree 1: \_\_\_\_\_ Degree 2: \_\_\_\_\_

Degree 3: \_\_\_\_\_ Degree 4: \_\_\_\_\_

|                       |                                   |                     |             |
|-----------------------|-----------------------------------|---------------------|-------------|
| School Name/Location: | Dates Attended (Mo./Yr to Mo./Yr) | Graduation (Mo./Yr) | Credit Hrs. |
| _____                 | _____                             | _____               | _____       |

Degree 1: \_\_\_\_\_ Degree 2: \_\_\_\_\_

Degree 3: \_\_\_\_\_ Degree 4: \_\_\_\_\_

***Attach additional sheets for schools if needed.***

## SECTION 2 – PART B – CURRICULUM GUIDELINES

(To be completed when applying for Associate Status from a non-COAMFTE program.) Courses may be used only once. Use graduate courses only.

**MARRIAGE AND FAMILY STUDIES** (3 courses minimum – 9 semester hours or 12 quarter or 135 didactic contact hours required): Courses in this area shall be theoretical in nature and have a major focus of system theory orientation. Topic areas may include systems theory, family development, blended families, cultural issues in families, family subsystems, major models of family systems theory, or gender issues in families.

| Educational Institution | Course Number | Course Title (Spell Out) | Dates To/From | Credit Hours | Contact Hours |
|-------------------------|---------------|--------------------------|---------------|--------------|---------------|
|                         |               |                          |               |              |               |
|                         |               |                          |               |              |               |
|                         |               |                          |               |              |               |
|                         |               |                          |               |              |               |
|                         |               |                          |               |              |               |

**MARRIAGE AND FAMILY THERAPY** (3 courses minimum – 9 semester hours or 12 quarter or 135 didactic contact hours required): Courses in this area shall have a major focus on family systems theory and systemic therapeutic interventions. Courses shall relate to major theories of family systems change and therapeutic practices evolving from each theoretical model. Major theoretical approaches may include structural communications family therapy, strategic object relations family therapy, behavioral family therapy, intergenerational family therapy, solution-oriented family therapy, narrative family therapy and systemic sex therapy.

| Educational Institution | Course Number | Course Title (Spell Out) | Dates To/From | Credit Hours | Contact Hours |
|-------------------------|---------------|--------------------------|---------------|--------------|---------------|
|                         |               |                          |               |              |               |
|                         |               |                          |               |              |               |
|                         |               |                          |               |              |               |
|                         |               |                          |               |              |               |
|                         |               |                          |               |              |               |

**HUMAN DEVELOPMENT** (3 courses minimum – 9 semester hours or 12 quarter or 135 didactic contact hours required): Courses in this area shall provide knowledge of individual personality development in both normal and abnormal manifestations. Topic areas may include human development, personality theory, human sexuality, and effects of gender and cultural issues on human development.

| <b>Educational Institution</b> | <b>Course Number</b> | <b>Course Title (Spell Out)</b> | <b>Dates To/From</b> | <b>Credit Hours</b> | <b>Contact Hours</b> |
|--------------------------------|----------------------|---------------------------------|----------------------|---------------------|----------------------|
|                                |                      |                                 |                      |                     |                      |
|                                |                      |                                 |                      |                     |                      |
|                                |                      |                                 |                      |                     |                      |
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|                                |                      |                                 |                      |                     |                      |

**PSYCHOPATHOLOGY / DSM** (1 course minimum – 3 semester hours or quarter or 45 didactic contact hours required): Courses in this area shall include psychopathology, diagnosis through use of DSM, or applications of DSM to marriage and family therapy.

| <b>Educational Institution</b> | <b>Course Number</b> | <b>Course Title (Spell Out)</b> | <b>Dates To/From</b> | <b>Credit Hours</b> | <b>Contact Hours</b> |
|--------------------------------|----------------------|---------------------------------|----------------------|---------------------|----------------------|
|                                |                      |                                 |                      |                     |                      |
|                                |                      |                                 |                      |                     |                      |
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|                                |                      |                                 |                      |                     |                      |
|                                |                      |                                 |                      |                     |                      |

**PROFESSIONAL STUDIES** (1 course minimum – 3 semester hours or quarter or 45 didactic contact hours required): Courses in this area may include professional ethics in marriage and family therapy, legal responsibilities of the therapist, professional socialization and the role of the professional organization, licensure or certification legislation, and independent practice issues.

| <b>Educational Institution</b> | <b>Course Number</b> | <b>Course Title (Spell Out)</b> | <b>Dates To/From</b> | <b>Credit Hours</b> | <b>Contact Hours</b> |
|--------------------------------|----------------------|---------------------------------|----------------------|---------------------|----------------------|
|                                |                      |                                 |                      |                     |                      |
|                                |                      |                                 |                      |                     |                      |
|                                |                      |                                 |                      |                     |                      |
|                                |                      |                                 |                      |                     |                      |
|                                |                      |                                 |                      |                     |                      |

**RESEARCH (1 course minimum – 3 semester hours or quarter or 45 didactic contact hours required):** Courses in this area may include statistics, research methods, quantitative methodology or other courses designed to assist the student to understand and perform research.

| <b>Educational Institution</b> | <b>Course Number</b> | <b>Course Title (Spell Out)</b> | <b>Dates To/From</b> | <b>Credit Hours</b> | <b>Contact Hours</b> |
|--------------------------------|----------------------|---------------------------------|----------------------|---------------------|----------------------|
| _____                          | _____                | _____                           | _____                | _____               | _____                |
| _____                          | _____                | _____                           | _____                | _____               | _____                |
| _____                          | _____                | _____                           | _____                | _____               | _____                |
| _____                          | _____                | _____                           | _____                | _____               | _____                |
| _____                          | _____                | _____                           | _____                | _____               | _____                |
| _____                          | _____                | _____                           | _____                | _____               | _____                |

**PRACTICUM / INTERNSHIP (1 course minimum – 300 hours of supervised direct client contact with individuals, couples, and families for family therapy.)** Applicants who did not complete a clinical practicum may satisfy the practicum requirement by using their first 300 post-master’s client contact hours as an Associate under supervision. These hours will not be counted toward the two years of required experience or the 200 hours of supervision.

| <b>Educational Institution</b> | <b>Course Number</b> | <b>Course Title (Spell Out)</b> | <b>Dates To/From</b> | <b>Credit Hours</b> | <b>Contact Hours</b> |
|--------------------------------|----------------------|---------------------------------|----------------------|---------------------|----------------------|
| _____                          | _____                | _____                           | _____                | _____               | _____                |
| _____                          | _____                | _____                           | _____                | _____               | _____                |
| _____                          | _____                | _____                           | _____                | _____               | _____                |
| _____                          | _____                | _____                           | _____                | _____               | _____                |
| _____                          | _____                | _____                           | _____                | _____               | _____                |
| _____                          | _____                | _____                           | _____                | _____               | _____                |

## **APPLICANT AFFIDAVIT**

I, the applicant named in the above, do hereby 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 an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected or my permit revoked by the Board.

Signature of Applicant : \_\_\_\_\_ Date: \_\_\_\_\_  
(Sign your name; do not print or type)



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### SUPERVISION PLAN FOR CLINICAL EXPERIENCE

**Please note: A Separate Supervision Plan must be submitted for each Board Approved Supervisor. All applicants applying for a Marriage and Family Therapist Associate Permit shall submit this form.**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Prior Names Used: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ SSN Last 4: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

### PRIMARY CLINICAL MARRIAGE & FAMILY THERAPY SETTING

Workplace Name: \_\_\_\_\_ County of Practice: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Description of agency function (Check One):

Hospital

Mental Health Agency

Private Practice

Other: \_\_\_\_\_

Beginning Date of This Plan: \_\_\_\_\_ Estimated Ending Date (at least one year from beginning): \_\_\_\_\_

### ADDITIONAL CLINICAL MARRIAGE & FAMILY THERAPY SETTING

Workplace Name: \_\_\_\_\_ County of Practice: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Description of agency function (Check One):

Hospital

Mental Health Agency

Private Practice

Other: \_\_\_\_\_

Beginning Date of This Plan: \_\_\_\_\_ Estimated Ending Date (at least one year from beginning): \_\_\_\_\_

## BOARD APPROVED SUPERVISOR FOR THIS PLAN

Full Name: \_\_\_\_\_ KY LMFT License #: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

## SUPERVISION PLAN FOR CLINICAL EXPERIENCE

**Please note: A Separate Supervision Plan must be submitted for each Board Approved Supervisor.**

- A. Provide a detailed description of the nature of this work setting (must include clients to be seen, therapies and treatment modalities that shall be used including the prospective length of treatment, and problems or conditions that shall be treated).**

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- B. Provide a detailed description of the nature, duration, and frequency of supervision in the practice, (must include number of hours of supervision per week, amount of group and individual supervision, and methodology for transmission of case information).**

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- C. Provide a detailed description of the conditions or procedures for termination of this relationship. Please consult 201 KAR 32:026 Section 2.**

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**D. Provide hours per week spent in direct client-professional relationship (include assessment and treatment only).**

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**SUPERVISOR'S STATEMENT**

I, the supervisor for the above-named candidate for licensure for the independent practice of marriage and family therapy, have devised and discussed this plan with said applicant and accept responsibility for its implementation. Further, I understand that upon completion of the Supervision Plan for Clinical Experience and application for licensure as a Marriage and Family Therapist, I will be asked to comment on the ethical behavior and therapeutic competency acquired by the applicant. If, for any reason, the conditions of this plan are changed, or this supervisory relationship is terminated or changed, I will immediately notify the Board. Further, I do hereby certify that my license is current and will be maintained throughout this period. I understand that I am accountable to the Board for the care given to the Marriage and Family Therapist Associate's clients.

Signature of Board Approved Supervisor : \_\_\_\_\_ Date: \_\_\_\_\_

**APPLICANT STATEMENT**

I, the applicant in the above plan, understand that pursuant to 201 KAR 32:026, Section 2, I will be expected to comply with the provisions in this plan in its entirety and must notify the Board of any modifications of this plan once it has been approved. Failure to do so may result in voiding the approval given by the Board and loss of supervision hours gained.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**APPLICANT AFFIDAVIT**

**I, the applicant named in the above, do hereby 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 an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected or my permit revoked by the Board.**

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_  
(Sign your name; do not print or type)



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### LICENSURE AS A MARRIAGE AND FAMILY THERAPIST ASSOCIATE PERMIT RENEWAL APPLICATION

#### INSTRUCTIONS

1. This form must be typed or printed legibly and completed in its entirety.
2. Reaffirmation of Supervision Plan(s) for Clinical Experience or new Supervision Plan(s) for Clinical Experience signed by Supervisor(s) and Associate must accompany this application. 201 KAR 32:026 Section 4.
3. This application must be submitted with the application fee of fifty dollars (\$50.00). This fee is non-refundable. All fees must be paid by check or money order made payable to the Kentucky State Treasurer. DO NOT SEND CASH.
4. Copies of Supervisory Log(s) must be included with this application.
5. You must include a twenty-dollar (\$20.00) late fee if postmarked within the thirty (30) days following the date of expiration.

#### PLEASE COMPLETE THE FOLLOWING (print or type):

Full Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Permit Number: \_\_\_\_\_ Original Permit Date: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Email Address: \_\_\_\_\_

Current employer and address: (only if different from mailing address)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Has your Marriage and Family Therapist Associate permit or any other professional credential in Kentucky or any other state been subject to disciplinary action? If yes, give details: YES NO

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you been convicted of a felony or misdemeanor since the last renewal of your permit? YES NO

If yes, what offense and give details including case number:

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

\_\_\_\_\_ As required by 201 KAR 32:060 Section 1(5), all current license holders must complete three (3) hours of training in the field of domestic violence.

### TO BE COMPLETED BY SUPERVISOR(S):

**Supervisors, please print below:**

Beginning date of supervision: \_\_\_\_\_ Ending date of supervision: \_\_\_\_\_

Total Clinical Supervision hours obtained since last annual renewal: \_\_\_\_\_ Hours

Total Client Contact hours obtained since last renewal: \_\_\_\_\_ Hours

**Signature of Board Approved Supervisor:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### TO BE COMPLETED BY PERMIT HOLDER:

**CONTINUING EDUCATION TRAINING: Effective January 1, 2017, at least ten (10) hours of Board Approved Continuing Education Units, Three (3) hours of these must be in the area of Ethics (yearly).**

| Training Titles (Designate Ethics Course with*)<br>Education | Dates Attended<br>MM/DD/YYYY | # Continuing<br>Units Earned |
|--------------------------------------------------------------|------------------------------|------------------------------|
|--------------------------------------------------------------|------------------------------|------------------------------|

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**DO NOT attach documentation unless you are audited. It is your responsibility to maintain documentation of continuing education.**

### APPLICATION AFFIDAVIT

I, the applicant named in the above, do hereby 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 an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected or my permit revoked by the Board.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_  
(Sign your name; do not print or type)



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Duplicate form as needed.

ASSOCIATE'S NAME: \_\_\_\_\_ PERMIT NO. \_\_\_\_\_

**SUPERVISOR'S NAME (Please Print):** \_\_\_\_\_ **LICENSE NO.** \_\_\_\_\_

[illegible]

**Page Total:**

Please use the following method for recording: .25 = 15 minutes; .5 = 30 minutes; .75 = 45 minutes; 1 or 1.0 = 1 hour (60 minutes)

**\*\*\*Raw data" means video recorded sessions, live observation, or co-therapy with a board approved supervisor. 201 KAR 32:010(9). Raw data must be from the supervisees own clinical work.**

**PAGE** \_\_\_\_\_ **of** \_\_\_\_\_