



KENTUCKY BOARD OF LICENSURE FOR MARRIAGE AND FAMILY THERAPISTS

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

201 KAR 32:030
DIRTY
FILED 9/14/2026

LICENSURE AS A MARRIAGE AND FAMILY THERAPIST APPLICATION

SECTION 1 – PERSONAL BACKGROUND

(Complete ALL questions; type or print all information clearly)

1. NAME: LAST FIRST MIDDLE SOCIAL SECURITY NUMBER
(As you want it to appear on your license)
2. MAILING ADDRESS: STREET CITY STATE ZIP
PHONE NUMBERS: WORK HOME CELL COUNTY OF RESIDENCE
EMAIL ADDRESS
3. Do you currently hold a Kentucky Marriage and Family Therapist Association Permit? ☐ Yes ☐ No
If yes, list permit # _____
4. Have you ever been credentialed as a Marriage and Family Therapist in any other state? ☐ Yes ☐ No
If yes, what state? _____ Is the credential active? ☐ Yes ☐ No
If yes, number and title of credential _____
5. Has any certification or licensure in Kentucky or any other state ever been disciplined? ☐ Yes ☐ No
If yes, give details. Use a separate page if needed. _____
6. Have you ever been discharged or forced to resign from satisfactory service from any position, from any professional training program, or from the program of any university? ☐ Yes ☐ No
If yes, please provide details. Use a separate page if needed. _____
7. Have you ever been convicted of a felony or misdemeanor? ☐ Yes ☐ No
If yes, name offense, case number and provide supporting court documentation on a separate page if needed. _____
8. Do you hold any level membership in the American Association for Marriage and Family Therapy? ☐ Yes ☐ No
If yes, what level? _____
9. Have you ever been sanctioned by AAMFT or by any professional association for ethical misconduct? ☐ Yes ☐ No
If yes, please provide details on a separate sheet.

☐ 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 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.

APPLICANT'S 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 license/permit revoked by the Board.

DATE: _____ APPLICANT'S SIGNATURE _____
(Sign your name - Do not Print or Type)



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(If additional pages are needed, you may reproduce this page.)

Applicant's Name: _____

SECTION 2 – EXPERIENCE

Begin with your present or most recent job and list fully and accurately the details of each job you have held relating to your professional experience during the entire timeframe of your status as a Marriage and Family Therapist Associate. You must obtain a minimum of 1,000 client contact hours over a minimum of two years.

Employed From: Mo. ____ Yr. ____ To: ____ Yr. ____	Describe Your
Title of Position: _____	_____
Name of Employer: _____	_____
MFT Board Approved Supervisor(s): _____	Total Number of Client Contact Hours: _____

Employed From: Mo. ____ Yr. ____ To: Mo. ____ Yr. ____	Describe Your Duties:
Title of Position: _____	_____
Name of Employer: _____	_____
MFT Board Approved Supervisor(s): _____	Total Number of Client Contact Hours: _____

Employed From: Mo. ____ Yr. ____ To: ____ Yr. ____	Describe Your
Title of Position: _____	_____
Name of Employer: _____	_____
MFT Board Approved Supervisor(s): _____	Total Number of Client Contact Hours: _____

Employed From: Mo. ____ Yr. ____ To: Mo. ____ Yr. ____	Describe Your Duties:
Title of Position: _____	_____
Name of Employer: _____	_____
MFT Board Approved Supervisor(s): _____	Total Number of Client Contact Hours: _____

Total of ALL MFT Direct Client Contact Hours: _____



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(If additional pages are needed, you may reproduce this page.)

Applicant's Name: _____

SECTION 3 – VERIFICATION OF CLINICAL SUPERVISION

A minimum of 200 hours of Clinical Supervision in marriage and family therapy is required.
Please be advised that the definition of an approved supervisor is found in 201 KAR 32:035, Section 2.

1. CLINICAL SUPERVISOR'S NAME: _____

Supervisor's LMFT license # _____ Is this an active license in KY? ☐ Yes ☐ No
Check type of Board Approved Supervisor:
____ Non-AAMFT Approved Supervisor ____ AAMFT Approved Supervisor ____ AAMFT Supervisor Candidate
Date of most recent KY law CEU: _____
Date of most recent training update: _____
Date of initial supervisor training: _____
Start and End dates for supervision contract: _____
Number of Supervisory Hours provided: Individual-____ Group-____ Raw Data-____
Do you know of any reason why this person should not be issued a license as a Marriage and Family
Therapist? ☐ Yes ☐ No Comments regarding ethical behavior and therapeutic competency:

Signature of BAS: _____

2. Additional CLINICAL SUPERVISOR'S NAME: _____

Supervisor's LMFT license # _____ Is this an active license in KY? ☐ Yes ☐ No
Check type of Board Approved Supervisor:
____ Non-AAMFT Approved Supervisor ____ AAMFT Approved Supervisor ____ AAMFT Supervisor Candidate
Date of most recent KY law CEU: _____
Date of most recent training update: _____
Date of initial supervisor training: _____
Start and End dates for supervision contract: _____
Number of Supervisory Hours provided: Individual-____ Group-____ Raw Data-____
Do you know of any reason why this person should not be issued a license as a Marriage and Family
Therapist? ☐ Yes ☐ No Comments regarding ethical behavior and therapeutic competency:

Signature of BAS: _____

- A. Total number of Individual Supervision Hours** _____
- B. Total number of Group Supervision Hours** _____
- C. Total of A and B:** _____
- D. Number of raw data hours completed** _____



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CHECKLIST FOR LICENSURE AS A MARRIAGE AND FAMILY THERAPIST

Please use this checklist to ensure that the application has been completed correctly and that you have forwarded all necessary information to the Board. Applications with information missing will not be processed or reviewed for approval.

- Section 1—Personal Background. If you have one or more “yes” responses to numbers 3 through 7 you MUST include the required information for your application to be approved. Insufficient information will cause your application to be deferred pending complete information.
- Section 2—Experience. Have you listed all a) employment settings where you provided therapy services and b) the clinician with credentials who provided supervision of your work toward licensure?
- Section 3—Verification of Clinical Supervision. Has each supervisor completed the segment of this section and provided a signature?
- Have you enclosed the required NON-REFUNDABLE \$50.00 application fee and additional \$175.00 which may be refunded with denial of your licensure application (\$225.00 total made payable to the Kentucky State Treasurer). If you choose not to send \$175.00 licensure fee in advance, you will be notified of the Board's decision in writing and licensure fee will be due prior to your license being issued.
- Have you used the Supervisory Log available on the website and **documented all supervision logs** signed by the appropriate supervisor and **documented all supervision hours** for **PARTIAL approval as an Associate?** Ensure that raw data hours are listed and identified as such and cover the entire Associate Permit timeframe.



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 | mft@ky.gov

APPLICATION FOR LICENSURE AS A MARRIAGE & FAMILY THERAPIST

SECTION 1 – PERSONAL BACKGROUND

Last Name: _____ First Name: _____ Middle Initial: _____

Previous Name: _____ SSN (Last 4): _____

Mailing Address: Street: _____ City: _____

State: _____ Zip Code: _____

Telephone Number: _____ Email Address: _____

County of Residence: _____

1. Do you currently hold a Kentucky Marriage and Family Therapist Associate Permit? YES NO
If yes, list permit # _____

2. Have you ever been credentialed as a Marriage and Family Therapist in any other state? YES NO

3. a. If yes, what state? _____ Is the license active at this time? YES NO
b. If yes, number and title of credential: _____

4. Has any certification or licensure in Kentucky or any other state ever been disciplined? YES NO
If yes, give details. *Use a separate page if needed.*

5. 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. *Use a separate page if needed.*

6. Have you ever been convicted of a felony or misdemeanor? YES NO
If yes, name offense, case number and provide supporting court documentation. *Use a separate page if needed.*

7. Have you ever been sanctioned by AAMFT or by any professional association for ethical misconduct?
YES NO
If yes, please provide details on a separate sheet.

SECTION 2 – EXPERIENCE

Begin with your present or most recent job and list fully and accurately the details of each job you have held relating to your professional experience during the entire timeframe of your status as a Marriage and Family Therapist Associate. You must obtain a minimum of 1,000 client contact hours over a minimum of two years.

Employed From: _____ to _____

Title of Position: _____

Name of Employer: _____

Total Number of Client Contact Hours: _____

MFT Board Approved Supervisor(s):

Describe your Duties:

Employed From: _____ to _____

Title of Position: _____

Name of Employer: _____

Total Number of Client Contact Hours: _____

MFT Board Approved Supervisor(s):

Describe your Duties:

Employed From: _____ **to** _____

Title of Position: _____

Name of Employer: _____

Total Number of Client Contact Hours: _____

MFT Board Approved Supervisor(s):

Describe your Duties:

Employed From: _____ **to** _____

Title of Position: _____

Name of Employer: _____

Total Number of Client Contact Hours:

MFT Board Approved Supervisor(s):

Describe your Duties:

Total of All MFT Direct Client Contact Hours: _____

SECTION 3 – VERIFICATION OF CLINICAL SUPERVISION

A minimum of 200 hours of Clinical Supervision in marriage and family therapy is required. Please see 201 KAR 32:035.

1. CLINICAL SUPERVISOR'S NAME:

Supervisor's LMFT license _____ Is this an active license in KY? Yes No

Check type of Board Approved Supervisor:

☐ Non-AAMFT Approved Supervisor

☐ AAMFT Approved Supervisor

☐ AAMFT Supervisor Candidate

Date of most recent KY law CEU: _____

Date of most recent training update: _____

Date of initial supervisor training: _____

Start and End dates for supervision contract: _____

Number of Supervisory Hours provided: Individual- _____ **Group-** _____ **Raw Data-** _____

Do you know of any reason why this person should not be issued a license as a Marriage and Family Therapist? Yes No

Comments regarding ethical behavior and therapeutic competency:

SIGNATURE OF BAS:

1. ADDITIONAL CLINICAL SUPERVISOR'S NAME:

Supervisor's LMFT license _____ Is this an active license in KY? Yes No

Check type of Board Approved Supervisor:

___ Non-AAMFT Approved Supervisor

___ AAMFT Approved Supervisor

___ AAMFT Supervisor Candidate

Date of most recent KY law CEU: _____

Date of most recent training update: _____

Date of initial supervisor training: _____

Start and End dates for supervision contract: _____

Number of Supervisory Hours provided: Individual-_____ Group-_____ Raw Data-_____

Do you know of any reason why this person should not be issued a license as a Marriage and Family Therapist? Yes No

Comments regarding ethical behavior and therapeutic competency:

SIGNATURE OF BAS:

A. Total number of Individual Supervision Hours: _____

B. Total number of Group Supervision Hours: _____

C. Total of A and B: _____

D. Number of raw data hours completed: _____

APPLICANT NAME: _____

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.

Date: _____

Signature of Applicant: _____



Kentucky Board of Licensure for Marriage & Family Therapists

Public Protection Cabinet – Department of Professional Licensing

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APPLICATION FOR LICENSURE AS A MARRIAGE AND FAMILY THERAPIST BY ENDORSEMENT

INSTRUCTIONS

1. This form must be typed or printed legibly and completed in its entirety.
2. This application must be submitted with the \$225 fee (including the nonrefundable \$50.00 application fee and the \$175.00 initial licensure fee which may be refunded with denial of your licensure application). All fees must be paid by check or money order made payable to the Kentucky State Treasurer. DO NOT SEND CASH.
4. Attach continuation sheets if more space is needed to provide information.
5. Refer to KRS 335.336 and 201 KAR 32:030.
6. The application must include:
 - a. Primary source verification of licenses from other states including any disciplinary action, sanctions, or suspension of license. Printed verification from the state's website, or a copy of a current license is NOT sufficient.
 - b. Proof of successful completion of the AMFTRB exam.
8. 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 Street, Second Floor, Frankfort, KY 40601.
9. Please see 201 KAR 32:110 if you intend to practice in Kentucky using Telehealth services.
10. Please be advised that, upon receiving a license from the Kentucky Board of Licensure for Marriage and Family Therapists, you are responsible for complying with all requirements set forth in KRS 335.300–399 and 201 KAR Chapter 32.

Personal Background:

Last Name: _____ First Name: _____ Middle Initial: _____

Previous Name: _____ Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Email Address: _____

County of Residence: _____

Examination Requirement:

Answer "Yes" or "No": **PROOF OF SUCCESSFUL COMPLETION OF THE EXAM MUST BE SUBMITTED WITH THIS APPLICATION**

Select one: AMFTRB BBS Date taken: _____ Passed: Yes No

List all licenses issued by any state which you now hold or have ever held as an independent Marriage and Family Therapist. Use additional sheets if necessary.

1. Issuing State: _____

 Date Verification was Requested: _____

2. Issuing State: _____

 Date Verification was Requested: _____

3. Issuing State: _____

 Date Verification was Requested: _____

NOTE: We **must** have a verification of licensure directly from the state or jurisdiction in which you hold, or have held, a license. A printed verification from the state Board's website is NOT sufficient. Be sure to request the verification in sufficient time for the Board to process it and get it to us at least fourteen (14) days prior to our next board meeting date.

Have you every 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? If yes, give details. Use a separate page if needed.

YES NO

Have you ever been convicted of a felony or misdemeanor, or do you have any pending criminal or civil charges? If yes, name offense, case number and provide supporting court documentation. Use a separate page if needed.

YES NO

Have you ever been sanctioned by AAMFT or by any professional association for ethical misconduct? If yes, give details. Use a separate page if needed. YES NO

Have you ever been subject to disciplinary action regarding any professional license issued by any state, or do you currently have any pending disciplinary matters? If yes, give details. Use a separate page if needed.

YES NO

APPLICANT'S 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: _____



KENTUCKY BOARD OF LICENSURE FOR MARRIAGE AND FAMILY THERAPISTS

201 KAR 32:020
DIRTY
FILED 9/14/2026

P.O. Box 1360, Frankfort, Kentucky 40602 ~ 911 Leawood Drive, Frankfort, Kentucky 40601

Phone (502) 564-3296 ~ <http://mft.ky.gov>

Applicant Name _____

LICENSURE AS A MARRIAGE AND FAMILY THERAPIST RENEWAL APPLICATION

Your Marriage and Family Therapist license expires on the date listed on our website. In accordance with KRS Chapter 335 and regulations governing this profession, you are required to renew your license each year by completing and submitting this form, the renewal fee of \$150.00 and listing the continuing education courses taken in the last licensure year on the next page.

NOTE: A minimum number of required continuing education units, including required Ethics CEUs must be listed; if you are a Board Approved Supervisor (BAS), CEUs required for **renewing** that status may also count as part of the total number of CEUs required. A late fee of \$75.00 must be submitted in addition to the renewal fee if processed after your expiration date and before the 90 day grace period. All fees must be paid by check or money order made payable to the Kentucky State Treasurer or online by credit card. (A service fee is added to credit card payments.) **Incomplete applications will not be processed or reviewed but will be returned to the applicant. There will be no exceptions.**

License Number: _____ Expiration Date: _____

1. Identity

NAME: Last First Middle (As you wish to appear on your license)

Social Security Number _____

2. Contact Information

Are there any changes in your contact information since your last application? Yes No
If yes, is the information change to your personal phone number () home address ()
business phone () business phone () business address () email contact ()?

Personal Mailing Address: STREET CITY STATE ZIP

Personal Phone Numbers: CELL HOME COUNTY OF RESIDENCE

Preferred Email Address _____

Name Of Employer/Business _____

Address: STREET CITY STATE ZIP

Business Phone Contact: Office _____



KENTUCKY BOARD OF LICENSURE FOR MARRIAGE AND FAMILY THERAPISTS

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Phone (502) 564-3296 ~ <http://mft.ky.gov>

Applicant Name _____

SECTION THREE

Effective July, 2016, 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.

LICENSEE STATEMENT

I, the licensee named in the above application, declare 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 misrepresentation or falsification, my license could be subject to disciplinary action by the Kentucky Board of Licensure of Marriage and Family Therapists.

Applicant's Signature _____ Date _____

(Sign your name and do not print or type)

Please use this checklist to ensure that your application has been completed correctly and that you have mailed all necessary information to the Board. Applications with information missing will not be processed or reviewed for approval.

- Section 1— Personal Background. If you answer "yes" to numbers 4 OR 5 you MUST include the required information for your application to be approved. Insufficient information will cause your application to be deferred pending complete information.
- Section 2—Continuing Education Units. Have you listed the minimum number of required continuing education units, including required Ethics CEUs? For Board Approved Supervisors, those continuing education units taken to renew the supervisor status may also be included in the overall CEU total. However, initial supervisor training CEUs cannot count in the overall total. PLEASE NOTE: There will be a \$75.00 penalty assessed in addition to a possible late fee of \$75.00 if the CEUs submitted do not meet all regulatory requirements at the time of renewal.
- Section 3—Have you signed (not printed or typed) and dated your application?
- Have you enclosed the required \$150.00 application fee made payable to the Kentucky State Treasurer? If your application is postmarked AFTER the expiration date of your license but before the end of the 90 day grace period, you must also include an additional late fee of \$75.00.



Kentucky Board of Licensure for Marriage & Family Therapists
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LICENSURE AS A MARRIAGE AND FAMILY THERAPIST RENEWAL APPLICATION

General Information:

- Your Marriage and Family Therapist license expires on the date listed on our website.
- In accordance with KRS Chapter 335.300-399 and 201 KAR Chapter 32, you are required to renew your license each year by completing and submitting this form, the nonrefundable renewal fee of \$150.00 and listing the continuing education courses taken in the last licensure year on the next page.
- A minimum number of required continuing education units, including required Ethics CEUs must be listed; if you are a Board Approved Supervisor (BAS), CEUs required for renewing that status may also count as part of the total number of hours required.
- A late fee of \$75.00 must be submitted in addition to the renewal fee if the application is postmarked after your expiration date and before the 90-day grace period. If you are submitting the paper version of this application, fees must be paid by check or money order made payable to the Kentucky State Treasurer. **DO NOT SEND CASH.**

Please mark the appropriate box:

Remaining on active status.

Requesting an inactive status. See 201 KAR 32:081. **REMINDER:** Persons on inactive status shall not practice Marriage and Family Therapy.

SECTION ONE: APPLICANT INFORMATION

License Number: _____ Expiration Date: _____

Identifying Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Prior Names Used: _____ Social Security Number: _____

Mailing Address: _____ Email: _____

City: _____ State: _____ Zip Code: _____

Personal Phone: _____ Business Phone: _____

Name of Employer/Business: _____ Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Changes in Contact Information:

Are there any changes in your contact information since your last application? YES NO

If yes, check any information where there is a change:	Personal phone numbers	Home address
Business address	Business phone	Business address
		Email contact

Applicant Questions:

1. Have you been convicted of a felony or misdemeanor since the last renewal of your license YES NO
If yes, name the offense, case number and give background information, including court documentation.
Add pages as needed.

2. Has your Marriage and Family Therapist license or any other professional credential in Kentucky YES NO
or any other state been subject to disciplinary action?

If yes, list credential, State involved, name the disciplinary action taken and give background information.
Add pages as needed.

SECTION TWO: CONTINUING EDUCATION

Please list the continuing education training completed during the last licensure year.

Do NOT attach documentation unless you are being audited. If you are being audited, you will be notified by the Board.

Training Titles - Designate Ethics Course with *	Dates Attended (MM/DD/YYYY)	Number of Continuing Education Units Earned
--	--------------------------------	--

Total Number of CEU's Earned this Licensure Cycle: _____

I verify with my initials that I have completed:

_____ Six hours of training in the field of suicide assessment, treatment and management as required by KRS 210.366

_____ Three hours of training in the field of domestic violence, as required by KRS 194A.540.

APPLICANT'S 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 license revoked by the Board.

Signature of Applicant : _____ Date: _____

CHECKLIST

Please use this checklist to ensure that the application has been completed correctly and that you have mailed all necessary information to the Board. Applications with missing information will not be processed or reviewed for approval.

- Section 1— Personal Background. If you answer “yes” to numbers 3 OR 4 you MUST include the required information for your application to be approved. Insufficient information will cause your application to be deferred pending complete information.
- Section 2—Continuing Education Units. Have you listed the minimum number of required continuing education units, including required Ethics CEUs? For Board Approved Supervisors, those continuing education units taken to renew the supervisor status may also be included in the overall CEU total.
- Have you enclosed the required \$150.00 application fee made payable to the Kentucky State Treasurer? If your application is postmarked AFTER the expiration date of your license but before the end of the 90-day grace period, you must also include an additional late fee of \$75.00.



KENTUCKY BOARD OF LICENSURE FOR MARRIAGE AND FAMILY THERAPISTS

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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 continuing education hours have listed.**

COMPLETE THE FOLLOWING (print on back)

I. Mailing Address:

Name: _____
Last First Middle
Street State Zip

2. E-Mail Address: _____ 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 at least (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 domestic violence within three years of Kentucky licensure approval.

CERTIFICATE OF VERACITY

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 statement of 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

REACTIVATION REVIEW - FOR BOARD MEMBER USE ONLY

Application: Approved _____ Approved Provisionally _____ Deferred _____ Denied _____ **Date** _____

Committee Signatures _____

Comments: _____

Resubmitted: _____ Date: _____

Approved _____ Approved Provisionally _____ Deferred _____ Denied _____

Committee Signatures _____

Comments: _____



Kentucky Board of Licensure for Marriage & Family Therapists

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APPLICATION FOR EXPIRED LICENSE REINSTATEMENT

GENERAL INFORMATION

- In accordance with KRS 335.340 the Board may reactivate your license within three years of license expiration.
- This form must be submitted with the \$100.00 reinstatement fee plus the \$150.00 annual renewal fee for each year since that date of expiration. The fee should be paid by check or money order made payable to the Kentucky State Treasury. DO NOT SEND CASH.
- 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. See 201 KAR 32:030 Section 8 and 201 KAR 32:060.

APPLICANT INFORMATION

Identifying Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Prior Names Used: _____ Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Business Phone: _____ SSN: _____

Email: _____

License Number: _____ Expiration Date: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Applicant Questions:

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

If yes, what offense and give details.

2. 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? YES NO

If yes, give details.

CONTINUING EDUCATION HOURS

Documentation to support the continuing education hours you have listed must be attached.

Training Titles - Designate Ethics Course with *	Dates Attended (MM/DD/YYYY)	Number of Continuing Education Units Earned

APPLICANT AFFIDAVIT

I, the licensee named in the above, do declare 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.

Signature of Applicant : _____ Date: _____



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, Fax (502) 564-4818 ~ <http://mft.ky.gov>

CONTINUING EDUCATION PROGRAM PROVIDER APPROVAL APPLICATION

PURSUANT TO 201 KAR 32:030, Section 9.

(1) There shall be a nonrefundable fee of \$100 for a single continuing education workshop offered an unlimited number of times in a calendar year, January 1 to December 31.

(2) There shall be a nonrefundable fee of \$300 for a provider designated as an approved sponsor for continuing education and that is providing more than one (1) continuing education program for two (2) consecutive calendar years, January 1 to December 31.

Please note that approval expires at the end of the calendar year.

CONTACT INFORMATION

Provider _____ Name of Primary Contact _____
Street Address _____ City _____ State _____ Zip Code _____
Phone Number _____ Email address _____

PROGRAM INFORMATION

Program Title: _____
of CE Hours being requested: _____
Program Site: _____
Program Date: _____
Method of Presentation: _____

Please Attach Documentation of the Following to This Application:

Published Course or seminar description:	Yes ☐	No ☐
Complete resume' of each instructor(s):	Yes ☐	No ☐
Copy of the program indicating hours of education:	Yes ☐	No ☐
Timed agenda including coffee and lunch breaks listed:	Yes ☐	No ☐
Copy of evaluation tool to be used:	Yes ☐	No ☐
Official certificate from the provider:	Yes ☐	No ☐

The official certificate must include the following statement:
"KY LMFT Board granted approval for this program on ____ (date.)"

Programs requiring board review and approval shall be submitted at least sixty (60) days prior to the beginning date of the program.

Applicant's Signature _____

Date _____

July 2021



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 | mft@ky.gov

APPLICATION FOR CONTINUING EDUCATION PROGRAM APPROVAL – PROVIDER

This form must be submitted at least sixty (60) days in advance of the commencement of the program with the applicable fee.

PURSUANT TO 201 KAR 32:030, Section 10:

(1) There shall be a non-refundable fee of \$100 for a single continuing education workshop offered an unlimited number of times within one year of approval. Please note that approval expires one year from the date of approval.

CONTACT INFORMATION

Provider: _____ Name of Primary Contact: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

PROGRAM INFORMATION

Program Title: _____ # of CE Hours Requested: _____

Program Site: _____ Program Date: _____

Method of Presentation: _____

ATTACHMENTS

Please attach documentation of the following to this application:

- | | | |
|---|-----|----|
| • Published Course or seminar description | YES | NO |
| • Complete resume' of each instructor(s) | YES | NO |
| • Copy of the program indicating hours of education | YES | NO |
| • Timed agenda including breaks listed | YES | NO |
| • Copy of evaluation tool to be used | YES | NO |
| • Official certificate from the provider | YES | NO |

The official certificate must include the following statement:

"KY LMFT Board granted approval for this program on _____ (date.)"

Programs requiring board review and approval should be submitted at least sixty (60) days prior to the beginning date of the program.

APPLICANT'S SIGNATURE: _____ DATE: _____



KENTUCKY BOARD OF LICENSURE FOR MARRIAGE AND FAMILY THERAPISTS

P.O. Box 1360, Frankfort, KY 40602 ~ 500 Mero St. 2 SC 32, Frankfort, KY 40601 Phone
(502) 782-8809, Fax (502) 564-4818 ~ <http://mft.ky.gov>

APPLICATION FOR CONTINUING EDUCATION PROGRAM APPROVAL INDIVIDUAL

(*For Post Approval Only)

Individual Licensee/Associate

License/Permit # _____

(Please print name) : _____
Last First Middle

Street Address City State Zip Code

Phone Number Email address

PROGRAM INFORMATION

Sponsoring Entity: _____

Program Title: _____

Program Speaker(s) _____

of CE Hours being requested: _____

Program Site: _____

Program Date(s): _____

Method of Presentation: _____

Please Attach Documentation of the Following to This Application:

____ Timed agenda of program including CEU's, presenters and breaks.

____ Complete bio of each presenter(s) to include education, credentials, and related experience.

____ Published Course or seminar description to include objectives and goals.

When possible, please submit request for approval prior to your renewal date.

Applicant's Signature _____

Date _____

2016



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 | mft@ky.gov

APPLICATION FOR CONTINUING EDUCATION PROGRAM POST-APPROVAL – INDIVIDUAL

Please submit request for approval prior to your renewal date.

APPLICANT INFORMATION

Individual Licensee/Associate: _____ License/Permit #: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

PROGRAM INFORMATION

Sponsoring Entity: _____ Program Date(s): _____

Program Title: _____ Program Site: _____

Program Speaker(s): _____

of CE Hours Requested: _____

Method of Presentation: _____

ATTACHMENTS

Please attach documentation of the following to this application:

- | | | |
|--|-----|----|
| • Timed agenda of program including CEU's, presenters and breaks. | YES | NO |
| • Complete bio of each presenter(s) to include education, credentials, and related experience. | YES | NO |
| • Published Course or seminar description to include objectives and goals. | YES | NO |
| • Certificate of completion. | YES | NO |

APPLICANT'S SIGNATURE: _____ DATE: _____



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, Fax (502) 564-4818 ~ <http://mft.ky.gov>

201 KAR 32:030
DIRTY
FILED 9/14/2026

APPLICATION FOR CONTINUING EDUCATION SPONSOR

This application is for providers to receive KY LMFT Board Approved Continuing Education status as an approved sponsor. "Sponsor" means a person or an organization approved by the Kentucky Board of Marriage and Family Therapy to provide more than (1) one continuing education program over the course of 2 years. The fee for review of a "Sponsor Application for Continuing Education Credit Approval" is \$300. Approval will be in effect for a period of two (2) consecutive years. Application must be submitted at least sixty (60) days in advance of the commencement of the program. An approved continuing education sponsor shall submit an annual report of the education programs offered during the year. The following courses will need to be individually approved by the board: the six-hour supervision training course, the one and-two hour refresher supervision course, the Kentucky ethics course, and the 15-hour telehealth course.

Continuing Education Sponsor Provider Information:

Name of Organization/Provider: _____
Mailing Address: _____
City, State, Zip: _____
Physical Address if Different from Above: _____
Business Phone: _____
Business E-mail: _____

Sponsor Administrator Information

The applicant must designate an authorized representative to serve as sponsor administrator. (The administrator is responsible for assuring that the continuing education programs offering Kentucky LMFT Board approved credit and the qualifications of all program presenters satisfy the Kentucky LMFT Board requirements). Among other responsibilities, the sponsor administrator serves as the primary contact person with the Kentucky LMFT Board concerning sponsor program matters.

Name: _____
Title: _____
E-mail Address: _____
Phone: _____

Sponsor status is granted by the KY LMFT Board to eligible providers demonstrating compliance with all sponsor provider requirements. If granted sponsor status, the approved sponsor is authorized to offer KY LMFT Board approved credit for qualifying programs and courses for a period of two (2) consecutive years. Individual courses will not need to be preapproved, except the six-hour supervision training course, the one and two hour refresher supervision course, the Kentucky ethics course, and the 15-hour telehealth course. There is no additional fee for these courses.

Sponsor Status Eligibility Requirements

In order to qualify for sponsor status, an application must satisfy all KY LMFT Board eligibility requirements, including the following:

- a. The applicant must present one continuing education course that would qualify for KY LMFT credit.
- b. Although only one course is presented, it is understood that it serves as an example and all courses providing KY LMFT Continuing Education credit must follow the same guidelines.
- c. The CE course presented must include the following:

Published course or similar presentation	Yes _____ No _____
Complete resume of each instructor(s)	Yes _____ No _____
Copy of the program indicating continuing education	Yes _____ No _____
Time agenda including coffee and meal breaks listed	Yes _____ No _____
Copy of the evaluation tool to be used	Yes _____ No _____
Official certificate from the provider	Yes _____ No _____
The official certificate must include the following statement: "KY LMFT Board granted approval for this program on _____ (date)."	

The above information **must** be kept on file for all of the programs and courses presented as KY LMFT Board approved. The Board may request a copy of the documentation at any time.

Check the delivery format(s) for which you are applying (You may check both):

_____ **Live Event Delivery Format:** Real-time, interactive programs either delivered in person or by electronic devices that permit the participant to interact with the presenter(s).

_____ **Home Study Delivery Format:** Text-based learning materials, on demand webinars, and other audiovisual materials that include an assessment demonstrating that the participant has completed the program.

1. Describe how continuing education of MFT's support the overall goals of the provider.

2. Describe the target audience (educational level and profession) to whom you have directed your continuing education programs.

3. The applicant will provide all legally required accommodations to participants. **(Live Event Delivery Format Only):** All live programs offered for KY LMFTs must be presented in facilities compliant with all federal and state laws, including The Americans with Disabilities Act (ADA).

YES _____ NO _____

4. Describe the process by which you select presenters/activities for your continuing education programs.

5. Does the provider maintain policies concerning program fees, refunds, and cancellations?

YES _____ NO _____

6. Describe the organization's procedure for verifying attendance including a sign-in/sign-out procedure.

7. Describe the organization's procedure for distributing certificates of completion.

8. Describe the record-keeping process that will be utilized to maintain all materials for a period of five years following each program.

9. Describe the method by which program evaluation results are obtained from participants and how the evaluation results are used for future program planning.

To receive KY LMFT CE credit, the program of study must meet the Continuing Education requirements as established by KY Law 201 KAR 32:060, Section 1 which reads as follows:

- (1) Effective January 1, 2017, a minimum of fifteen (15) approved continuing education hours shall be accrued by each licensee and a minimum of ten (10) approved continuing education hours shall be accrued by each associate during each one (1) year renewal period.
- (2) All hours shall be in "the practice of marriage and family therapy" as defined by KRS 335.300 and shall relate to the professional application of psychotherapeutic and systems theories and techniques to the delivery of services to individuals, couples, and families.

KRS 335.300(4) provides: "The practice of marriage and family therapy" means the identification and treatment of cognitive, affective, and behavioral conditions related to marital and family dysfunction that involve the professional application of psychotherapeutic and systems theories and techniques in the delivery of services to individuals, couples, and families. Nothing in this section shall be construed to authorize any licensed marriage and family therapist or marriage and family therapy associate to administer or interpret psychological tests in accordance with provisions of KRS Chapter 319.

I attest that the information provided in this application is complete. If approved as a continuing education sponsor, the provider will comply with the terms set forth by the MFT Board. Board approval will be for a period of two (2) consecutive years and will include all programs and courses that meet Board regulations as stated above. The Board has the right to audit, at any time, programs and courses to evaluate if they meet requirements.

Name of Authorized Representative: _____

Signature: _____ Date: _____

Send application, required materials, and payment to:
Kentucky Board of Licensure for Marriage and Family Therapy
P.O. Box 1360, Frankfort, KY 40602





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 | mft@ky.gov

APPLICATION FOR CONTINUING EDUCATION SPONSOR

Application must be submitted at least sixty (60) days in advance of the commencement of the program.

General Information:

- This application is for providers seeking Kentucky Board of Licensure for Marriage and Family Therapists Approved Sponsor status to offer continuing education programs.
- Upon the approval of this application, the person or organization approved by the Kentucky Board of Licensure for Marriage and Family Therapists may provide more than one (1) continuing education program within two (2) consecutive calendar years of approval.
- There shall be a nonrefundable fee of \$300 for review of this application.
- An approved continuing education sponsor shall submit an annual report of the education programs offered during the year.
- The following courses shall require the submission of separate Continuing Education Application – Provider applications to the Board:
 - The six (6) hour supervision training course;
 - The one (1) and two (2) hour refresher supervision courses;
 - The Kentucky ethics course; and
 - The fifteen (15) hour telehealth course.

CONTINUING EDUCATION SPONSOR PROVIDER INFORMATION:

Name of Organization/Provider: _____

Mailing Address: _____

City, State, Zip: _____

Physical Address if
Different from Above: _____

Business Phone: _____

Business Email: _____

Sponsor Administrator Information

The applicant must designate an authorized representative to serve as sponsor administrator. (The administrator is responsible for assuring that the content of all programs offering Kentucky LMFT credit and the qualifications of all program presenters satisfy the Kentucky LMFT Board requirements). Among other responsibilities, the sponsor administrator serves as the primary contact person with the Kentucky LMFT Board concerning sponsor program matters.

Name: _____

Title: _____

E-mail Address: _____

Phone: _____

Sponsor Status Eligibility Requirements



KENTUCKY BOARD OF LICENSURE FOR MARRIAGE & FAMILY THERAPISTS

PUBLIC PROTECTION CABINET — DEPARTMENT OF PROFESSIONAL LICENSING

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In order to qualify for sponsor status, an application must satisfy all KY LMFT Board eligibility requirements, including the following:

- a. The applicant must present one continuing education course that would qualify for KY LMFT credit.
- b. Although only one course is presented, it is understood that it serves as an example and all courses providing KY LMFT Continuing Education credit must follow the same guidelines.
- c. The CE course presented must include the following:

Published Course or seminar description:	☐ Yes	☐ No
Complete resume' of each instructor(s):	☐ Yes	☐ No
Copy of the program indicating hours of education:	☐ Yes	☐ No
Timed agenda including breaks listed:	☐ Yes	☐ No
Copy of evaluation tool to be used:	☐ Yes	☐ No
Official certificate from the provider:	☐ Yes	☐ No

The official certificate must include the following statement: "KY LMFT Board granted approval for this program on ____ (date.)"

The above information **must** be kept on file for each of the programs and courses presented as KY LMFT Board approved. The Board may request a copy of the documentation at any time.

Check the delivery format(s) for which you are applying (You may check both):

____ Live Event Delivery Format: Real-time, interactive programs either delivered in person or by electronic devices that permit the participant to interact with the presenter(s).

____ Home Study Delivery Format: Text-based learning materials, on demand webinars, and other audiovisual materials that include and assessment demonstrating that the participant has completed the program.

1. Describe how continuing education of MFT's supports the overall goals of the provider.

2. Describe the target audience (educational level and profession) to whom you have directed your continuing education programs.

3. The applicant will provide all legally required disability accommodations to participants. (Live Event Delivery Format Only): All live programs offered for KY LMFT credit will be presented in facilities compliant with all federal and state laws, including The Americans with Disabilities Act (ADA).

YES _____ NO _____



KENTUCKY BOARD OF LICENSURE FOR MARRIAGE & FAMILY THERAPISTS

PUBLIC PROTECTION CABINET — DEPARTMENT OF PROFESSIONAL LICENSING

P.O. Box 1360, Frankfort, Kentucky 40602

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4. Describe the process by which you select presenters/authors for your continuing education programs.

5. Does the provider maintain policies concerning program fees, refunds, and cancellations?

YES _____ NO _____

6. Describe the organization's procedure for verifying attendance including a sign-in/sign-out procedure.

7. Describe the organization's procedure for distributing certificates of completion.

8. Describe the record-keeping process that will be utilized to maintain all materials for a period of five years following each program.

9. Describe the method by which program evaluations are obtained from participants and how the evaluation results are used for future program planning.

To receive KY LMFT CE credit, the program of study must meet the Continuing Education requirements as established by 201 KAR 32:060, Section 1 which reads as follows:

1. A minimum of fifteen (15) approved continuing education hours shall be accrued by each licensee and a minimum of ten (10) approved continuing education hours shall be accrued by each associate during each one (1) year renewal period.
2. All hours shall be in "the practice of marriage and family therapy" as defined by KRS 335.300 and shall relate to the professional application of psychotherapeutic and systems theories and techniques to the delivery of services to individuals, couples, and families.



KENTUCKY BOARD OF LICENSURE FOR MARRIAGE & FAMILY THERAPISTS

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KRS 335.300(4) provides: “The practice of marriage and family therapy” means the identification and treatment of cognitive, affective, and behavioral conditions related to marital and family dysfunction that involve the professional application of psychotherapeutic and systems theories and techniques in the delivery of services to individuals, couples, and families. Nothing in this section shall be construed to authorize any licensed marriage and family therapist or marriage and family therapy associate to administer or interpret psychological tests in accordance with provisions of KRS Chapter 319.

AFFIDAVIT

I attest that the information provided in this application is complete. If approved as a continuing education sponsor, the provider will comply with the terms set forth by the MFT Board. Board approval will be for a period of two years and will include all programs and courses that meet KY law as stated above. The Board has the right to audit, at any time, programs and courses to evaluate if they meet requirements.

NAME OF AUTHORIZED REPRESENTATIVE: _____

DATE: _____ APPLICANT'S SIGNATURE: _____