

**KENTUCKY BOARD OF LICENSURE
OF MARRIAGE AND FAMILY THERAPISTS**

PO Box 1360
Frankfort, KY 40602
(502) 782-8809
<http://mft.ky.gov>

MFT LICENSE REINSTATEMENT APPLICATION

Name: _____ **SSN:** _____
Address: _____
City: _____ **State** _____ **License #** _____ **Expiration Date:** _____
Zip: _____

Your Marriage and Family Therapist license expired on the date indicated above. In accordance with KRS 335.340 the Board may approve to reinstate your license **within three years of the anniversary date of the issue of renewal**. Reinstatement may be requested with the completion and submission of this form, a reinstatement fee of \$100.00 plus \$100 annual renewal fee for one year since the date of last active licensure, and evidence of completion of the annual requirement of continuing education hours (fifteen [15] clock hours, **three (3) hours must be in Ethics Training**). Fee should be paid by check or money order made payable to the **Kentucky State Treasurer**. Please indicate on the back of this form the continuing education hours obtained, including course title, and complete date. **Please attach documentation to support the continuing education hours you have listed.**

PLEASE COMPLETE THE FOLLOWING (Please print)

1. Present Mailing Address:

Name: _____

Address: _____

E-Mail Address: _____ **Date** _____ **Month** _____

2. Present Business Address:

Name: _____

Address: _____

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

4. License Number _____ Social Security Number _____

5. 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 _____

6. 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,

(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

CERTIFICATION OF TRUTH

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 omission, my license could be subject to disciplinary action by the Kentucky Board of Licensure of Marriage and Family Therapists.

Date _____ Applicant's Signature _____
(Sign in ink - Do not print or type)

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

*** REINSTATEMENT 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: _____



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 Frankfort, Second Floor, Kentucky 40601 (Overnight Delivery Only)

Phone: (502) 782.8809 | Fax: (502) 564.4818 | mft.ky.gov | mft@ky.gov

APPLICATION FOR REVOKED LICENSE REINSTATEMENT

GENERAL INFORMATION

- In accordance with KRS 335.360 the Board may reinstate your license within five years of license revocation.
- This form must be submitted with the \$100.00 reinstatement fee plus the \$175.00 initial licensure fee. The fee should be paid by check or money order made payable to the Kentucky State Treasurer. 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: _____ Revocation Date: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Applicant Questions:

1. Have you been convicted of a felony or misdemeanor in any jurisdiction since the revocation of your license?

YES NO

If yes, what offense and give details and supply supporting documentation.

2. Have you received any disciplinary action in any other state since the revocation of your license?

YES NO

If yes, what offense and give details and supporting documentation.

REHABILITATION STATEMENT

Describe in detail all actions or efforts you have taken within the last five years that demonstrate your rehabilitation and fitness for reinstatement of your license. Include all supporting documentation.

Duplicate form as needed.

CONTINUING EDUCATION HOURS

Documentation to support the continuing education hours you have listed must be attached.
(Add additional pages as needed)

Training Titles - Designate Ethics Course with *

Dates Attended	Number of Continuing	(MM/DD/YYYY)	Education Units Earned
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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: _____