State of Utah
Department of Commerce
Division of Occupational and Professional Licensing

Request to Extend: Associate Marriage and Family Therapist Counselor License

APPLICANT INFORMATION

Full Legal Name: _____
First *Middle* *Last*

All Previous Legal Names: _____

AMFT/AMFT Extern License Number: _____

SSN: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

_____
City *State* *ZIP Code*

Phone: _____ **Email:** _____

Please Select ONE:

- ☐ I am a United States citizen OR a non-citizen of the United States who is lawfully present.
- ☐ I am a foreign national not physically present in the United States.
- ☐ None of the above, please explain: _____

Driver License or State ID Card: _____
State of Issue *License Number* *Expiration Date*

NOTE: If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of legal presence in the United States.

CHECKLIST

You must include the following items with this request:

- ☐ Narrative explaining why you are requesting the extension and your plan to complete the outstanding license requirements, including the length of the extension you are requesting.
- ☐ Verification of Hours (see attached form) completed by your supervisor attesting to the hours you have completed thus far. Only hours used while licensed as an AMFT or AMFT Extern can be counted. Use a separate form for each supervisor and/or location.
- ☐ Completed Extension Request Worksheet (see attached)
- ☐ Documentation of Continuing Education (if required). Copies of certificates must include your name, date of the course, name of the course provider, name of the instructor, course title, and number of hours of continuing education credit.

Submit the above items with your completed application to:

In person or via express delivery:
Division of Occupational and Professional Licensing
Heber M Wells Building, 1st Floor Lobby
160 E 300 S
Salt Lake City, UT 84111

US Postal Service:
Division of Occupational and Professional Licensing
PO BOX 146741
Salt Lake City, UT 84114-6741

If you have questions, please contact the Division via our direct email address, doplbureau3@utah.gov , or via the phone or fax listed below.

Extension Request Worksheet

APPLICANT INFORMATION

Full Legal Name: _____
First *Middle* *Last*

Mailing Address: _____
Street/PO Box *City* *State/Zip*

I am requesting and extension in order to complete (check all that apply): ☐ Hours ☐ Exam ☐ Other: _____

EXPERIENCE

In addition to completed Verification of Hours forms from each supervisor, please provide the following information:

Have you completed the 4000 hour POST-GRADUATE experience?

☐ Yes – Date Completed: _____

☐ No – Overall Amount Completed: _____

Hours of Mental Health Therapy with Couples or Families: _____

Other Hours of Mental Health Therapy: _____

Additional Hours of MFT Training: _____

Total Direct Supervision Hours: _____

EXAM HISTORY

Have you taken and passed the required exam?

☐ Yes – Date Completed (include score report): _____

☐ No – Check all that apply, and provided the appropriate information for each question:

☐ I have attempted on the following dates (include score reports):

_____, _____

_____, _____

☐ I am scheduled to take the exam on (date): _____

☐ I am not scheduled, put anticipate taking the exam on (date): _____

Verification of Post-Graduate Supervised Experience

Each supervisor must complete a separate form. The hours from all forms must total 4,000.

APPLICANT INFORMATION

To be completed by the applicant.

Full Legal Name: _____
First *Middle* *Last*

Mailing Address: _____
Street/PO Box *City* *State/Zip*

EMPLOYMENT INFORMATION

To be completed by the Supervisor.

Name of Establishment: _____

Name of Supervisor: _____ **License Number:** _____

Establishment Address: _____
Street/PO Box *City* *State/Zip*

Telephone Number: _____ **Email:** _____

Dates of Supervision as an AMFT: _____ to _____
MM/DD/YYYY *MM/DD/YYYY*

Hours of Direct Supervision: _____

Hours of Mental Health Therapy with Couples or Families: _____

Other Hours of Mental Health Therapy: _____

Additional Hours of MFT Training: _____

Total of all supervised marriage and family therapy training hours: _____

Describe the applicant's duties: _____

_____

_____

Did the applicant and supervisor work in the same place of employment? ☐ Yes ☐ No
If "no", describe how you were able to provide supervision: _____

_____

I do hereby certify that the applicant for licensure as a clinical mental health counselor has successfully completed the above hours of post-graduate supervised experience as a W-2 employee of the facility listed. I certify that the experience supervised meets the requirements outlined in R156-60c-302b and 401.

I further certify that the applicant is qualified and competent to practice as a clinical mental health counselor.

Signature of Supervisor: _____ **Date:** _____