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

☐ **Associate Marriage and Family Therapist**
☐ **Associate Marriage and Family Therapist Extern**

APPLICANT INFORMATION

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

All Previous Legal Names: _____

Other DOPL Licenses Held: _____

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 lawful presence in the United States.

AFFIDAVIT AND RELEASE

1. I certify that I am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
5. I certify that I do not currently pose a direct threat to myself, to my clients, or to the public health, safety or welfare because of any circumstance or condition.
6. I understand that I am responsible to update the Division of any changes relating to my license/certification/registration.

Signature of Applicant: _____ Date _____

QUALIFYING QUESTIONNAIRE

Do not leave any question blank.

DOPL may request additional documentation if the information submitted is insufficient.

1. ☐ Yes ☐ No Have you EVER had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, resigned, or surrendered while under investigation, or otherwise **disciplined in any way**?

2. ☐ Yes ☐ No Do you CURRENTLY have **any criminal action active or pending**?

3. ☐ Yes ☐ No WITHIN THE PAST 10 YEARS, have you pled **guilty** to, **no contest** to, entered into a **plea in abeyance,** or been **convicted** of **a misdemeanor** in any jurisdiction?

4. ☐ Yes ☐ No Have you EVER pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a **felony** in any jurisdiction?

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "Yes" to questions 2,3, or 4 you must submit the following for EACH and EVERY incident:

- personal account of the incident
- police report(s)
- court record(s)
- probation/parole officer report(s)

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

NOTE:

- **DISCLOSE** charges that were later held in abeyance, diverted, reduced, or dismissed.
- **DISCLOSE** motor vehicle offenses such as driving while impaired or intoxicated. But you do not need to disclose minor traffic offenses such as parking or speeding violations.
- You do **not need to disclose** juvenile offenses, unless you were tried as an adult.
- **DISCLOSE** if you are restricted from possession, purchase, transfer, or ownership of a firearm or ammunition (even if your restriction is based on a non-reportable juvenile conviction).
- You do **not need to disclose** legally expunged or sealed criminal history incidents.

For more information, see DOPL's criminal history FAQs.

PROFESSIONAL LICENSES

List all other licenses, registrations or certification issued by any state which you now hold or have ever held in any profession. *(Use additional sheets if necessary.)*

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

MEDICAL QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer each question. Do not leave any question blank.

A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: _____

2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: _____

3. Is any action pending against you now by:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: _____

4. ☐ Yes ☐ No Have you been named as a defendant in a malpractice suit?

5. ☐ Yes ☐ No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered **"Yes"** to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. *NPDB website: http://www/npdb.hrsa.gov.*

If you answered **"Yes"** to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

EDUCATIONAL COURSE REQUIREMENTS

To be completed by applicants who have not graduated from a COAMFTE accredited program in marriage and family therapy. Graduates from COAMFTE accredited programs are not required to complete this section.

Use each course only once. *(Use additional sheets if necessary.)*

Theoretical Foundations of Marital and Family Therapy: *(minimum 6 semester or 9 quarter hours)*

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Assessment and Treatment in Marriage and Family Therapy *(minimum 9 semester or 12 quarter hours)*

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Human Development and Family Studies: *(minimum 6 semester or 9 quarter hours)*

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Professional Ethics: *(minimum 3 semester or 4 1/2 quarter hours)*

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Research Methodology and Data Analysis *(minimum 3 semester or 4 1/2 quarter hours)*

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Electives in Marriage and Family Therapy: *(minimum 3 semester or 4 1/2 quarter hours)*

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Supervised Clinical Practicum: *(minimum 600 hours, at least 500 direct contact hours of which 250 hours are with couples or families present and 100 hours of face to face supervision)*

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

Course Title: _____ Course # _____ University: _____

NOTE: *You can expedite the review process by providing a copy of the graduate catalog course description and/or syllabus of any identified course.*

Verification of Supervision for Post-Graduate Mental Health Practice Hours

SUPERVISEE INFORMATION

To be completed by the supervisee.

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

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

License Number: _____ **License Type:** _____

SUPERVISOR INFORMATION

To be completed by the supervisor.

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

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

License Number: _____ **License Type:** _____ **Issue Date*** _____

**Proposed supervisors must have been actively engaged in licensed practice for at least 2 years before supervising post-graduate hours.*

For Supervisors of AMFT's: Please indicate which of the following you have completed in accordance with Utah Admin Code R156-60b-302d(3).

- ☐ Currently approved by AAMFT as an MFT supervisor.
- ☐ Successfully completed a supervision course in a COAMFTE accredited MFT program at an accredited university.
- ☐ Successfully completed 20 clock hours of instruction sponsored by AAMFT or the Utah Association for Marriage and Family Therapy.

For all license types:

☐ Yes ☐ No Is the supervisee a W-2 employee?

☐ Yes ☐ No Is the supervisor and supervisee working in the same place of employment?

If no, please provide a detailed explanation of how supervision is being conducted:

_____

_____

_____

Date Supervision contract was signed: _____

I certify I have read Utah Admin. Code R156-60-302. Supervised Training Requirements-Supervision Contract-Duties and Responsibilities of Supervisor and Supervisee. I understand that hours must be documented using the Division provided Post-Graduate Mental Health Supervised Hours form.

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

Signature of Supervisee: _____ **Date:** _____

Supervision for Post-Graduate Mental Health Practice Hours

Use this form to track your supervision as an AMFT. Total of all hours must be at least 4,000.
Do not turn this form in with your AMFT application. It should be turned in with your MFT application.

SUPERVISEE INFORMATION

Full Legal Name: _____ **License Number:** _____ **Email:** _____
First Middle Last

SUPERVISED HOURS

Supervised Hours. Use additional sheets as needed.

Supervisor	Dates Supervised *(MM/DD/YYYY to MM/DD/YYYY)*	Total Hours	Hours of Mental Health Therapy Training	Hours of Direct Supervision	Did every 10 client hrs. include at least 1 hr. of face to face?	Supervisor's Signature
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
Total from all supervisors:						

Please list each supervisory meeting. Use additional sheets as needed.

Date	Location	Format *(Individual, small group, etc.)*	Supervisor	Supervisor Evaluation (use additional sheets if needed)

Signature of Supervisee: _____ **Date:** _____

APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience; you do not need to include it with your application.
NOTE: Incomplete applications will be denied.

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

ALL APPLICANTS

The following items are required to complete your application:

- ☐ $85.00 non-refundable application-processing fee, made payable to "DOPL".
- ☐ Supporting documentation for any "yes" answers provided on either of the qualifying questionnaires
- ☐ Documentation of meeting the education requirement *(submit one of the options below)*:
  - Official transcripts documenting completion of a master's or doctorate degree from a marriage and family program accredited by COAMFTE.
  - Official transcripts evidencing completion of a master's or doctorate degree in marriage and family therapy from an institution which is accredited by a professional accrediting body approved by CHEA and completion of course requirements. Please use page 4 of this application to record the required courses. ***NOTE:*** *You can expedite the review process by providing a copy of the graduate catalog course description and/or syllabus of any identified course.*

  Note: Transcripts are considered "official" when they are sent directly from the school to DOPL or sealed in an envelope bearing the school's stamp/seal on the envelope flap.
- ☐ "Verification of Supervision for Post-Graduate Mental Health Practice Hours", found in this application. **Note:** This form is not required to obtain a license, but you cannot begin your post-graduate hours until it is on file and approved by the Division.

NOTE TO EXTERNS

A person who applies for licensure who has the MFT degree required but who is found to be deficient in specific courses as required by Utah Administrative Code R156-60b-302(a) may be issued an externship license if approved by DOPL. An extern license expires three years from the date of issuance. This license IS NOT renewable or extendable. If a person does not complete the education requirement and obtain full licensure within the three year time period, he/she will be required to discontinue practice until completing the education and being granted a license.

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, b3@utah.gov, or via the phone or fax listed below.