

Application for Marital & Family Therapy Licensure

Iowa Department of Public Health/Bureau of Professional Licensure

PLEASE PRINT

Instructions are found on page 5

1. _____ 2. _____
Last Name *First Name and Middle Name*
3. _____
Mailing Address (Including PO Box if applicable)
4. _____ 5. _____
City, State, Zip Code *E-Mail Address*
6. _____ 7. _____ 8. _____ -- --
Daytime Phone (Including Area Code) *Date of Birth* *Social Security Number**
9. Male Female 10. _____
Gender (optional question) *If any of your documentation is in a name other than your current name, list the previous names of record.*

The following questions must be answered. If you answer "Yes" to any of the next six questions, (1) attach a signed letter of explanation providing the details of the incident, (2) attach a copy of any court ordered evaluations, showing completion and recommendations, and (3) attach a copy of all official court documents regarding your conviction/malpractice suit, including final disposition and/or settlement. You must answer "Yes" even when a conviction or judgment has been deferred or expunged from your record.

11. Been convicted, found guilty of or entered a plea of guilty or no contest to a felony or misdemeanor crime (Other than minor traffic violations with fines under \$500)?	Yes	No
12. Had any judgments or settlements paid on your behalf as a result of a malpractice suit or claim against you?	Yes	No
13. Been investigated by a licensing, registration, or certification authority or organization; or had a licensing, registration, or certification authority or organization institute disciplinary action against you related to your professional practice? (If the investigation or action was instituted by this licensing board you may answer "NO" to this question).	Yes	No
14. Been disciplined or sanctioned by any licensing, registration, or certification authority or organization related to your professional practice? (If this licensing board took the disciplinary action, you may answer "NO" to this question).	Yes	No
15. Developed a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? (If you are currently a participant in the Impaired Practitioner Review Committee, you may answer "NO" to this question.)	Yes	No
16. Been engaged in illegal or improper use of drugs or other chemical mood altering substances? (If you are currently a participant in the Impaired Practitioner Review Committee, you may answer "NO" to this question.)	Yes	No

Type of Application:

17. Licensure requested by Temporary License Permanent License
18. Have you taken and passed the AMFTRB examination in Marital and Family Therapy? Yes No
Date taken: _____
- If no, do you wish to inform the Board of any physical or mental condition that would require special accommodations for the administration of the examination? Yes No
19. Are you or have you ever been licensed, certified, or registered in another state territory, or country? Yes No
If yes, list the two letter postal code of the states below.

(Please note: Official verifications must be received directly from each state's licensing board office.)

20. Have you achieved American Association for Marriage and Family Therapy clinical membership? Yes No
(If yes, submit proof of clinical membership)

21. **SUPERVISED CLINICAL EXPERIENCE:**

Complete this section and have each supervisor complete and return the "Attestation of Supervision" form to the board office.

A. Supervisor Name: _____

Dates Supervised: From _____ to _____
Month/Year Month/Year

B. Supervisor Name: _____

Dates Supervised: From _____ to _____
Month/Year Month/Year

C. Supervisor Name: _____

Dates Supervised: From _____ to _____
Month/Year Month/Year

D. Supervisor Name: _____

Dates Supervised: From _____ to _____
Month/Year Month/Year

Other supervised clinical experience -- Continue on separate sheet using same format.

EDUCATION (Please check the applicable boxes; transcripts must be sent from the school directly to this office)

22. Masters: _____
Name of Educational Institution

Name of Educational Institution

23. Doctorate: _____
Name of Educational Institution

24. Highest Degree date: _____
Month/Year

25. **Applicant must complete either (A or B) depending on education and accreditation:** (Please read very carefully.)

A. Graduate of a COAMFTE Accredited Marital and Family Therapy Program

I hold a master's or doctoral degree in marital and family therapy of at least 45 semester credit hours or 60 quarter credit hours. My masters or doctoral **program** was accredited specifically in marital and family therapy from a program accredited by the American Association for Marriage and Family Therapy (AAMFT) Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE).

NOTE: Some institutions hold COAMFTE accreditation in related programs. Answer YES to this question **only** if:

- You graduated from a masters or doctoral Marital and Family Therapy **program** in a nationally accredited institution.
- Your Marital and Family Therapy **program** was accredited by COAMFTE at the time of graduation.

Yes No

If you answered YES to this question, request that your school submit an official transcript with the school seal that identifies the date of graduation and degree earned directly to the Iowa Board of Behavioral Science.

B. Graduate of a non-COAMFTE Accredited Marital and Family Therapy Program

I hold a degree that may be content equivalent to a master’s or doctoral degree in marital and family therapy with emphasis in marital and family therapy from a college or university accredited by an agency recognized by the U.S. Department of Education.

NOTE: Answer YES to this question if **all** the following apply:

- You graduated from a master’s or doctoral program in marital and family therapy or an equivalent program with emphasis in marital and family therapy.
- The masters or doctoral **program** from which you graduated was not COAMFTE Accredited in Marital and Family Therapy at the time of graduation.
- The institution from which you earned the masters or doctoral degree was accredited by an agency recognized by the U.S. Department of Education at the time of graduation.
- You completed at least 45 semester or 60 quarter credit hours in marital and family therapy content equivalent areas at the masters or doctoral level.
- You are prepared to submit a transcript, course descriptions or syllabi, and credential evaluation fee to the national credentialing agency that conducts initial education review for the Iowa Board of Behavioral Science.

Yes No

If you answered YES to this question, request an application for education review from the Center for Credentialing and Education at 888-817-8283 (toll free) or cce@cce-global.org. Submit the completed application for education review to the Center for Credentialing and Education.

I certify that I have carefully read the questions on this application and have answered them completely and truthfully. I declare under penalty of perjury that my answers, and all other statements or information submitted by me in this application process, are true and correct. If it is determined at any time that I have provided misleading or false information on or in support of this application, I understand that my application may be denied or that I may be subject to disciplinary action and criminal prosecution if I am already licensed.

I understand that I am required to update answers or information submitted herewith if the response or the information changes during the time period the application is pending. I also understand that this application is a public record in accordance with Iowa Code, Chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law. Finally in submitting this application, I consent to any reasonable inquiry that may be necessary to verify the information I have provided on or in conjunction with this application.

This information is collected pursuant to Iowa Code Chapters 252J, 261 & 272C. Failure to provide mandatory information will result in license denial. **Privacy Act Notice:** Disclosure of your Social Security Number on this license application is required by 42 U.S.C. § 666(a)(13) and Iowa Code § 252J.8(1). The number will be used in connection with the collection of child support obligations and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code § 421.18.

26. _____
Applicant must sign here in ink _____ **Date**

Applications must be complete and signed to be processed. No application will be considered complete until all required supporting documents and fees have been received in the board office. Questions regarding the application process may be directed to 515 281-4422 or paulette.lappe@idph.iowa.gov. An applicant who has been denied licensure by the board may appeal the denial and request a hearing on the issues related to licensure denial by serving a notice of appeal and request for hearing upon the board not more than 30 days following the date of mailing of the notification of licensure denial to the applicant.

When you are licensed, you will be able to view and print your licensure status. Go to www.licensediniowa.gov. Click on License Search, insert your name, and select your profession. Your license and wallet card will be mailed to you after Active status is posted.

All applicants must mail this form bearing their signature in ink and the licensure fee to:

**The Iowa Board of Behavioral Science
Lucas State Office Bldg., 5th Floor
321 E. 12th Street
Des Moines, Iowa 50319-0075**

www.idph.state.ia.us/licensure

Name _____

Date Received _____

INSTRUCTIONS/CHECKLIST. To complete the application, answer each question completely in ink. The following is a list of the supporting documents and fees required for licensure. It is the applicant's responsibility to see that all required documents and fees reach the board office.

Applicants for Permanent Licensure		For Office Use Only
<input type="checkbox"/>	The non-refundable licensure fee is \$120. Make check or money order payable to The Iowa Board of Behavioral Science.	<input type="checkbox"/> Received
<input type="checkbox"/>	FOR GRADUATES OF COAMFTE ACCREDITED MFT PROGRAMS ONLY: Official transcripts with school seal, degree earned, and date of graduation sent directly from the masters or doctoral mental health counseling program/institution to the Board of Behavioral Science	<input type="checkbox"/> Received <input type="checkbox"/> N/A
<input checked="" type="checkbox"/>	FOR GRADUATES OF NON-COAMFTE ACCREDITED MFT PROGRAMS ONLY: Official transcripts with school seal, degree earned, and date of graduation sent directly from the masters or doctoral mental health counseling program/institution to the Center for Credentialing and Education (CCE). Notification of approval, official transcript, and file sent by CCE to the Board of Behavioral Science	<input type="checkbox"/> Received
<input type="checkbox"/>	Proof of clinical membership in the American Association for Marriage and Family Therapy. (if appropriate)	<input type="checkbox"/> Received <input type="checkbox"/> N/A
<input type="checkbox"/>	Official examination scores sent directly to the board office from the examination service.	<input type="checkbox"/> Received
<input type="checkbox"/>	Applicants who hold or have held a marital and family therapist license in any other jurisdiction must have official verification of licensure status mailed directly to this office from each state where you have held a license. This must include expiration date and any pending or past disciplinary action.- _____	<input type="checkbox"/> Received <input type="checkbox"/> N/A
<input type="checkbox"/>	Supervision form(s)	<input type="checkbox"/> Received
Applicants for Temporary Licensure		For Office Use Only
<input type="checkbox"/>	The non-refundable licensure fee is \$120. Make check or money order payable to The Iowa Board of Behavioral Science.	<input type="checkbox"/> Received
<input type="checkbox"/>	FOR GRADUATES OF COAMFTE ACCREDITED MFT PROGRAMS ONLY: Official transcripts with school seal, degree earned, and date of graduation sent directly from the masters or doctoral mental health counseling program to the Board of Behavioral Science	<input type="checkbox"/> Received <input type="checkbox"/> N/A
<input checked="" type="checkbox"/>	FOR GRADUATES OF NON-COAMFTE ACCREDITED MFT PROGRAMS ONLY: Official transcripts with school seal, degree earned, and date of graduation sent directly from the masters or doctoral mental health counseling program/institution to the Center for Credentialing and Education (CCE). Notification of approval, official transcript, and file sent by CCE to the Board of Behavioral Science	<input type="checkbox"/> Received
<input type="checkbox"/>	Supervision form(s) Prior approval of the applicant's supervisor(s)	<input type="checkbox"/> Received
<input type="checkbox"/>	Official examination scores sent directly to the board office from the examination service.	<input type="checkbox"/> Received
For Office Use:		
<input type="checkbox"/>	Approved for Licensure	Initial/Date: _____
<input type="checkbox"/>	Not Approved for Licensure	Initial/Date: _____
Comments:		Staff Initials: _____ Checked By: _____