Marriage & Family Therapist (MFT) License Application Packet

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Marriage and Family Therapist
Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Washington State Department of Health

Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the required forms required.

- ☐ **Do you hold a credential in Washington State?** Check yes or no. If you do hold a credential in Washington State, please provide your license number.
- ☐ **Application Fee**. This fee is non-refundable. You can check the online **fee page** for current fees.
- ☐ **1. Demographic Information:**
  Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

  Legal Name: List your full name: first, middle, and last.

  Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

  Birth date: Provide the month, day and year of your birth.

  Birth place: Provide the city, state and country where you were born.

  Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See **WAC 246-12-310**.

  Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

  Email: Enter your email address, if you have one.

  Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.
- ☐ **2. Personal Data Questions:**
  All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question.

If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Education:**
List in date order your educational preparation and post-graduate training. Attach additional completed pages if you need more space.

☐ **4. Educational Qualifications–Non COAMFTE Accredited Programs**
You are required to complete this section if your graduate school is not accredited by the Commission on Accreditation of Marriage and Family Therapy Education (COAMFTE).

Exam Information

- You will be sent an approval letter after you are approved to take the exam. The letter tells you how to register for the exam. You must pass a national exam (AMFTRB).
- The department receives score reports 6 to 8 weeks from the testing company. You will receive your score by mail. Scores will not be given over the phone. Once you have completed all requirements and have passed the AMFTRB exam and the initial license fee is received, you will get your license.
- If the exam is not required and all other requirements are met, including the initial license fee, you will receive your license.

☐ **5. Experience**
Beginning with current employment, list all activities and account for all periods of time from graduation to the present. A resume will **not** substitute for completion of the application. Please use the initials **N/A** (not applicable) if you have not had professional training and experience.

☐ **6. Examination Data:**
If you took and passed the AAMFT exam, you have met the exam requirement. You must get a written verification from AAMFT sent directly to the Department of Health.

☐ **7. Other License, Certification, or Registration:**

List **all** states (including Washington State) where licenses/certifications/registrations are or were held. Specifically list licenses/certifications/registrations granted by examination, endorsement, or grandparenting.

An “Out of State Verification for Registration/Certification/License” form is enclosed and must be sent to each state listed above. Enter your full name and birth date at the top of the form so the state may identify you. Also contact each state board listed for any fees they might charge you for processing the verification form.

- [ ] **8. AIDS Education and Training Attestation:**
Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of four hours is required. Course content can be found in **WAC 246-12-270**.

- [ ] **9. Continuing Education Attestation:**
Complete 36 hours of continuing education, with six in professional ethics. See **RCW 18.225.090**.

- [ ] **10. Applicant's Attestation:**
You must sign and date this for us to process the application.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **http://www.doh.wa.gov/hsqa/professions/military/** and include supporting documentation with your application.

Experience Requirement

Minimum of **two calendar years** of full-time marriage and family therapy:

a. 100 hours must be with a licensed marriage and family therapist with at least five years clinical experience.

b. 100 hours can be with an equally qualified licensed mental health practitioner.

Total experience requirements include:

a. A minimum of 3000 hours of experience.

b. 1000 hours must be direct client contact, of those 1,000 hours:
   - A minimum of 500 hours must be gained in diagnosing and treating couples and families.

c. A minimum of 200 hours of qualified supervision with a supervisor. Of those 200 hours:
   - 100 hours must be one-on-one supervision.
   - 100 hours can be one-on-one or group supervision.

COAMFTE Accredited Program

If you have completed a master's program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) of the American Association for Marriage and Family Therapy, you can be credited with the following:

a. 500 hours of direct patient contact.

b. 100 hours of formal meetings with an approved supervisor.

If you are not sure whether your university was COAMFTE approved, contact your university.

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Background Check Stamp Here	Date Stamp Here

Revenue: 0207050000

Marriage and Family Therapist License Application

Do you hold a credential in Washington State? ☐ No ☐ Yes

If yes, license # ___________________________________

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions) ☐ Male ☐ Female

Name	First	Middle	Last

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip Code	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address:

Mailing address if different from above address of record

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

For Office Use Only

License # ___________________________________ Issue Date ___________________________________

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

   Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

   The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

   Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

   To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction .... ☐ ☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? .... ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? .... ☐ ☐
   b. Diverted controlled substances or legend drugs? .... ☐ ☐
   c. Violated any drug law? .... ☐ ☐
   d. Prescribed controlled substances for yourself? .... ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? .... ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .... ☐ ☐

9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? .... ☐ ☐

10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? .... ☐ ☐

3. Education

Provide in date order all of your graduate school(s) attended, major, month, and year the degree was granted. Request your transcripts from the graduate school(s) you attended. Have the graduate school send **directly** to the Department of Health.

Graduate School	Degree and Major	Start (mm/yyyy)	End (mm/yyyy)

4. Educational Qualifications—Non COAMFTE Accredited Programs

You must have a masters degree in marriage and family therapy or equivalent course work to apply. If a course listed does not have a clear title describing the content, provide an official syllabus, official course outline or statement from the professor.

The equivalent graduate study course must include courses in marital and family therapy, individual development, psychopathology, human sexuality, research, professional ethics and law, supervised clinical practice, and electives. A total of 45 semester credits or 60 quarter credits are required. A minimum of 27 semester credits or 36 quarter credits are required in the first five areas of study: Marital and Family Systems, Marital and Family Therapy, Individual Development, Psychopathology, Human Sexuality and Research.

1. Marital and Family Systems (2 courses) minimum 6 semester credits or 8 quarter credits.

Course Title	Number	Semester Credits	Quarter Credits

2. Marital and Family Therapy (2 courses) minimum 6 semester credits or 8 quarter credits

Course Title	Number	Semester Credits	Quarter Credits

3. Individual Development (1 course) minimum 2 semester credits or 3 quarter credits

Course Title	Number	Semester Credits	Quarter Credits

4. Psychopathology (1 course) minimum 2 semester credits or 3 quarter credits

Course Title	Number	Semester Credits	Quarter Credits

5. Human Sexuality (1 course) minimum 2 semester credits or 3 quarter credits

Course Title	Number	Semester Credits	Quarter Credits

6. Research (1 course) minimum 3 semester credits or 4 quarter credits

Course Title	Number	Semester Credits	Quarter Credits

7. Professional Ethics and Law (1 course) minimum 3 semester credits or 4 quarter credits

Course Title	Number	Semester Credits	Quarter Credits

8. Supervised Clinical Practice 9 semester credits or 12 quarter credits

Course Title	Number	Semester Credits	Quarter Credits

9. Electives (1 course) minimum 3 semester credits or 4 quarter credits

Course Title	Number	Semester Credits	Quarter Credits

5. Experience

List all experience in date order.

Indicate Type of Experience or Practice and Location	Inclusive Dates of Experience	
	Entrance Date (mm/yyyy)	Leaving Date (mm/yyyy)

6. Examination Data

Have you taken and passed the Association of Marital and Family Therapy Regulatory Board (AMFTRB) examination? ☐ Yes ☐ No Year ___________

Are you currently a clinical member of the American Association of Marriage and Family Therapy (AAMFT)?
☐ Yes ☐ No Year __________

7. Other License, Certification, or Registration

List all states (including Washington State) where licenses, certifications and registrations are or were held.

State/ Jurisdiction	License/Certification/Registration Type	Method Licensed			License/Certification/Registration	
		Exam	Endorse	Grandfathered	Year Issued	Number

8. Aids Education and Training Attestation

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.
I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

☐ School curriculum
☐ Employer/Other

Applicant's Initials	Date

9. Continuing Education Attestation

I, ____, declare I completed thirty-six hours of continuing
(Name of Applicant)

education, with six hours in professional ethics.

Applicant's Initials	Date

10. Applicant's Attestation

I,__________________________________ , declare under penalty of perjury under the laws of the
(Name of Applicant)

state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read RCW **18.130.170** and RCW **18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local, or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated ______________________________ at ____
(mm/dd/yyyy) (City, state)

by: ___________________________________
(Original Signature of Applicant)

Marriage and Family Therapist Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Out of State Verification of Registration / Certification / License as a Marriage and Family Therapist or Associate

Applicant Name: ______________________________ Birth date: ______________

I, ______________________________, Secretary of ______________,

hereby certify that ______________________________

was granted state: ☐ Registration ☐ Certificate ☐ License

Number: ______________________ to practice ______________________

in the State of ______________ on the ________ day of ____________, 20 ______.

Legal/Disciplinary Action: ☐ Yes ☐ No If Yes, explain: ______________________________

____

____

On the basis of: ☐ Successfully passing the Association of Marriage and Family Therapy Regulatory Board's

(AMFTRB) Examination in Marital and Family Therapy Score ______________ Date ______________.

☐ Yes ☐ No 1,000 hours Postgraduate Direct Client Marriage and Family Therapy.

☐ Yes ☐ No 200 hours Postgraduate Formal Supervision. 100 hours must be one-on-one supervision.

☐ Yes ☐ No 500 hours in diagnosing and treating couples and families.

☐ Yes ☐ No 3,000 hours of experience in a minimum of 24 months full-time marriage and family therapy.

Status of License: ☐ Current ______________ ☐ Expiration Date ______________

Acting In Behalf of the:
Official Name of Board ______________________________

Phone ______________________________

Secretary ______________________________

Date Certification Prepared ______________________________

Return to address above.

Marriage and Family Therapist Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Marriage and Family Therapy Supervision and Experience Verification

Applicant:

Use a separate form for each supervisor verifying your postgraduate supervision and professional experience for each practice setting. This form may be duplicated. Fill out Section 1 and forward the verification form to the supervisor for completion.

1. Print or Type Clearly:

Name	Last	First	Middle	Birth date
Address				
City		State		Zip Code

2. Approved Supervisor:

The above individual seeks verification of supervised marriage and family therapy experience for license as a marriage and family therapist. An approved supervisor is a licensed marriage and family therapist with at least five years' clinical experience or an equally qualified mental health practitioner. Of the total supervision, one-hundred hours must be with a qualified licensed marriage and family therapist. Supervisors must also meet the requirements of WAC 246-809-134. Please complete the following:

Supervisor Name		Credential Number	Date Issued	
Current Street Address				Current Phone
City	State			Zip Code
Supervisor Signature			Date Signed	

3. Supervised Postgraduate Experience:

Applicants must have a minimum of two calendar years of full time counseling experience **and** 3,000 hours of supervised experience with an approved supervisor. Approved supervisors must meet the qualifications of WAC 246-809-134.

Of the 3,000 hours:

- At least one thousand (1,000) hours must be direct client contact.
  Of the one thousand (1,000) hours
  - □ At least five hundred (500) hours must be gained in diagnosing and treating couples and families.
- At least two hundred (200) hours of qualified supervision with an approved supervisor.
  Of the two hundred (200) hours, one hundred must be one-to-one by an approved supervisors listed below:
  - □ One hundred (100) hours must be with a licensed marriage and family therapist with at least five years' clinical experience.
  - □ The remaining one hundred (100) hours may be with an equally qualified licensed mental health practitioner.

Months of Supervision	From mm	dd	yyyy	To mm	dd	yyyy

	Hours Required	Total Hours Verified
A. **Direct Client Contact** (1,000 hours required) with an approved supervisor	At least 500 hours	
B. **Direct Client Contact Diagnosing and treating couples and families** (All direct client contact may be gained in diagnosing and treating couples and families) with an approved supervisor	At least 500 hours	
C. **Qualified Supervision** (200 hours). One hundred (100) hours must be with a licensed marriage and family therapist with at least five years' clinical experience. (All qualified supervision may be gained with a licensed marriage and family therapist.)	At least 100	
D. **Qualified Supervision, one-to-one**, may be gained with an equally qualified licensed mental health practitioner	At least 100	
E. **All other hours** Hours not listed in Section A, B, C, or D may be listed here	n/a	
F. **Total Hours required** (must equal 3,000)	**A+B+C+D+E = F Total of 3,000**	

Washington State Department of Health
Marriage and Family Therapist Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Marriage and Family Therapy Statement of Qualifications

Note to Supervisor:

The experience requirement consists of a minimum of two calendar years of full-time marriage and family therapy. Of the total supervision, one hundred hours must be with a licensed marriage and family therapist with at least five years clinical experience; the other one hundred hours may be with an equally qualified licensed mental health practitioner.

Do Not sign this form verifying applicant's hours unless you meet the criteria and can provide documentation if requested to do so.

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Signature ____

Title ____

Print Full Name ______________________________ Date ____________

Street Address ____

City ______________________________ State ________ Zip Code __________

Daytime Phone ____

Credential Number ____________________ Date of Issuance ____________________

Please return this form directly to the address above.

Approved Supervisor
Licensed Marriage and Family Therapist

To the Supervisor:

An approved supervisor must have at least five years clinical experience in accordance with **RCW 18.225.090**.

Please review **WAC 246-809-134**. To supervise a candidate for license, you must hold a license without restrictions that has been in good standing for at least two years.

You shall not be a blood or legal relative or cohabitant of the license candidate, their peer or someone who has acted as their therapist within the last two years.

Prior to the commencement of any supervision you must provide the license candidate this declaration, stating you have met the requirements of **WAC 246-809-134** and you qualify as an approved supervisor.

As an approved supervisor, I attest I have completed the following:

A minimum of fifteen clock hours of training in clinical supervision obtained through:

- A supervision course.
- Continuing education credits on supervision.
- Supervision of supervision.
- Or any combination of these.

And twenty-five hours of experience in supervision of clinical practice

An American Association for Marriage and Family Therapy (AAMFT) approved supervisor is considered to have met the above mentioned qualifications. Please submit proof of AAMFT approval.

I attest I will gain thorough knowledge of the supervisor's practice activities including:

- Practice setting.
- Record keeping.
- Financial management.
- Ethics of clinical practice.
- A backup plan for coverage.

Declaration of Supervision - must be completed by supervisor and provided to license candidate prior to the commencement of supervision in accordance with **WAC 246-809-134**.

I, ________________________________ , a licensed ________________________ in the State of__________
(Name of Supervisor)

with license #________________________ attests to __________________________________that I have read
(Name of Candidate)
and met all the requirements in connection with **WAC 246-809-134**.

Signature of Supervisor ____ Date________________

RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act.. RCW 18.130
Administrative Procedure Act ....RCW 34.05
Administrative procedures and requirements .... WAC 246-12
Marriage & Family Therapists RCW .... RCW 18.225
Marriage & Family Therapists WAC .... WAC 246-809

On-Line

AIDS Training Resources .... Reference Page
Licensed Marriage and Family Therapist ....Web Page