



Marriage & Family Therapist Associate License Application Packet

Contents:

1. 670-096... Contents List/SSN Information/Mailing Information 1 page
2. 670-097... Application Instructions Checklist 3 pages
3. 670-098... License Application 6 pages
4. 670-007... Out of State Credential Verification Form 1 page
5. 670-099... Approved Supervisor Verification..... 1 page
6. RCW/WAC and Online Web Site Links..... 1 page

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 Associate
Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Marriage and Family Therapist Associate 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 ink. It is your responsibility to submit the required forms.

Application Fee. This fee is non-refundable. You can check the [fee page](#) for current fees.

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.

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 questions. 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 your educational preparation. If you need more space, attach a piece of paper.

Approved educational programs include:

- Any college or university accredited by a national or regional accrediting body recognized by the Commission on Recognition of Postsecondary Accreditation or its successor; or
- A program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE).

Transcripts:

Your school must send official transcripts directly to Marriage and Family Therapist Associate Credentialing.

4. Educational Qualifications:

List equivalent course of graduate study or doctoral that includes courses in marital and family systems, marital and family therapy, individual development, psychopathology, human sexuality, research, professional ethics and law, supervised clinical practice and electives. A total of forty-five semester credits or sixty quarter credits are required. A minimum of twenty-seven semester credits or thirty-six 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.

5. Other License, Certification, or Registration:

List all states, including Washington, where credentials are or were held. Specifically list credentials by examination, endorsement, or grandparented.

An Out-of-State Credential Verification Form is enclosed and must be sent to each state you listed. Enter your full name and birth date at the top of the form so the state can identify you. Also contact each state board listed for any fees they may charge you for processing the verification.

6. Examination Data:

Check the Yes or No box to indicate whether you have taken and passed the AMFTRB exam. If yes, write in the year taken. Check the Yes or No box to indicate whether you are a clinical member of the AAMFT. If yes, write in the year joined. Verification must be sent directly from the AAMFT to the Department of Health.

7. Declaration Working Toward Licensure:

Declare that you are working toward licensure as a Marriage and Family Therapist.

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. Applicant's Attestation:

You must sign and date this for us to process the application. Read this very carefully.

We appreciate your interest in obtaining a credential. You will be notified in writing if further documentation is required. If your application is incomplete, you will be mailed or emailed a letter regarding the deficiencies.

- The application is considered incomplete if requested information is left blank. Put N/A or place a line through a section instead of leaving it blank.
- You must keep your address up to date in order to receive a courtesy renewal notice. Any renewal postmarked or presented to the department after midnight on the expiration date is late.

To receive notifications regarding the profession, please join our listserv at:

<http://listserv.wa.gov/cgi-bin/wa?A0=LICENSED-COUNSELORS>.

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.

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Background
Check
Stamp
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Date
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Revenue: 0207050000

Marriage and Family Therapist Associate License Application

Do you hold a credential in Washington State? No Yes

If yes, credential #

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 County

Country

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

Email address

Mailing address (if different from above)

City State Zip 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 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.

4. Educational Qualifications–Non COAMFTE Accredited Programs

You must have a masters or doctoral degree in marriage and family therapy or a behavioral science masters or doctoral degree with equivalent course work to apply. If any course listed does not specify clearly in its title the nature and content, provide an official syllabus, official course outline, or statement from the professor.

The equivalent course of graduate study 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 forty-five semester credits or sixty quarter credits are required. A minimum of twenty-seven semester credits or thirty-six 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. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held.

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

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 _____ Verification must be sent directly from the AAMFT to the Department of Health

7. Declaration Working Toward Licensure

I declare that I am working toward licensure as a Marriage and Family Therapist.

Applicant's Initials	Date

8. Aids Education and Training Attestation

School curriculum

Employer/Other

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS, which included 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.**

Applicant's Initials	Date

9. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of the state of
Name of Applicant

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



Washington State Department of

Health

Marriage and Family Therapist Associate Credentialing

P.O. Box 47877

Olympia, WA 98504-7877

360.236.4700

Out of State Credential Verification

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 Expired Date _____

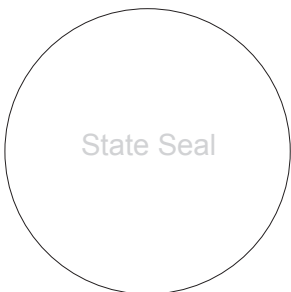
Acting In Behalf of the: Official Name of Board _____

Phone _____

Secretary _____

Date Certification Prepared _____

Return to address above.



State Seal

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Washington State Department of

Health

Marriage and Family Therapist Associate Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360.236.4700

Approved Supervisor Verification Licensed Marriage and Family Therapist Associate

To the Supervisor:

Please review [WAC 246-809-134](#). To supervise a licensed marriage and family therapist associate, you must hold a license without restrictions that has been in good standing for at least two years.

You must not be a blood or legal relative or cohabitant of the licensed associate, licensed associate's peer, or someone who has acted as the licensed associate's therapist within the past two years.

Prior to the commencement of any supervision you must provide the licensed associate a declaration, stating that 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; or
 - Continuing education credits on supervision; or
 - Supervision of supervision; or
 - Or any combination of these; and
- **Twenty-five hours of experience in supervision of clinical practice; or**
- **An American Association for Marriage and Family Therapy (AAMFT) approved supervisor is considered to have met the qualifications above. 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
- Applicants whose supervised postgraduate experience began before September 30, 2006, are exempt from the requirements as shown in the paragraph above.

Declaration of Supervision—must be completed by supervisor and provided to licensed associate prior to the commencement of supervision in accordance with [WAC 246-809-134](#).

I, _____, a licensed _____ in the State of Washington
(Name of Supervisor)

with license # _____ attests to _____ that I have read
(Name of Licensed Associate)

and met all the requirements in connection with [WAC 246-809-134](#).

Signature of Supervisor _____ Date _____

This form must be provided before a credential can be issued.

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RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act.....	<u>RCW 18.130</u>
Administrative Procedure Act	<u>RCW 34.05</u>
Administrative procedures and requirements	<u>WAC 246-12</u>
Marriage & Family Therapists RCW	<u>RCW 18.225</u>
Marriage & Family Therapists WAC	<u>WAC 246-809</u>
Standards of Professional Conduct	<u>WAC 246-16</u>

On-Line

AIDS Training Resources	<u>Reference Page</u>
Marriage and Family Therapist Associate	<u>Web Page</u>

List-Serv

To receive emails regarding important marriage and family therapist professional information, please join our interested parties at [Listserv](#)