Marriage and Family Therapist (MFT) License Application Packet

Contents:

Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. 42 U.S.C. § 666(a)(13); RCW 26.23.150. It will be used under the state's child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you have questions.

In order to process your request:

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

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

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

Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

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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. The cost of the background check is at the applicant's expense.

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

☐ **Application Fee**. This fee is non-refundable. You can check the online **fee page** for current fees. This fee may be paid by a personal check or money order, payable to the Department of Health.

☐ **Select if the following applies:**
Spouse or Registered Domestic Partner of Military Personnel

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you do not have one.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

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.

Address: List the address we should use to send any information about 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.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Education:**

List in date order, most recent to later, your educational preparation and post-graduate training. Attach additional pages if you need more space.
You must submit official transcripts to verify your education. If transcripts were submitted with your associate application, you do not need to resubmit them.

☐ **4. Educational Qualifications–Non COAMFTE Accredited Programs**

You are required to complete this section if your graduate school was not accredited by the Commission on Accreditation of Marriage and Family Therapy Education (COAMFTE).

☐ **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 mark **N/A** or not applicable if you have not had professional training and experience.

☐ **6. Examination Data:**

If you took and passed the AMFTRB exam, you have met the exam requirement. You must get a written verification from AMFTRB sent directly to the Department of Health.

Exam Information

- You must pass a national exam (AMFTRB). 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. All special testing accommodations must be requested through Professional Testing Corporation (PTC) when registering for the examination.
- The Department of Health receives score reports within four weeks of the close of the testing window from the testing company. You will receive your score by mail from Professional Testing Corporation (PTC). Scores will not be given over the phone by the department. 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.

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

List **all** states (including Washington State) where credentials are or were held.

An Out of State Verification 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. Continuing Education Attestation:**
Complete 36 hours of continuing education, with six hours in professional law and ethics. See **RCW 18.225.090**.

☐ **9. Applicant's Attestation and Signature:**
You must sign and date this for the department to process the application.

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 **List-Serv** at **http://listserv.wa.gov** and select the group titled licensed counselors.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

Postgraduate Supervised Experience Requirement

A minimum of 3,000 hours of experience of marriage and family therapy as outlined:

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

b. 200 hours of direct supervision with a qualified supervisor; of those 200 hours:
   - 100 hours must be with a licensed marriage and family therapist with at least five years of clinical experience.
   - 100 hours can be with an equally qualified mental health practitioner as defined in **WAC 246-809-110(3)**.
   - If you have held an active Marriage and Family Therapist credential for the past five consecutive years or more in another state or territory, without a disciplinary record or disqualifying criminal history, you are deemed to have met the supervised experience requirements of this chapter for Washington state licensure as defined in **WAC 246-809-130(1)**.
   - Certified chemical dependency professionals can qualify for supervised experience hours reductions as defined in **WAC 246-809-130(2)**.

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.

Note: Probationary license with **RCW 18.225.140**. An applicant holding a credential in another state may be certified to practice in this state without examination if the secretary determines that the other state's credentialing standards are substantially equivalent to the standards in this state.

• Verification of holding or have held within the past twelve months a credential in good standing from another state/territory of the United States which has a scope of practice that is substantially equivalent to or greater than the scope of practice for Marriage and Family Therapist.

• Have no disciplinary record or disqualifying criminal history

• The department must determine what deficiencies, if any, exist between the education and experience requirements of the other state's credential. (Full application and supporting documents must be received prior to the issuance of the Probationary certificate.)

Washington State Department of HEALTH

Date Stamp Here

Revenue: 0207050000

Marriage and Family Therapist License Application

Please print clearly. Follow the instructions provided. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so may result in a delay in processing your application.

Select if the following applies:

☐ Spouse or Registered Domestic Partner of Military Personnel ☐ Probationary License

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	**National Provider Identifier Number (NPI)** (Enter 10 digit number)	☐ Male ☐ Female ☐ Prefer not to answer ☐ X

Name First Middle Last

Birth date (mm/dd/yyyy)

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):

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.

If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

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
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?	☐	☐
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?	☐	☐

3. Education

Provide in date order, most recent to later, 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. ☐ Program is COAMFTE accredited.

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 six areas of study: Marital and Family Systems, Marital and Family Therapy, Individual Development, Psychopathology, Human Sexuality, and Research. If you have a licensed marriage and family therapy associate credential, you do not need to complete this section.

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, most recent to later. Attach additional pages if you need more space.

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 credentials are or were held.

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

8. 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

9. 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 have read all laws and rules related to my profession.

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
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 _____

State Seal

Acting In Behalf of the: _____
Official Name of Board

Phone _____

Secretary _____

Date Certification Prepared _____

Return to address above.

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Washington State Department of HEALTH

Marriage and Family Therapist
Credentialing
P.O. 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 the first section and forward the verification form to the supervisor for completion. The required total number of supervision hours are listed, but you may need to provide more than one supervision form to obtain the total number of hours needed for licensure.

1. Print 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 licensure 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 (enter 10 digit #)
City	State	Zip Code
Supervisor Signature		Date Signed

3. Supervised Postgraduate Experience:

The experience requirements for the marriage and family therapist applicant's practice area include successful completion of a supervised experience requirement.

Total experience requirements include:

A minimum of 3,000 hours of supervised experience:

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

b. 200 hours of direct supervision with a qualified supervisor; of those 200 hours:
   - 100 hours must be with a licensed marriage and family therapist with at least five years of clinical experience.
   - 100 hours can be with an equally qualified mental health practitioner as defined in **WAC 246-809-110(3)**.

Note: One-on-one supervision means face-to-face supervision with an approved supervisor, involving one supervisor and no more than two licensure candidates. Group Supervision means face to face supervision with an approved supervisor, involving one supervisor and no more than six licensure candidates.

Diagnosing and treating couples and families—At least 500 hours is required.	A.	
Direct Client Contact—with an approved supervisor. List all hours not listed in diagnosing and treating couples and families.	B.	
Boxes A + B must equal 1,000 hours		1.
Number of hours of group supervision.	C.	
List the number of one-on-one supervision—100 hours are required.	D.	
Boxes C + D must equal 200 hours		2.
List all hours that have not been listed above.		3.
Total 3,000 hours of experience is required (Total of boxes 1, 2 and 3.)		

Months of Supervision	From mm	dd	yyyy	To mm	dd	yyyy

Applicants who have completed a master's program accredited by the Commission on Accreditation for Marriage and Family Therapy Education of the American Association for Marriage and Family Therapy may be credited with 500 hours of direct client contact and 100 hours of formal meetings with an approved supervisor. Verification will be documented upon the review of your transcripts.

Supervisor:

I certify that the above information is, to the best of my knowledge accurate and complete. I understand that the Department may request additional information, if it is needed, to evaluate the application of the individual named on this document. I also attest I meet or exceed the educational and supervision requirements to be an approved supervisor.

Signature_____ Date _____

Return this form to the address on page one of this form.

Marriage and Family Therapist Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Approved Supervisor Declaration for Licensed Marriage and Family Therapist Candidates

To the Supervisor:

Please review **WAC 246-809-134**. To supervise a license candidate, 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 candidate, licensed candidate's peer, or someone who has acted as the licensed candidate's therapist within the past two years.

Prior to the commencement of any supervision you must provide the licensed candidate a declaration, stating that you have met the requirements of **WAC 246-809-134** and you qualify as an approved supervisor if hours were gained in Washington State.

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

Declaration of Supervision—must be completed by supervisor and provided to licensed candidate prior to the commencement of supervision in accordance with **WAC 246-809-134** if hours were gained in Washington.

I, _____, a licensed _____in the State of _____
(Name of Supervisor) (Supervisor's License Type)

with license # _____ attests to _____that I have read
(Supervisor's License Number) (Name of Licensed Candidate)
and met all the requirements in connection with **WAC 246-809-134**.

Signature of Supervisor _____ Date _____

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RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Marriage and Family Therapists Laws, RCW 18.225

Marriage and Family Therapists Rules, WAC 246-809

Standards of Professional Conduct, WAC 246-16

Online

Licensed Marriage and Family Therapist Web Page