

STATE OF MAINE

BOARD OF COUNSELING PROFESSIONALS LICENSURE

APPLICATION FOR FULL OR CONDITIONAL MARRIAGE AND FAMILY THERAPY LICENSURE



Department of Professional and Financial Regulation
Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8674
Office Facsimile: (207) 624-8637
HEARING IMPAIRED (888) 577-6690
Internet: www.maine.gov/professionallicensing

Office located at: 122 Northern Avenue, Gardiner, Maine

APPLICANT INFORMATION GUIDE

The application material you have requested from the Board of Counseling Professionals is enclosed. It contains all the relevant materials you need to complete your application for licensure as a Marriage and Family Therapist in the State of Maine. Please read all the information carefully. If you have any questions after reading this packet, please call or e-mail our office.

FURNISHED TO APPLICANT

- Applicant Information Guide
- Application for Licensure Form
- Accommodation Request Form
- Reference Form
- Supervisor's Affidavit Form
- Proposed Supervision Plan Form
- Degree/Internship Verification Form
- Verification of Licensure Form
- Examination Information Sheet
- Request for Examination Form
- Educational Requirements Worksheet for Marriage and Family Therapist
- Disclosure Statement Information Sheet
- Authorization of Credit Card Payment Form
- NPDB/HIPDB Self-query Report Information Sheet

ADDITIONAL RESOURCES

- Licensing Law for Counseling Professionals

Please read these carefully and review periodically for changes. You are responsible for knowing and complying with all Maine Laws throughout your licensure.

Available: <http://janus.state.me.us/legis/statutes/32/title32ch119sec0.html> or call (207) 624-8674

- Licensing Rules for Counseling Professionals

Please read these carefully and review periodically for changes. You are responsible for knowing and complying with all Board Rules throughout your licensure.

Available: <http://www.maine.gov/sos/cec/rules/02/chaps02.htm#514> or call (207) 624-8674

- Licensing Rules for the Department of Professional and Financial Regulation

Available: <http://www.maine.gov/sos/cec/rules/02/chaps02.htm#041>

- Statutory Authority, Titles 5 & 10

Available: <http://janus.state.me.us/legis/statutes/10/title10ch0sec0.html>

<http://janus.state.me.us/legis/statutes/5/title5ch0sec0.html>

APPLICATION PROCEDURE

- Please submit your application materials by mail or hand delivery to our offices. Fax submissions will not be accepted. If the application you submit to us is complete, it will be prepared and presented to the Board for official action.
- If there are deficiencies with your application, you will be notified by mail.
- **If all components of the application are not complete ten (10) days prior to the Board meeting the application will not be reviewed at that meeting.** Due to the volume of applications being reviewed by the Board at any given time, we cannot guarantee a particular review date, but the Board will endeavor to expedite the review of your application
- Please do not call our office regarding the status of your application. Information about the status of applications may be found at the Office of Licensing & Registration's website: <http://www.maine.gov/professionallicensing>. We appreciate your thoughtful attention to this request.

CONTINUING EDUCATION

Continuing education is required for the renewal of a license. A minimum of fifty-five (55) contact hours of approved continuing education including fifteen (15) hours of supervision and four (4) hours of ethics must be completed during the preceding twenty-four (24) month period. Please be sure to periodically review the Rules, Chapter 8 §4 for more information or for possible changes to continuing education requirements.

Full/Conditional Licensure

Please read and review Chapters 2-6 of the Board's Rules for requirements. A complete application shall include the following:

- A completed and signed Application; (Pages 7 – 10)
- Official Transcript forwarded directly to the Board by the Academic Institution;
- A completed Verification of Internship Form (Page 18) by the university that attests to the number of internship hours, and also describes the counseling activities, setting, and supervisor credentials of the internship experience;

Full licensure:

- Completed Supervisor's Affidavit Forms; (Page 15)

Conditional Licensure:

- A completed Proposed Supervision Plan Form; (Page 16)
- Three (3) Reference Forms to be completed by professionals in the counseling field and dated within one (1) year prior to the date of application; (Page 14)
 - Official proof of a passing score on an examination as prescribed in the Rules, forwarded to the Board directly by the organization holding the test scores;
- or**
- A request for Examination (Please be sure to indicate test date on form); (Page 22)
- A copy of your Disclosure Statement;
- A completed Educational Requirements Worksheet accompanied by course brochures/catalogs; (Page 23)
- A NPDB/HIPDB Self-Query Reports;
- Payment of an Application fee of \$25.00;
- Payment of a Licensure fee (Permanent \$200, Conditional \$150); and
- Payment of a Criminal History Check fee of \$15.00.

All Checks/Money Orders should be made payable to the "Treasurer, State of Maine". If paying by credit card, please use the Credit Card form. All fees can be in one payment.

Licensure for Applicants Licensed in Another Jurisdiction

Please read and review Chapter 6 of the Board's Rules for requirements. There are three (3) pathways to licensure as outlined below:

- **Pathway 1:** Reciprocal agreement between the State of Maine and another jurisdiction. Currently, the State of Maine Board of Counseling Professionals Licensure has not entered into any reciprocal agreements with other jurisdictions. Therefore, applicants should submit their application according to either Pathway 2 or Pathway 3 if already licensed in another jurisdiction.
- **Pathway 2 (Substantially Equivalent License):** Applicant submits evidence of five (5) years actively practicing with a substantially equivalent license immediately preceding application that is in good standing, or
- **Pathway 3 (Substantially Similar Qualifications):** The applicant's qualifications are substantially similar to Maine's licensing requirements with a license that is in good standing.

Pathway 2 applications shall include the following:

- A completed and signed Application; (Pages 7 – 10)
- Official Transcript forwarded directly to the Board by the Academic Institution;
- Three (3) Reference Forms to be completed by professionals in the counseling field and dated within one (1) year prior to the date of application; (Page 14)
- A copy of the relevant licensing law and Board rules of the licensing or certifying state of jurisdiction from which you are applying;
- A copy of all mental health licenses under which applicant has practiced during the five (5) consecutive years immediately preceding this application;
- A completed Verification of Licensure Form from the jurisdiction(s) in which the applicant was ever licensed; (Pages 19 – 20)
- A copy of your Disclosure Statement;
- A resume and summary of applicant's mental health practice;
- A NPDB/HIPDB Self-Query Reports;
- Payment of an Application fee of \$25.00;
- Payment of a Permanent Licensure fee of \$200.00; and
- Payment of a Criminal History Check fee of \$15.00.

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Pathway 3 applications shall include the following:

- A completed and signed Application; (Pages 7 – 10)
- Official Transcript forwarded directly to the Board by the Academic Institution;
- Three (3) Reference Forms to be completed by professionals in the counseling field and dated within one (1) year prior to the date of application; (Page 14)
- A completed Verification of Internship Form (Page 18) by the university that attests to the number of internship hours, and also describes the counseling activities, setting, and supervisor credentials of the internship experience;
- A completed Educational Requirements Worksheet accompanied by course brochures/catalogs; (Page 23)
- Completed Supervisor's Affidavit Forms; (Page 15)
 - Official proof of a passing score on an examination as prescribed in the Rules, forwarded to the Board directly by the organization holding the test scores;
- or**
- A request for Examination (Please be sure to indicate test date on form); (Page 22)
- A copy of the relevant licensing law and Board rules of the licensing or certifying state of jurisdiction from which you are applying;
- A copy of all mental health licenses under which applicant practiced;
- A completed Verification of Licensure Form from the jurisdiction(s) in which the applicant was ever licensed; (Pages 19 – 20)
- A copy of your Disclosure Statement;
- A NPDB/HIPDB Self-Query Reports;
- Payment of an Application fee of \$25.00;
- Payment of a Permanent Licensure fee of \$200.00; and
- Payment of a Criminal History Check fee of \$15.00.

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Change of Status from Conditional to Full Licensure

If you are submitting an application for full licensure near the expiration date of your conditional license, you should include a completed and signed renewal application in your application packet to the board. The inclusion of your renewal application is intended to avoid a potential gap in licensure between your conditional license and the board's approval of your application for full licensure. In the event that your renewal application needs to be processed, you will be contacted by the board and will be requested to pay the renewal fee before the renewal application is processed.

A complete application shall include the following:

- A completed and signed Application; (Pages 7 – 10)
- Submission of evidence of completing the required continuing education activities for current conditional licensing cycle;
- A copy of your Disclosure Statement;
- A completed and signed Supervisor's Affidavit's Form (Page 15);
- A NPDB/HIPDB Self-Query Reports if not previously submitted to this office;
- Payment of an Application fee of \$25.00;
- Payment of a Licensure fee of \$200.00; and
- Payment of a Criminal History Check fee of \$15.00.

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Board of Counseling Professionals Licensure
 35 STATE HOUSE STATION
 AUGUSTA, MAINE
 04333-0035
 OFFICE PHONE (207) 624-8674
 TTY/HEARING IMPAIRED (888) 577-6690

Office Use Only
License # _____
Cash # _____
Check # _____
MF1421 \$240
XM1421 \$190

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

APPLICATION FOR LICENSURE

<p><u>Notice regarding Social Security Number Disclosure</u></p> <p>The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.</p>	<p><u>Notice regarding Public Information</u></p> <p>This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, mailing address and other information listed on this application may be posted on the State's website.</p>
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Check Appropriate Category		
Marriage & Family Therapist <input type="checkbox"/> Standard	Marriage & Family Therapist <input type="checkbox"/> Conditional	Marriage & Family Therapist <input type="checkbox"/> Other Jurisdiction

Personal Information		
Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration requires a criminal history records check as part of the application process for all applicants. Please indicate below any alias or maiden names accordingly.		
Name:	Any Other Names Used:	
Mailing Address:		
City:	State:	Zip Code:
Daytime Phone <i>(include area code)</i> :	Social Security Number:	Date of Birth:
E-mail Address:		

Employment Information

Workplace Name:		Work Phone <i>(include area code)</i> :
Mailing Address:		
City:	State:	Zip Code:

**Undergraduate and Graduate Education
(Official transcripts must be submitted directly from Institution)**

Name of Academic Institution:		
Mailing Address:		
City:	State:	Zip Code:
Degree Granted:		Date Conferred:

Name of Academic Institution:		
Mailing Address:		
City:	State:	Zip Code:
Degree Granted:		Date Conferred:

Name of Academic Institution:		
Mailing Address:		
City:	State:	Zip Code:
Degree Granted:		Date Conferred:

Counseling Experience

Workplace Name:	Dates Employed:
Mailing Address:	
City:	Zip Code:

Counseling Experience (continued)

Workplace Name:		Dates Employed:
Mailing Address:		
City:	State:	Zip Code:

Workplace Name:		Dates Employed:
Mailing Address:		
City:	State:	Zip Code:

Supervisors

(Applicants for Conditional license must submit a written plan for completing supervision)

Name:		
Mailing Address:		
City:	State:	Zip Code:

Name:		
Mailing Address:		
City:	State:	Zip Code:

Criminal Background Disclosure

Have you ever been convicted by any court of any offense?

[] YES [] NO

If yes, provide a written statement on a separate sheet of paper that includes the date of the offense and a detailed description of the events surrounding the conviction. Submit your written statement and a copy of the court judgment(s) with this application. **Failure to disclose convictions may result in fines, suspension and/or revocation of a license.**

Credentialing History

Have you ever held a professional license/certification/registration in this or any other state/country? [] YES [] NO

If yes:

Profession	License #	State/Country	Date Issued	Expiration Date

Have you ever taken a counseling examination? [] YES [] NO

If yes:

Which Exam?	Where?	Date Taken:
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Disciplinary History

1. Has any jurisdiction taken disciplinary action against any professional license/certification/registration you hold or have held or denied your application for licensure? If yes, please enclose a detailed explanation and copies of disciplinary action. [] YES [] NO

2. Do you have pending against you any complaints from a regulatory board or professional organization? If yes, please enclose a detailed explanation. [] YES [] NO

3. Have you ever been or are you currently a defendant in a civil proceeding related to your professional activities? If yes, please enclose a detailed explanation. [] YES [] NO

Other State/Jurisdiction Licensure (See Chapter 6 of the Board Rules)

Issuing Authority:	License Type:
State/Country:	License Issue Date:

Affirmation

By submitting this application I understand that the Board of Counseling Professionals Licensure will rely upon this information for issuance of my license and that this information is truthful and factual and that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

SIGNATURE: _____ DATE: _____



JOHN ELIAS BALDACCI
GOVERNOR

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

ANNE L. HEAD
DIRECTOR

ACCOMMODATION REQUEST FORM

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission. **Please note:** Some accommodation requests may require additional documentation. (see next page)

Name: _____

Mailing Address: _____

City: _____

State: _____

Zip Code: _____

Telephone (include area code): _____

Social Security Number: _____

Accommodations Requested for the _____ Examination.

Check all that apply:

- Accessible Testing Site
- Separate Testing Site
- Braille
- Large Print
- Tape
- Reader as Accommodation for Visual Impairment
- Scribe/Amanuensis as Accommodation for Visual or Motor Impairment
- Reader as Accommodation for Learning Disability
- Scribe/Amanuensis as Accommodation for Learning
- Sign Language Interpreter
- Extended Time
 - Time-and-a-half
 - Double time
 - More than double time (specify) _____
- Use of Computer or Other Adaptive Equipment (specify) _____
- Other: _____

SIGNATURE: _____ DATE: _____



DOCUMENTATION OF DISABILITY NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known _____ since _____ in my capacity as a
(test applicant) (date)

(professional title)

The applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, he/she should be accommodated by providing the following (check all that apply):

- Taped test
- Large print test
- Reader
- Scribe/amanuensis
- Extended time
 - Time-and-a-half
 - Double time
 - More that double time (please justify) _____
- Separate Testing Area
- Use of Computer or Other Adaptive Equipment (please specify) _____
- Other (please specify) _____

SIGNATURE: _____ TITLE: _____

DATE: _____ LICENSE # (if applicable): _____



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04333-0035

Office Use Only	
License #	_____
Cash #	_____
Check #	_____
MF1421	\$240
XM1421	\$190

ANNE L. HEAD
DIRECTOR



AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: (applicant fees being paid for)		
Mailing Address: (applicant fees being paid for)		
City:	State:	Zip Code:
County:	Telephone #: (____) _____ - _____	
Name of cardholder: (if other than applicant)		
Mailing Address: (if other than applicant)		
City:	State:	Zip Code:

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

Visa MasterCard _____ **Card number**

Expiration date: _____ / _____ / _____ in the amount of: \$ _____

Signature: _____ Date: _____ / _____ / _____



PRINTED ON RECYCLED PAPER

OFFICE PHONE: (207)624-8674

FAX: (207)624-8637

(888)577-6690 (HEARING IMPAIRED)
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REFERENCE FORM

EACH APPLICANT MUST HAVE ONE (1) FORM COMPLETED BY THREE (3) DIFFERENT COUNSELING PROFESSIONALS. PLEASE PRINT OR TYPE.

Name of Applicant:		
Mailing Address:		
City:	State:	Zip Code:
Telephone (include area code):		Social Security Number:

Name of Counseling Professional:	Telephone (include area code):	
Mailing Address:		
City:	State:	Zip Code:
Professional Title:	Relationship to Applicant:	

It is required that each applicant shall demonstrate trustworthiness, ethical integrity and competence to engage in the practice of counseling in such a manner as to safeguard the interests of the public.

Do you believe that the above said applicant demonstrates trustworthiness, ethical integrity and competence? Yes_____ No_____

COMMENTS: _____

Signature of Counseling Professional

Date





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Mailing Address:		
City:	State:	Zip Code:
Telephone (include area code):		Social Security Number:

Name of Counseling Professional:	Telephone (include area code):	
Mailing Address:		
City:	State:	Zip Code:
Professional Title:	Relationship to Applicant:	

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Do you believe that the above said applicant demonstrates trustworthiness, ethical integrity and competence? Yes_____ No_____

COMMENTS: _____

Signature of Counseling Professional

Date





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Mailing Address:		
City:	State:	Zip Code:
Telephone (include area code):		Social Security Number:

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Mailing Address:		
City:	State:	Zip Code:
Professional Title:	Relationship to Applicant:	

It is required that each applicant shall demonstrate trustworthiness, ethical integrity and competence to engage in the practice of counseling in such a manner as to safeguard the interests of the public.

Do you believe that the above said applicant demonstrates trustworthiness, ethical integrity and competence? Yes_____ No_____

COMMENTS: _____

Signature of Counseling Professional

Date





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ANNE L. HEAD
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SUPERVISOR'S AFFIDAVIT

To be completed by supervisor in accordance with Chapters 2 through 6 of the Board's Rules

Check one: [] New Applicant [] Conditionally licensed			
Name of Applicant:		Social Security Number:	
Name of Approved Supervisor:	Supervisor's License Title:	Supervisor's License Number:	
State of Licensure:	Original Date:	Expiration Date:	Years in Practice:
Facility or Agency:		Telephone (include area code):	
Mailing Address:			
City:	County:	State:	Zip Code:
IN WHICH SPECIALTY AREA: (Please check)		SUPERVISION: (List number of hours)	
Clinical Professional Counselor	[]	Individual	_____
Marriage and Family Therapist	[]	Group Supervision	_____
Professional Counselor	[]	Total number of supervision hours	_____
Pastoral Counselor	[]		
SUPERVISED EXPERIENCE: (List number of hours)*			
Hours of direct counseling with individuals _____ couples _____ families _____ groups _____			
Total hours of direct counseling _____			
Supervised experience in counseling other than the direct provision of counseling _____			
Total number of hours of supervised experience _____			
On the supervisor's stationary, signed and dated, please comment on the following:			
1. Please describe the applicant's functions in terms of prevention, diagnosis and treatment of mental illness/disorders and psychosocial treatment. (For the clinical licenses only – LCPC, LMFT, Pastoral).			
2. Please state briefly the licensee's personal character, ethical conduct, and competence.			
3. Please comment on the licensee's ability to function as a counselor (i.e. strengths and weaknesses).			
I HEREBY ATTEST THAT THE ABOVE-NAMED APPLICANT IS/WAS UNDER MY SUPERVISION FROM THE PERIOD OF _____ TO _____. I ALSO ATTEST THAT ALL INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.			
Supervisor's Signature _____		Date _____	
Applicant's Signature _____		Date _____	





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04333-0035

ANNE L. HEAD
DIRECTOR

**PROPOSED SUPERVISION PLAN
CONDITIONAL COUNSELOR LICENSURE**

Name of Applicant:	Social Security Number:
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SUPERVISION PLAN

Name of Supervisor:	Title:	
Supervisor's License Number:	First Date of Issue:	
Facility or Agency:	Work Telephone Number <i>(include area code)</i> :	
Mailing Address:		
City:	State:	Zip Code:

**SUPERVISION MUST EQUAL 1 HOUR/30 HOURS OF DIRECT COUNSELING SERVICE.
PLEASE DOCUMENT SPECIFIC PLANS THAT COVER THE FOLLOWING:** (Use separate sheet if needed)

Goals of Plan:

Objectives of Plan:

If providing clinical supervision for a clinical license, please focus on diagnosis and treatment:

I HEREBY ATTEST THAT THE ABOVE NAMED APPLICANT IS UNDER MY SUPERVISION FOR THE PERIOD BEGINNING_____. I ALSO ATTEST THAT ALL OF THE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Supervisor's Signature_____ Date_____

Applicant's Signature_____ Date_____



APPROVED SUPERVISOR FORM

Name of Supervisor: _____

Number of years of counseling experience in the modality (e.g. clinical, marriage & family therapy, pastoral) which you intend to do supervision: _____

Answer one (1) or both of the following:

1. Describe training received in counseling supervision:

2. List the number of years and types of experiences in providing supervision to mental health professionals:

Provide a separate written statement detailing your supervision philosophy, orientation and experience.

I HEREBY ATTEST THAT ALL THE INFORMATION ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Supervisor's Signature: _____ Date: _____



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04333-0035

ANNE L. HEAD
DIRECTOR

DEGREE/INTERNSHIP VERIFICATION FORM

To: Board of Counseling Professionals Licensure 35 State House Station Augusta, ME 04333-0035	Date:
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Student Name:	Social Security Number:	
Institution:		
Mailing Address:		
City:	State:	Zip Code:

Degree Verification	
Date of Graduation:	Program:
Degree Awarded:	Concentration of Degree Awarded:
Accreditation:	

Internship Verification		
Dates of Internship:	Direct Client Contact Hours:	Total Contact Hours:
Internship Experience: Please indicate whether the counseling activities, setting and supervisor were or were not clinical in nature ("clinical" is defined as the diagnosis and treatment of mental health disorders).		
Signature of Person Verifying Degree/Internship: _____		
Printed Name: _____	Title: _____	
Department: _____	Date: _____	





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DIRECTOR

VERIFICATION OF LICENSURE FORM

The applicant listed below is applying for licensure to practice as a marriage and family therapist in the State of Maine. The Maine Board of Counseling Professionals Licensure requests written verification from each state that applicant holds or has held any certification, licensure, or credential. This is your authority to release any information in your files, favorable or otherwise. **Please mail this verification directly to the Maine Board of Counseling Professionals Licensure at the above listed address.**

The section below is to be completed by the applicant and forwarded to the State Board in which you hold or have held a license to practice counseling, family therapy or pastoral counseling. Any associated fees are the responsibility of the applicant. If verification of licensure is needed for more than one (1) state, please copy form as needed.

Name:		
Mailing Address:		
City:	State:	Zip Code:
License Number:	State:	Date of Issue:
Signature of Applicant:		Date:

The remaining portion is to be completed by the State Licensing Board where the applicant holds or has held a license to practice counseling, family therapy or pastoral counseling.

Name of Licensee:	License Type:	
License Number:	Is License Current? [] YES [] NO	
Date Issued:	Original License Date:	Expiration Date:



VERIFICATION OF LICENSURE (PAGE 2)

Name of Exam Taken:	Date Exam Passed:
---------------------	-------------------

If no examination was taken, how was licensure obtained?

Grandfathered
 Endorsement/Comity
 State

What were the requirements for education and supervision at the time the license was issued?

Are there any pending complaints against this licensee? If yes, please explain:	[] Yes [] No
--	-------------------

Have there been any other actions taken against this licensee? If yes, please explain:	[] Yes [] No
---	-------------------

Is the licensee considered to be in good standing in your state? If no, please explain:	[] Yes [] No
--	-------------------

State Board Seal	Signature: _____ Printed Name: _____ Title: _____ State: _____ Phone Number _____ Date: _____
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ANNE L. HEAD
DIRECTOR

Examination Information

The National Counselors Examination

To qualify for conditional licensure as a Professional Counselor, a Clinical Professional Counselor, or a Pastoral Counselor applicants must achieve a passing score on The National Counselor Examination (NCE) administered by NBCC. The computer-based NCE is offered monthly. After the Board approves your eligibility for examination, a registration form will be sent to you. This form will list the exam dates, registration dates and exam location.

- There is a study guide available for the NCE. More information is available at the following website: <http://www.nbcc.org/extras/pdfs/nceprepguideorder.pdf>

The National Clinical Mental Health Counseling Examination

As of January 1, 2008, to qualify for full licensure as a Clinical Professional Counselor or a Pastoral Counselor applicants must achieve a passing score on The National Clinical Mental Health Counseling Examination (NCMHCE) administered by NBCC. The computer-based NCMHCE is offered monthly. After the Board approves your eligibility for examination, a registration form will be sent to you. This form will list the exam dates, registration dates and exam location.

- There is a study guide available for the NCMHCE. More information is available at the following website: <http://www.nbcc.org/extras/pdfs/nceprepguideorder.pdf>

The Marital and Family Therapy Examination

To qualify for either a conditional or full license as a Marriage and Family Therapist applicants must achieve a passing score on The Marital and Family Therapy Examination administered by AMFTRB.

- A request for examination (next page) must be submitted at least ninety (90) days prior to exam.
- Please note, applicants who apply for examination must submit all materials required for licensure before approval to sit for an examination will be granted.
- More information regarding this exam is available at the following website: <http://www.amftrb.org/exam.cfm>

Page 21



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OFFICE PHONE: (207)624-8674

FAX: (207)624-8637

(888)577-6690 (HEARING IMPAIRED)
OFFICES LOCATED AT: 122 NORTHERN AVENUE,
GARDINER, MAINE
www.maine.gov/professionallicensing



JOHN ELIAS BALDACCI
GOVERNOR

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
Board of Counseling Professionals Licensure
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

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REQUEST FOR EXAMINATION
APPLICANTS WHO APPLY FOR EXAMINATION MUST SUBMIT ALL MATERIALS REQUIRED FOR LICENSURE BEFORE APPROVAL TO SIT FOR AN EXAMINATION WILL BE GRANTED.

Please fill in the information requested below and **return this form** with all other required application materials to the Board at the above address.

Check Appropriate Category
<input type="checkbox"/> NCE (applicants for conditional licensure as a Professional, Clinical, or Pastoral Counselor)
<input type="checkbox"/> NCMHCE (applicants for full licensure as a Clinical Counselor or Pastoral Counselor)
<input type="checkbox"/> PES (applicants for conditional/full licensure as a Marriage and Family Therapist)

Marriage and Family Therapist applicants only:			
	Approval Deadline	Registration Deadline	Exam Dates
Please circle requested date	12/3/2007	12/28/2007	1/14/2008 to 2/9/2007
	3/10/2008	5/2/2008	5/19/2008 to 06/14/2008
	7/14/2008	8/29/2008	9/15/2008 to 10/11/2008

If you require special accommodations, please fill out the **Accommodation Request Form** and return it with your application materials.

Name of Applicant:		
Mailing Address:		
City:	State:	Zip Code:
Telephone (work):		Telephone (home):
Date of Birth:	Social Security Number:	Today's Date:





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**Educational Requirements Worksheet for
Licensed Marriage and Family Therapist**

INSTRUCTIONS: Place the relevant course(s) from your transcripts into the appropriate category on the worksheet. A course may not be used twice to fulfill more than one (1) content area. **NOTE:** You must attach a college catalog, description or syllabus to substantiate the specific material included in each course listed on the worksheet.

Content Area	Course No.	Course Title	Credit Hours	
			Qrt.	Sem.
1. Marital and Family Studies (minimum of 9 semester hours with 3 semester hours in general systems theory)				
2. Marital and Family Therapy (minimum of 9 semester hours)				
3. Human Development (minimum of 6 semester hours)				
4. Human Sexuality				
5. Diagnosis and Treatment				
6. Professional Orientation				
7. Research and Evaluation				
8. Practicum				
9. Internship				

NOTE: The following page contains the definitions of the above content areas

Page 23



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Educational Requirements for Licensed Marriage and Family Therapist

Chapter 4, Section 1

Marital and Family Studies: Nine (9) semester hours or quarter-hour equivalent in theories of family development, general systems theory, theories of family functioning, the family life cycle, sociology of the family, families under stress, contemporary family forms, family sub-systems, family of origin and external societal influences, family pathology such as addiction, child abuse and sexual abuse, and other related topics. Three (3) of the nine (9) semester hours must be in general systems theory.

Marital and Family Therapy: Nine (9) semester hours or quarter-hour equivalent in the study of major marital and family therapy treatment approaches and techniques to provide a substantive understanding of systems change. The coursework may include strategic, structural, integrative experiential, systems, neo-analytic, communications and behavioral treatment modalities.

Human Development: Six (6) semester hours or quarter-hour equivalent in the study of human development across the life cycle, personality theory and cognitive development.

Human Sexuality: Studies that provide an understanding of human sexuality over the life cycle, sex roles, sexual function and dysfunction.

Diagnosis and Treatment: Studies that provide an understanding of psychopathology, the diagnosis and statistical manual and its use in counseling, psychopathology, the development of treatment plans and the use of related services, and the role of assessment, intake interviews, and reports.

Professional Orientation: Studies that provide an understanding of professional roles and functions, professional organizations and associations, history and trends within the profession, ethical and legal standards, and professional preparation standards and professional credentialing.

Research and Evaluation: Studies that provide an understanding of the types of research, basic statistics, research report development, research implementation, program evaluation, needs assessment, and ethical and legal considerations associated with research and evaluation.

Practicum: A course of clinical instruction that provides practical experience in counseling for the purpose of developing marriage and family counseling skills. These experiences allow students to perform, on a limited basis, some counseling activities that a regularly employed licensed marriage and family therapist would be expected to perform.

Internship: A full academic year of supervised marriage and family counseling experience consisting of at least 900 clock hours, including a minimum of 360 clock hours of direct client contact. The internship provides an opportunity for the student to perform all the activities that a regularly employed marriage and family therapist would be expected to perform.



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04333-0035

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SUGGESTED FORMAT FOR DISCLOSURE STATEMENT

Disclosure Statement

- A. Name, M.S.**
Such-and-such Counseling Service
555 Main Street
City, Maine (207) 666-7777
- B. Degree:** Highest degree and related field of study
Licensure: Please indicate here the license/registration type, original or renewal license, and the projected begin and end date of license term (2 year cycle). **(If conditionally licensed, please indicate).**
(Example: LCPC, original: 9/03 expiration: 9/05)
- C. Areas of competence** - I am trained for work with individuals, couples, and(continued concisely, but with a much detail as necessary to give clients an idea of the range of your skills and scope of your license/registration).
- D. Course of Action**- At the first interview(Include a description of your usual process of intake, assessment, and goal setting. If clinically licensed, please also explain your process for diagnosing and treating. This is designed to give your prospective client an idea of what to expect in counseling).
- E. Confidentiality** - A statement indicating the limits and scope of confidentiality. The following exceptions **must** be included:
1. Threat of serious harm to self or others.
 2. Reasonable suspicion of child abuse, or abuse of elder or any incapacitated person.
 3. Court order.
 4. Voluntary release signed by client or guardian.
 5. In defense against legal action or formal complaint which client makes before a court or regulatory board.
 6. During supervisory consultations.
- F. Supervision** – A statement indicating supervision arrangement of counselor, when applicable.
- G. Fee schedule, hours of business, policy regarding third party payments** – explained with words that are clearly understood.
- H. Accountability** - A statement to the effect that “the practice of counseling is regulated by the Department of Professional and Finance Regulation, and complaints may be registered by contacting: Board of Counseling Professionals Licensure
35 State House Station
Augusta, ME 04333
(207) 624-8674

Page 25

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04333-0035

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**National Practitioner Data Bank (“NPDB”) and
Healthcare Integrity and Protection Data Bank (“HIPDB”)
Self-Query Reports**

Pursuant to 10 M.R.S.A. §8003, sub-§10*, the Office of Licensing and Registration will require all applicants to submit a NPDB/HIPDB Self-Query Report as part of the initial application for licensure within each of the following allied health licensure programs effective **November 1, 2007**. Applications received without the NPDB/HIPDB self-query report will be considered incomplete which will further delay the application process.

* **“National disciplinary record system.** Within the limits of available revenues, all bureaus, offices, boards or commissions internal or affiliated with the department shall join or subscribe to the national disciplinary record system used to track interstate movement of regulated professionals who have been the subject of discipline by state boards, commissions or agencies and report disciplinary actions taken within this State to that system.”

Alcohol and Drug Counselors

License Alcohol and Drug Counselors
Certified Alcohol and Drug Counselor
Certified Clinical Supervisor
Alcohol and Drug Counselor Aide

Athletic Trainers

Athletic Trainers

Chiropractic Licensure

Chiropractor, Chiropractic Assistant
Chiropractic Acupuncture

Complementary Health Care

Acupuncturist, Naturopathic Doctor,
Naturopathic Acupuncture, Chinese Herbal
Formulation Certification

Counseling Professionals

LP, PC, LMFT, LCPC, RC
Including Conditional

Dietetic Practice

DI, DT / Including Temporary

Hearing Aid Dealers and Fitters

Hearing Aid Dealer and Fitter / Trainees

Massage Therapists

Massage Therapist

Nursing Home Administrators

AD, MLA, RC

Occupational Therapy

OT, OTA / Including Temporary

Physical Therapy

Physical Therapists
Physical Therapists Assistants

Pharmacy

Pharmacist
Pharmacist Technician
Pharmacies
Mail Order Pharmacies
Mail Order Contact Lens Suppliers
Wholesale Distributor
Manufacturer

Podiatric Medicine

Podiatrist, Resident Podiatrist

Psychologists

Psychologist, Psychologist Examiners
Including Conditional and Temporary

Radiologic Technologists

Radiologic Technologists – 3 authorities
Limited Radiographers / Special Permit
Including Temporary

Respiratory Care

Respiratory Therapist
Respiratory Technician
Associate

Social Worker Licensure

LS, LX, LM, LC, MC

SLP and Audiologists

SLP, Audiologist

The instructions to request a self-query report are available at NPDB/HIPDB’s website:
www.npdb-hipdb.hrsa.gov

The website includes a Fact Sheet on self-querying, as well as FAQs to assist you in requesting a report. Customer Service Contact information is provided below:

NPDB-HIPDB Customer Service Center

Tel: (800)767-6732

TDD: (703)802-9395