STATE OF MAINE
BOARD OF COUNSELING PROFESSIONALS LICENSURE

MFT EXAMINATION APPLICATION TO QUALIFY FOR CONDITIONAL OR FULL MARRIAGE AND FAMILY THERAPIST LICENSURE

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

Office Telephone: (207) 624-8626
Office Facsimile: (207) 624-8637
TTY USERS CALL MAINE RELAY 711
Internet: www.maine.gov/professionallicensing

Office located at: 76 Northern Avenue, Gardiner, Maine

Revised 11/2018

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://www.mainelegislature.org/legis/statutes/32/title32ch119sec0.html

- 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

- Licensing Rules for the Department of Professional and Financial Regulation

Please read these carefully and review periodically for changes. You are responsible for knowing and complying with Office of Professional and Occupational Regulation Rules, Chapters 10, 11 and 13, throughout your licensure.

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

- Statutory Authority, Titles 5 & 10

Available: http://www.mainelegislature.org/legis/statutes/10/title10ch901sec0.html

http://www.mainelegislature.org/legis/statutes/5/title5ch341sec0.html

APPLICATION PROCEDURE

- Please submit your application materials by mail or hand delivery to our offices. Submissions by fax or e-mail will not be accepted. The application will be reviewed in the order it was received.
- If there are deficiencies with your application, you will be notified by mail. **Please note:** Candidates whose applications have been incomplete for more than one (1) year will be required to submit **new** applications and fees if they still wish to be considered for examination.
- Please do not call our office regarding the status of your application. Information regarding the status of applications may be found at the Office of Professional and Occupational Regulation's website: http://www.maine.gov/professionallicensing. We appreciate your thoughtful attention to this request.

License Examination

Please review Chapter 4 of the Board's Rules carefully. Chapter 3 outlines the requirements for licensure as a clinical professional counselor. An application will not be approved unless the applicant meets all qualifications as outlined in the Board's Rules. A complete application shall include the following:

- ☐ A completed and signed Application;
- ☐ Payment of an Application fee of $25.00;
- ☐ A copy of your Official Transcript;
- ☐ A completed Educational Requirements Worksheet accompanied by course descriptions, syllabi and/or catalogs; (Submit only if your mental health counseling program was not CACREP accredited at the time the degree was awarded) or COAMFTE accredited with a doctoral degree. (Educational Worksheets can be found under "Applications and Forms" on our website)

  Note: Course descriptions should be taken directly from course catalogues current at the time the courses were completed.

- ☐ A completed Verification of Internship Form 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;

Please note:
Once you have passed the examination, you must submit an application for licensure.

STATE OF MAINE DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
Mailing Address: 35 State House Station, Augusta, Maine 04333 **Courier/Delivery address**: 76 Northern Avenue, Gardiner, Maine 04345
Phone: (207) 624-8603 Fax: (207) 624-8637 TTY users call Maine relay 711 Web: www.maine.gov/professionallicensing

Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035.
- **Where are you located?** 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** 8:00 a.m. to 5:00 p.m. weekdays.
- **Can I come to Gardiner to drop off my application?** Yes.
- **Can I come to Gardiner to pick up my license?** No. Your license will be emailed to you.
- **How can I check the status of my application?** You can check our website:
- http://pfr.informe.org/almsonline/almsquery/welcome.aspx.
- **How far back do I go answering the criminal conviction question?** Any conviction, ever.
- **Can I fax my application?** No.

NOTICES

BACKGROUND CHECK: 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 Professional and Occupational Regulation requires a criminal history records check as part of the application process for all applicants.

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRSA §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

SOCIAL SECURITY NUMBER: The following statement is made pursuant to the Privacy Act of 1974 (§7(B)). Disclosure of your Social Security Number Is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 35 MRSA §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(C)(2)(C)(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 §191.

Before you seal the envelope, did you:

- Complete every item on the application including the criminal background disclosure question.
- Sign and date your application.
- Include the required fee(s). Make checks payable to "Maine State Treasurer" or complete the credit card section on the application. DO NOT SEND CASH.
- Make a copy of your application to keep for your records.

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
INDIVIDUAL LICENSE EXAMINATION APPLICATION

APPLICANT INFORMATION (please print)			
FULL LEGAL NAME *FIRST* *MIDDLE INITIAL* *LAST*			
ANY OTHER NAMES EVER USED			
DATE OF BIRTH *mm / dd / yyyy*	SOCIAL SECURITY NUMBER		
MAILING ADDRESS			
CITY	STATE	ZIP CODE	COUNTY
PHONE ( )	FAX ( )	E-MAIL	

CRIMINAL BACKGROUND DISCLOSURE

NOTE: Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.

1. **Have you ever been convicted by any court of any crime? (circle one) NO YES**
   If yes, enclose a detailed description of what happened (including dates) and a copy of the court judgment.
2. **Has any jurisdiction taken disciplinary action against any professional license you hold or have held, or denied your application for licensure? (circle one) NO YES**
   If yes, enclose a detailed explanation and copies of all documents.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Professional and Occupational Regulation will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.

SIGNATURE **DATE**

Board of Counseling Professionals Licensure Examination

Please Select License Type:

- ☐ Marriage & Family Therapist, Full (MF1421)
- ☐ Marriage & Family Therapist, Conditional (XM1421)

Required Fee: $25

Rev. 11/2018

Office Use Only:
1446 - $25.00

Office Use Only:
Check #_____
Amount:_____
Cash #_____
Lic. #_____

PAYMENT OPTIONS:

Make checks payable to "Maine State Treasurer" – if you wish to pay by Mastercard, Visa, Discover or American Express fill out the following:

NAME OF CARDHOLDER (please print) *FIRST* *MIDDLE INITIAL* *LAST*

I authorize the Department of Professional and Financial Regulation, Office of Professional & Occupational Regulation to charge my ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN EXPRESS the following amount: $_____

☐ **I understand that fees are non-refundable**

Card number: *XXXX-XXXX-XXXX-XXXX* Expiration Date *mm / yyyy*

SIGNATURE **DATE**

Graduate Education A copy of Official transcripts must be submitted		
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:	

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

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 national counseling examination? [ ] YES [ ] NO

If yes:

Exam Title:	Location:
Date Taken:	Select One: [ ] Pass [ ] Fail

Exam Title:	Location:
Date Taken:	Select One: [ ] Pass [ ] Fail

Affirmation

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Professional and Occupational Regulation will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.

SIGNATURE: _____ DATE: _____

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AUGUSTA, MAINE
04333-0035

Paul R. LePage
Governor

Anne L. Head
Commissioner

Examination Information

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.

- 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

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REQUEST FOR EXAMINATION
APPLICANTS WHO APPLY FOR EXAMINATION MUST SUBMIT ALL MATERIALS REQUIRED 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
☐ **MFT** (Applicants for conditional/full licensure as a Marriage and Family Therapist)

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:		Today's Date:

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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)*:		

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: _____

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OFFICE PHONE: (207)624-8626 OFFICES LOCATED AT: 76 NORTHERN AVENUE, GARDINER, MAINE FAX: (207)624-8637
www.maine.gov/professionallicensing

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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SUPERVISOR'S AFFIDAVIT (For Full Licensure)

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:			
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)

Clinical Professional Counselor [ ]
Marriage and Family Therapist [ ]
Professional Counselor [ ]
Pastoral Counselor [ ]

SUPERVISION: (List number of hours):

Individual _____
Group Supervision _____
Total number of supervision hours _____

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 SUPERVISON 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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DEGREE/INTERNSHIP VERIFICATION FORM
(For Conditional License or Full License if not submitted with Previous Conditional Application)

To: Board of Counseling Professionals Licensure 35 State House Station Augusta, ME 04333-0035	Date:

Student Name:	Student ID 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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Educational Requirements Worksheet for Licensed Marriage and Family Therapist

Applicant's Name: _____ Applicant's School: _____

INSTRUCTIONS: Place the relevant course(s) from your transcripts into the appropriate category on the worksheet. A course cannot 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.	Credit Hours 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

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: Students 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, ad 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.