Behavioral Sciences Regulatory Board
700 SW Harrison St. Suite 420
Topeka, KS 66603-3929

Phone: 785-296-3240
Fax: 785-296-3112
www.ksbsrb.ks.gov

David B. Fye, JD, Executive Director
Laura Kelly, Governor

INSTRUCTIONS FOR CLINICAL MARRIAGE AND FAMILY THERAPY LICENSURE
LCMFT

1. Before you begin to complete the application read all the instructions and review the statutes and regulations so that you will understand the information being requested. The statutes and regulations can be found on our website, www.ksbsrb.ks.gov
2. **If you are currently an LMFT in Kansas, you will need to submit the following documentation:**
   - The completed application form (pages 1 -4);
   - The application fee (See Appendix A);
   - The Post-Graduate Supervisor Attestation(s).

   If you are not currently an LMFT in Kansas, you will need to additionally submit the following documentation:
   - An official transcript;
   - The three (3) completed Professional Reference forms;
   - The Out-of-State Clearance Form, if you were or are currently licensed in another state;
   - The Graduate Practicum Review Form, if you graduated from a non-COAMFTE school;
   - The Academic Background Form, if you graduated from a non-COAMFTE school;
3. Exam scores, if applicable.
4. **Criminal Conviction/s-** You are required to report the following convictions:
   A. Conviction of Any felony
   B. Conviction of any misdemeanor crime against a person

   Either of the above listed convictions will require you to complete the Conviction Packet. You may click on this link to download the: **Conviction Packet** or you may find this packet on our website, **www.ksbsrb.ks.gov** under forms. You must return the required documentation with your application packet. **Your application will not be reviewed without this information.** Your application will require a determination from the full Board on eligibility for licensure. **Please allow extra time for a decision to be made on your application.**
5. Instructions for paying the $50 application fee may be found on **Appendix A**. FEES ARE NON-REFUNDABLE.
6. As part of the application process, each applicant is required to provide an official transcript from the Registrar's office of the college or university where your degree was granted. Request that the school send the transcript directly to the Board office. **We will not accept transcripts sent from the applicant.** (If we already have your transcript, with the degree posted, you don't need to send it again).
7. As part of your completed application packet if aren't already licensed as an LMFT in Kansas, you are required to submit three (3) Professional Reference Forms. After completing Section 1 of the form, send them to each of the three individuals who will serve as your professional references.
   a) Each of your references should complete the reference form and return it to you. You will then include these reference forms with your application and any other required material. NOTE: The individuals providing a reference should seal the envelopes and then sign the back of the sealed envelopes so that the Board is assured of the confidentiality and integrity of the referencing process. **The Board will NOT accept references that are not in sealed, signed envelopes.**
   b) By regulation, your references must be from individuals that are licensed or authorized by law to practice marriage and family therapy or in a related behavioral science field. The professional references shall be familiar with your work as a therapist and not related to you.
   c) One of the references must be from the on-site practicum supervisor who provided supervision as part of your master's degree graduate program.
8. The Board cannot determine whether you are eligible to sit for the examination until all the application materials have been received and approved by the BSRB.
9. Once you are eligible to sit for the examination, you will be provided information about scheduling the exam. The BSRB does not give the exam, we approve you to take the exam.
10. If you have met all the requirements for licensure except passing the examination, you may request a temporary license. **NOTE: We must have your official transcript, with the degree posted before we can issue a temporary license.**
11. If you are or have ever been licensed, registered, or certified as a marriage and family therapist in another state, please have the Out-of-State Clearance Form completed by the State board in which you were or are licensed. They should send the form directly to the BSRB.

    Please allow 30 days for review of your application. You may now **check the status of your application on our website** www.ksbsrb.ks.gov, under *"Services."*

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APPLICATION FOR LICENSURE AS A LICENSED CLINICAL MARRIAGE AND FAMILY THERAPIST: LCMFT

Application Fee: $50.00 please see Appendix A

I. Identifying information: (Please type or print clearly in ink)

Legal Name: _____ _____ _____
Last **First** **Middle**

Maiden/Other names used: _____ **Gender**: _____

Date of Birth: _____ **Social Security Number:** _____ (**Note:** Your social security number is required pursuant to 42 U.S.C.S. § 666(a)(13), K.S.A. 74-148 and K.S.A. 74-139, and may be used for child support enforcement purposes or provided to the Kansas director of taxation upon request.)

Ethnic Information: (Optional) African American _____ Native American _____ Asian Indian _____ Asian-Other _____
Hispanic _____ Pacific Islander _____ White – Non Hispanic _____ Other _____
(Please Specify)

Languages that you speak: (Optional) English _____ Spanish _____ Sign _____ Other _____
(Please Specify)

Preferred E-Mail Address: _____ **Preferred Mailing:** Home____ Business____

Home Phone: _____ **Cell Phone (optional):** _____

Home Address:_____ **Apartment Number:**_____

City: _____ **State:** _____ **Zip+4:**_____

Business Name: _____ **Business Phone:** _____

Business Address: _____ **Suite Number:** _____

City: _____ **State:** _____ **Zip+4:**_____

Address of Record: (**Note:** The address of record is not required. It is a separate address that will be kept on file to be given out when requested by the public through the Kansas Open Records Act. If you do not indicate an address of record, your preferred mailing address will be used.)

Street Address: _____

City: _____ **State:** _____ **Zip+4:**_____

II. Information on Previous Licensure:

A. Have you ever filed any application for licensure or registration in Kansas? Yes____No____
If "yes", please answer the following questions:

1. Under what name:_____
2. When:_____For which credential:_____

B. Do you currently hold, or have you ever held a certificate, registration or license to practice in the behavioral or health sciences in another state or jurisdiction? Yes____No____
If "yes", please answer the following questions:

1. Under what name:_____
2. When:_____For which credential:_____
3. In which state of jurisdiction, and what type of credential:_____

If you currently hold, or have ever held a certificate, registration, or license to practice in one of the behavioral or health sciences in another state or jurisdiction, you will need to have the former state Board(s) complete an Out-of-State Clearance Form. They should send the completed form directly to the BSRB.

III. Merit of the Public Trust:

A. If you answer yes to question 1 and/or 2, regarding convictions, you are required to complete the Conviction Packet. Click on this link to download Conviction Packet or you may find this packet on our website, www.ksbsrb.ks.gov under forms. See # 4 in the instructions. _

1. Have you ever been convicted of a felony? Yes____No
2. Have you ever been convicted of a misdemeanor crime against a person? Yes____No

B. If you answer "Yes to any of the following questions, **You are required to submit as part of your application a signed, dated, type-written explanation that gives specific details including disposition of the matter.** ____

3. Have you ever had a complaint filed with a professional association or a marriage and family therapist certifying, licensing, or registering body against you for alleged unethical behavior or unprofessional conduct? Yes____No____
4. Have you ever had disciplinary action taken against you for unethical behavior, unprofessional conduct or any other grounds? Yes____No____
5. Have you used any alcohol, narcotic, barbiturate other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent within the last 2 years? Yes____No____
6. Have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice behavioral sciences with reasonable skill and safety within the past 2 years? Yes____No____
7. Have you used controlled substances which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the direction of a licensed health care provider within the past 2 years? Yes____No____
8. Has any state, jurisdiction, providence, or professional organization denied your application for credentials or professional membership? Yes____No____
9. Have you ever been sued for malpractice, or agreed to pay a settlement in a malpractice suit? Yes____No____
10. Has any governmental agency ever substantiated allegations made against you for physical, mental or emotional abuse or neglect, sexual abuse, or exploitation of (1) a child, (2) a resident of an adult care home, medical care facility, psychiatric hospital or state institution for the mentally retarded, or (3) an adult? Yes____No____

If you are currently licensed as an LMFT in Kansas, you may proceed to Section V--Supervised Post-Graduate Experience

IV. Educational Qualifications and Professional References:

A. **Transcript(s):** As part of the application process, each applicant is required to provide an official transcript, with the degree posted, from the Registrar's office of the college or university where your degree was granted. Please direct the school to send the transcript directly to the Board office. We will not accept transcripts sent directly from the applicant.

B. List all accredited colleges or universities you have attended at the graduate level:

INSTITUTION	DATES OF ATTENDANCE		MAJOR AND/OR CONCENTRATION	DEGREE RECEIVED	DATE DEGREE CONFERRED
	FROM	**TO**			

C. Give other name(s) under which your coursework was taken or your degree was conferred, if different from the name you use now: _____

D. Which ONE of the following degree qualifications do you have currently?
   1. A masters degree or doctoral degree in marriage and family therapy from a college or university marriage and family therapy program that at the time of your graduation was accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE.) If you do not know the accreditation status of your program, call COAMFTE's office at 202-467-5102 to inquire. If the program was accredited at the time of your graduation, you **do NOT** need to fill out the Academic Background Form or Graduate Practicum Review Form.
   2. A masters or doctoral degree in one of the related fields: social work, psychology, counseling, healing arts, nursing, education, human development and family studies, or theology, that **INCLUDED** coursework that meets the educational requirements outlined in statute 65-6404 (a) (3). If your degree is in one of these fields, you **WILL** need to complete the Academic Background Form and the Graduate Practicum Review Form.
   3. A masters or doctoral degree in one of the related fields: social work, psychology, counseling, healing arts, nursing, education, human development and family studies, or theology, with **ADDITIONAL** coursework that meets the educational requirements outlined in statute 65-6404 (a) (3). If your degree is in one of these fields, you **WILL** need to complete the Academic Background Form and the Graduate Practicum Review Form.

E. Graduate Practicum Review form: At the time of application, submit in the unopened envelope that has been signed or stamped by the graduate program director, the completed Graduate Practicum Review Form. Note: This form must be completed by the marriage and family therapy program director from the college or university that academically supervised the masters degree marriage and family therapy practicum experience.

F. At the time of application, submit 3 professional references in the unopened envelopes that have been signed across the seal by each reference, including the reference from the individual who provided the direct clinical supervision of your on-site graduate program practicum. The Professional Reference Forms need to be completed by individuals that are licensed to practice marriage and family therapy at the graduate level or in a related behavioral science field, they cannot be related to you, and they must be able to attest to your professional competency and character.

G. Provide the names and mailing addresses of the three individuals that completed the Professional Reference Forms on your behalf. **Please place an asterisk/star (*) next to the person(s) who provided the direct supervision of your graduate program practicum.**

Name: _____

Address: _____

Name: _____

Address: _____

Name: _____

Address: _____

V. Supervised Post-Graduate Work Experience:

A. List the name and current address of the supervisor(s) that completed the post-graduate supervisor's attestation forms that are included with your application packet.
Name of Supervisor _____
Current Address _____
Phone _____
Dates of supervision _____

B. Did you complete your post-graduate supervised experience in accordance with a Clinical Supervision Training Plan and amendments as approved by the Board? Yes____No____
If "no", provide either "1" or "2" with your application:
   1. A description of any changes from your Board approved Clinical Supervision Training Plan and amendments that occurred during your post-graduate experience, complete with your rationale for making the changes: **OR**
   2. Job descriptions of each position you held while obtaining supervised experience including information on the practice settings, dates of employment/practice, specific marriage and family services you provided while under supervision, and any applicable documentation of your supervisory contract or experience.

VI. Examination:

A. If you have not previously taken the Examination in Marital and Family Therapy developed by the Association of Marital and Family Therapy Regulatory Boards (AMFTRB) and achieved a passing score, you will be notified in writing if you are eligible to register and sit for the examination. Applicants must first satisfy the educational requirements to be authorized by Behavioral Sciences Regulatory Board (BSRB) to register for the examination.

B. Did you complete the national Examination in Marital and Family Therapy through the Kansas Board office? Yes____No____ **If you answered "no", provide either "1" or "2" below:**

1. Name of the state other than Kansas in which you took the national Examination in Marital and Family Therapy (include verification of score on the Out-of-State Clearance Form, or scores sent directly to the BSRB office from the Professional Examination Service).

   _____

2. Name of the examination you completed that you believe to be acceptable to the Board (include verification of your passing score on the Out-of-State Clearance Form, or scores sent to the BSRB office from the examination service).

   _____

A. Date exam was taken:_____Location of Exam:_____

VII. Applicant's Attestation:

A. I have reviewed the licensure eligibility requirements prior to submitting this application. Yes____No____

B. I have completed the application materials and procedures honestly and in good faith. Yes____No____

C. I understand that the members and staff of BSRB are compelled by law to uphold, implement and enforce the licensure statutes and regulations as written. Yes____No____

D. I understand that all state records pertaining to application and licensure may be used to conduct research or program evaluation, but any such research will not personally identify the applicants or licensees, either directly or indirectly. Yes____No____

E. I understand that the Board has the statutory authority to refuse to grant licensure to, or may suspend, revoke, condition, limit, qualify, or restrict the license of any individual that has knowingly made a false statement on a BSRB form required for licensure or licensure renewal. Yes____No____

F. I **have read** and am familiar with the statutes and regulations governing the practice of clinical marriage and family therapy in Kansas. Yes____No____

G. I understand that **once the Board receives my application I am bound by, and will abide by the statutes and regulations** governing the practice of clinical marriage and family therapy in Kansas. Yes____No____

Signature: _____Date:_____

NAME or ADDRESS CHANGE: It is the applicant's responsibility to notify the Board in writing of any name or address change that might occur during the application process.

Kansas
Behavioral Sciences
Regulatory Board

APPLICATION FOR LICENSURE AS A LICENSED CLINICAL MARRIAGE AND FAMILY THERAPIST: LCMFT

Graduate Practicum Review Form

This form is NOT required of applicants that graduated from a COAMFTE accredited or candidacy program

Instructions for Applicant: Section 1 should be completed by the applicant and then sent to the Graduate Program Director of the Marriage and Family Therapy Program for completion. Please include a self-addressed, stamped envelope. Additional copies of this form may be made and used as needed by the applicant. The applicant shall submit the completed Graduate Practicum Review Form in the unopened envelope that has been signed or stamped across the seal by the Graduate Program Director, at the time of application.
Section 2: The Graduate Program Director should complete Section 2 and return the completed form in a sealed envelope signed across the seal to the applicant.

I. Section 1: To be completed by the Applicant:

A. Applicant's Name:_____

B. Student ID:_____ ___

C. Applicant's Mailing Address:_____

D. Degree and Graduation Date:_____

E. Educational Institution:_____

F. Graduate Program Director:_____

G. Mailing Address:_____

II. Section 2: To be completed by Graduate Program Director and returned to the Applicant in a sealed envelope signed across the seal:

The above-named applicant has applied to the Kansas Behavioral Sciences Regulatory Board for licensure as a clinical marriage and family therapist. It appears that the graduate program from which the applicant graduated was not accredited or approved for candidacy status by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) *as of the date the applicant graduated*. For the Board to make a determination as to whether the applicant meets educational qualifications pursuant to K.S.A. 65-6404 (a)(2) as defined in K.A.R. 102-5-3. **It is required that this form *be completed by the graduate program director and returned to the applicant for submission in the application packet.*** Please return this completed form to the applicant in the enclosed envelope, sealed, with your signature/stamp across the seal.

A. Please state the regional accreditation held by the university awarding the master's or doctoral degree completed by the applicant:

_____

B. Please state the professional accreditation (if any) held by the graduate program completed by the applicant:

_____

C. As part of the applicant's graduate program, please verify that the applicant satisfactorily completed a marriage and family therapy practicum experience or its equivalent as follows:
   1. A part-time clinical experience integrating didactic with clinical experience completed concurrently with didactic coursework at a typical rate of 5-10 hours of direct client contact per week: Yes____No____
   2. At least 350 hours of face-to-face client contact conducting therapy and assessment with individuals, couples, families, and/or groups: Yes____No____
   3. **If no, how many hours were completed?** _____

4. At least 60 hours of supervision inclusive of at least 30 hours of individual supervision and up to 30 hours of group supervision with 6 or less supervisees, provided by the program's core faculty and off-site supervisors: Yes____No____

5. Individual supervision at least once a week over a period of one year Yes____No____

If you answered "no" to any of the above items, please explain:

_____

_____

I hereby affirm that to the best of my knowledge all answers to the above items are true and correct.

(Print):_____
Graduate Program Dean or Director

(Signature):_____Date: _____
Graduate Program Dean or Director

Email:_____ Phone Number: _____

Kansas
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APPLICATION FOR LICENSURE AS A LICENSED CLINICAL MARRIAGE AND FAMILY THERAPIST: LCMFT

Academic Background Form

Name:_____ Date:_____

Student ID:_____ Date of Conferral of Graduate Degree(s):_____

List level of degree(s)conferred and field/department of study:_____

University:_____City/State:_____

To establish educational eligibility related to K.S.A. 65-6405(a) as defined in K.S.A. 65-6404(a)(3), applicants that did not complete their degree in a COAMFTE accredited program are required to complete the following information, as it relates to their academic background.

Please indicate the courses you completed that meet these requirements, including only graduate level courses. Courses cannot be duplicated. If the relationship between the courses(s) you took and the course content category is not readily apparent, please attach course syllabus or the university's course catalog to this form.

The following activities shall **NOT** be reported, substituted for or counted toward the academic coursework requirements:

1. coursework taken for undergraduate credit;
2. independent studies;
3. thesis or independent research courses;
4. academic coursework that was audited;
5. academic coursework that has a failing or incomplete grade;
6. nonacademic coursework or training;
7. continuing education, in-service, or on-the-job training.

Please remember that fifteen (15) graduate credit hours supporting diagnosis or treatment of mental disorders is required for the LCMFT license. Please indicate in the far right column which hours you will be claiming to meet the 15 hour requirement if you intend to apply for the LCP license at any time.

Please see K.S.A. 65-6404 and K.A.R. 102-5-3 for more detail

Note: If your college or university awarded quarter or trimester credit hours rather than semester hours, please indicate by putting a Q (for quarter hours) or a T (for trimester hours) adjacent to the reported number of credit hours throughout the form.

1. **Marriage and Family Therapy Practicum Course** consists of a part-time clinical experience integrating didactic with clinical experience and is completed concurrently with didactic coursework at a typical rate of 5-10 hours of direct client contact per week.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement
_____	_____		_____	Yes No
_____	_____		_____	Yes No
_____	_____		_____	Yes No

2. **Human Development and Family Study Courses** (Minimum of 9 semester credit hours required). Includes courses where the interplay between interpersonal and intrapersonal development is stressed and issues of gender, ethnicity and ecosystems are addressed as they relate to human development. Such courses may include studies in sexuality, sexual functioning, sexual identity, sexism, stereotyping and racism.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement
_____	_____		_____	Yes No
_____	_____		_____	Yes No
_____	_____		_____	Yes No

3. **Theoretical Foundation Courses** (Minimum of 9 semester credit hours required.) Includes an overview of the historical development of systems theory and cybernetics and a study of the life cycle of the family and the process and modification of family structures over time. Such courses may include studies in the birth of the first child, adolescent sexual development, death of a family member and issues of context including gender and ethnicity.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement
_____	_____	_____	_____	Yes No
_____	_____	_____	_____	Yes No
_____	_____	_____	_____	Yes No

4. **Marital and Family Assessment and Therapy Courses** (Minimum of 9 semester credit hours required.) Include courses that underscore the interdependence between diagnosis of assessment and treatment by insuring that students can use appropriate assessment instruments and methods within a systemic context. Such courses shall also provide a thorough understanding of the major models of system change including but not limited to structural, strategic, intergenerational, contextual, experiential, systemic and behavioral models, teach the principles and techniques evolving from each model and address the indications and contraindications of using each technique, the rationale for intervention, and the role of the therapist and the importance of considering gender and ethnicity.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement
_____	_____	_____	_____	Yes No
_____	_____	_____	_____	Yes No
_____	_____	_____	_____	Yes No

5. A Professional Study Course (Minimum of 3 semester credit hours required.) Includes courses(s) that contribute to the development of a professional attitude and identity by examining the role of professional socialization, professional organizations, licensure and certification, the code of ethics, legal responsibilities and liabilities of clinical practice and research and inter-professional cooperation as these topics relate to the profession and practice of marriage and family therapy. **NOTE: A generic course in ethics is not appropriate for this area of study.**

Course #	Course Title	Credit Hrs	University	15 Hr Requirement
_____	_____	_____	_____	Yes No
_____	_____	_____	_____	Yes No
_____	_____	_____	_____	Yes No

6. **A Research Course** (Minimum of 3 semester credit hours required.) Include course(s) where students gain an understanding of research methodology, data analysis, computer research skills and evaluation and critical examination of professional research reports. The emphasis of the course shall be placed on the quantitative and qualitative research which is relevant to marriage and family therapy.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement
_____	_____	_____	_____	Yes No
_____	_____	_____	_____	Yes No
_____	_____	_____	_____	Yes No

7. Please list any additional graduate courses that you have completed and that may be applicable to the educational requirements.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement
_____	_____	_____	_____	Yes No
_____	_____	_____	_____	Yes No
_____	_____	_____	_____	Yes No

Kansas
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APPLICATION FOR LICENSURE AS A LICENSED CLINICAL MARRIAGE AND FAMILY THERAPIST: LCMFT

Professional Reference Form

Instructions: Section 1 is to be completed by the applicant and then sent to the referencing individuals for completion. Additional copies of this form may be made and used as needed by the applicant. **Completed Professional Reference forms shall be submitted in the unopened sealed envelopes by the applicant at the time of application**.
Section 2 is to be completed by the referencing individual, sealed and signed over the seal, and then returned to the applicant.

SECTION 1: This section is to be completed by the applicant.

To: Name of reference (please print): _____

From: Name of Applicant (please print): _____

I am applying for licensure as a clinical marriage and family therapist in the State of Kansas and I am required to provide information to support that application. This form, bearing may signature, gives my consent and authorization to release any and all information and/or documents that may be material to an evaluation of my merit of the public trust. I authorize the Behavioral Sciences Regulatory Board (BSRB) and its representatives to consult with you regarding my professional competence, character, ethical qualifications, health status, ability to work cooperatively with others and other qualifications for licensure.

I release from liability any and all individuals, institutions and organizations that provided information to the BSRB or its representatives, in substantial good faith and without malice, concerning my merit or the public trust and my qualifications for licensure. I consent to the inspection by the BSRB and its representatives of all documents that may be material to an evaluation of my qualifications and competence. I understand that this consent for release of information will be in effect for a period of one year from the date of consent.

Please mail this completed form directly to me in a sealed envelope with your signature across the seal. **Please be certain to seal the envelope and sign over the seal.** I am responsible for submitting to BSRB the completed form in its sealed envelope as part of my application packet.

Signature of Applicant: _____ Date:_____

SECTION 2: The qualified referencing individual should answer all of the following questions to the best of their knowledge. The reference should then return this completed form to the applicant in a sealed envelope. The reference should sign his/her name over/across the seal on the envelope to insure confidentiality.

To qualify to serve as a professional reference, the referencing individual must be:

1. unrelated to the applicant;
2. authorized by law to practice marriage and family therapy or at the graduate level in a related field;
3. able to address the applicant's professional conduct, competence and merit of the public trust;
4. one of the references must be from the on-site graduate program practicum supervisor.

Note: If you do not qualify to serve as a professional reference, please alert the applicant. If you do qualify to serve as a professional reference, please complete the form and return it, at your earliest convenience, to the applicant as indicated above. Please be sure to sign over the seal on the back of the sealed envelope before returning it to the applicant. Thank you.

I. Professional Reference's Qualifications:

A. Professional Reference's Name:_____

B. Do you hold a professional license? Yes____No____ **If "yes", please answer the following questions:**

1. Professional Licenses held:_____License #:_____

2. State of Issuance:_____Issuance Date:_____Expiration Date:_____

C. Agency:_____

D. Agency Address:_____

E. Phone: _____ Email: _____

F. Professional Reference's Graduate Degree: _____

G. Professional Title: _____

H. Were you the applicant's graduate program on-site practicum supervisor? Yes____No____

I. Are you related by blood or marriage to the applicant? Yes____No____
If "yes", state relationship:

_____

J. How long have you known the applicant? _____

K. What relationship (such as employer, supervisor, co-worker, instructor and the like) have you had with the applicant which has aided you in forming any opinion of his/her character:

_____

II. Professional Reference's Knowledge of the Applicant:

A. Please consider the candidate's behavior in the following areas: good judgement, integrity, honesty, fairness, credibility, reliability, respect for others, respect for the laws of the state and nation, self-discipline, self-evaluation, initiative, and commitment to the profession of clinical marriage and family therapy and its values and ethics. Does the candidate, in your opinion, possess the moral standards and fitness required for working as a clinical marriage and family therapist? Yes____No____
If your answer is "no", please elaborate in detail on attached sheet.

B. Are you aware of any significant facts concerning the applicant's background, which would reflect unfavorably on the applicant's character and fitness to practice clinical marriage and family therapy? Yes____No____
If the answer is "yes", then please state these facts in detail on an attached sheet.

C. Do you recommend the applicant for licensure to practice clinical marriage and family therapy in Kansas?
If not, please elaborate in detail in an attached statement. Yes____No____

D. If you desire, please expand upon any of the foregoing answers or add any comments or information that you believe will aid the Behavioral Sciences Regulatory Board (BSRB) in evaluating the applicant's merit of public trust for licensure as a clinical marriage and family therapist in Kansas. For such purpose you may supplement this Professional Reference Form by typewritten letter addressed to the Board and attached hereto.

III. Professional Reference's Attestation:

Reference's Attestation: I certify the foregoing answers and information furnished above are given in good faith with the understanding that it will be utilized for purposes of determining the applicant's merit of the public trust to be licensed and to practice as a professional clinical marriage and family therapist in the State of Kansas. Any response or information I have provided is true and correct to the best of my knowledge and belief. Where I have relied upon other sources of information, they are only those which I believe to be accurate and reliable.

Signature: _____Date:_____

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David B. Fye, JD, Executive Director

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APPLICATION FOR LICENSURE AS A LICENSED CLINICAL MARRIAGE AND FAMILY THERAPIST: LCMFT

Out-of-State Clearance Form

Instructions:
Section 1 is to be completed by the applicant and then sent to the out-of-state board for completion. Additional copies of this form may be made and used as needed by the applicant.
Section 2 is to be completed by a representative of the out-of-state board, and then returned directly to us.

I. SECTION 1: This section is to be completed by the applicant:

A. Name:_____

B. Social Security #:_____Date of Birth:_____

C. Maiden or other name in which license was issued:_____

D. Type of Credential held in the other state_____

E. Type or Field of Practice: _____

F. License Number:_____

G. Date Issued:_____Date of Expiration:_____

H. Level of Licensure (Baccalaureate, Masters, Doctorate):_____

II. SECTION 2: This section is to be completed by the State Board. Upon completion, please return this form to: BSRB, 700 S.W. Harrison St, Ste 420, Topeka, KS 66603-3929:

A. Type of Credential (please circle applicable designation): Licensure____ Registration____ Certification____

B. Type or Field of Practice:_____

C. Lic/Reg/Cert Number:_____

D. Date Issued:_____Date of Expiration:_____

E. Level of Lic/Reg/Cert (Baccalaureate, Masters, Doctorate):_____

F. Is Lic/Reg/Cert in Good Standing? Yes____No____ **If "no", please state reason(s):**

_____

_____

G. Has the Lic/Reg/Cert ever been suspended or revoked? Yes____No____ **If "yes", please state reason(s):**

_____

_____

H. Did the applicant take the Examination in Marital and Family Therapy developed by the Association of Marital and Family Therapy Regulatory Boards (AMFTRB) to qualify for the Lic/Reg/Cert? Yes___No____
If "yes", please complete the following:

1. Date of Exam:_____Passed: ☐ Failed: ☐
2. Exam Level:_____
3. Exam Form #:_____Applicant's Exam ID#:_____

I. Did the applicant take an examination other than the Examination in Marital and Family Therapy?
Yes____No____

1. Name of exam:_____

2. Date exam was taken:_____Location of exam:_____

J. Additional comments:

Signature of State Board Representative:_____

Printed Name:_____

Official Title/Position:_____

State/Jurisdiction _____

Mailing Address:_____
State city state zip

Phone Number:_____Fax Number:_____

Date:_____

Behavioral Sciences Regulatory Board
700 SW Harrison St. Suite 420
Topeka, KS 66603-3929
David B. Fye, JD, Executive Director

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www.ksbsrb.ks.gov
Laura Kelly, Governor

APPLICATION FOR LICENSURE AS A CLINICAL MARRIAGE AND FAMILY THERAPIST: LCMFT

Post-graduate Supervised Clinical Experience
Supervisor's Attestation

Consent and Authorization to Release Information

Supervisor's Name (Please print):_____

To my supervisor:
I am applying for license as a clinical marriage and family therapist in the state of Kansas, and I am required to provide information in support of that application. This form bearing my signature, gives my consent and authorization to release any and all information and documents that may be material to an evaluation of my qualifications and competence.

I authorize the Behavioral Sciences Regulatory Board (BSRB) and its representatives to consult with you regarding my professional competence, character, ethical qualifications, ability to work with others, and any other qualifications for licensure.

I release from liability any and all individuals, institutions, and organizations that provide information to the BSRB or its representatives, in substantial good faith and without malice, concerning my professional conduct, ethics, character and other qualifications for licensure. I consent to the inspection by the BSRB of all documents that may be material to an evaluation of my qualifications and competence. I understand that this consent for release of information will be in effect for a period of one year from the date of consent.

Please return this completed attestation to me IN A SEALED ENVELOPE, WITH YOUR SIGNATURE OVER THE SEAL. I am responsible for submitting this completed reference, in the unopened sealed envelope as part of my application packet.

Printed name of Applicant _____

Signature of Applicant _____ Date: _____

I. Work site where supervised postgraduate hours were accrued:

A. Agency/Practice Setting (worksite) name: _____

B. Address: _____

C. Phone: _____Email: _____

D. Date range of supervision provided solely by you: From_____to _____
(Provide end date. Do not write current/present)

II. Supervised hours while under your supervision:

A. Average number of hours that applicant worked per week: _____

B. **Total** number of post graduate clinical experience **hours** that applicant completed _____

C. Total number of post graduate clinical experience hours that involved **direct, face to face clinical contact providing psychotherapy and evaluation** _____

D. Total number of supervision **hours** provided to the applicant: _____

E. Total number of hours of supervision provided **individually** to the applicant _____
   - How many hours of **individual supervision were provided using real-time interactive televideo?** _____

F. Total number of hours of clinical supervision provided in a **group** setting with six or less supervisees: _____
   - How many hours of **group supervision were provided using real-time interactive televideo?** _____

III. Supervisor's Information and Qualifications

Name _____ Phone _____
Email _____
Address 1 _____
Address 2 _____
City _____ State _____ Zip Code _____

A. Graduate degree:_____Year conferred: _____
B. License type and number: _____
C. Original date of issue: _____State:_____
D. Is this license an independent, clinical level of licensure? Yes____No____
E. Were you under any disciplinary sanction, restriction or have any disciplinary action pending by a professional licensing or credentialing board at the time you provided supervision Yes____No____
F. Did you have, at least in part, clinical responsibility for the supervisee's practice of clinical marriage and family therapy? Yes____No____
G. Did you have knowledge and experience with the supervisee's client population? Yes____No____
H. Did you have knowledge and experience with the methods of practice that the supervisee employs? Yes____No____
I. Were you a member of the staff in the supervisee's practice setting? Yes____No____

If "no", please answer the following questions:

1. Did you have an understanding of the organization and administrative policies and procedures of the practice setting? Yes____No____
2. Did you understand the mission of the practice setting? Yes____No____
3. Was the extent of your responsibilities clearly defined with respect to the client cases to be supervised and your role, if any, in the personnel evaluation within the practice setting? Yes____No____
4. Was the responsibility for payment for supervision clearly defined? Yes____No____
5. If the supervisee paid you directly for supervision, did you maintain your responsibility to the client and the practice setting? Yes____No____
6. Were the parameters of client confidentiality defined and agreed to by the clients? Yes____No____

IV. Supervisor's requirements within the supervision process:

A. If the applicant's supervision process began after July 1, 2000:
   1. Did you meet with the supervisee to provide at least 1 hour of supervision for every 15 hours of direct clinical client contact? Yes____No____
   2. Did you meet with the supervisee at least 2 separate times monthly? Yes___No____
   3. Did you meet with the supervisee for individual supervision at least once monthly? Yes___No____
   4. Did your supervision include diagnosis and treatment of mental disorders? Yes___No____

   If you answered "no" to any above questions, please explain:

B. If the applicant's supervision process began before July 1, 2000:
   1. If providing clinical supervision, did you meet in person with the supervisee to provide at least 1 supervision session for every 20 hours of direct clinical client contact? Yes___No____
   2. If providing clinical supervision, did you meet with the supervisee a minimum of 4 hours monthly? Yes___No____

   If you answered "no" to any above questions, please explain on a separate page.

C. If you provided supervision in a group format, how many supervisees were in those groups? _____
D. Did you provide oversight, guidance and direction of the supervisee's practice by assessing and evaluating the supervisee's performance? Yes____No____
E. Did you provide supervision in a process distinct from personal therapy, didactic instruction, or marriage and family therapy consultation? Yes___No____
F. Did you ensure that your scope of responsibility and authority in the supervisee's practice setting was clearly defined? Yes____No____
G. Did you periodically evaluate the supervisee's role and their clinical functioning as a marriage and family therapist? Yes____No____
H. Did you provide supervision consistent with the education, training, experience, and ability of the supervisee? Yes____No____

V. Evaluation of the Applicant's supervised experience:

Summarize the types of clients and client services provided during the supervised clinical experience:

A. Assess the applicant's performance regarding the following components of clinical marriage and family therapy practice. **NOTE: If you rate any of the following categories as "unacceptable," attach a statement outlining the basis for those ratings or your reservations concerning licensing this applicant for independent clinical marriage and family therapy.**

	Acceptable	Unacceptable
1. Assessment	_____	_____
2. Diagnosis	_____	_____
3. Treatment (psychotherapy)	_____	_____
4. Client centered advocacy	_____	_____
5. Consultation	_____	_____
6. Evaluation	_____	_____

B. Please evaluate the applicant's merit of public trust in regard to the following qualities:

	Acceptable	Unacceptable
1. Good judgment:	_____	_____
2. Integrity:	_____	_____
3. Honesty:	_____	_____
4. Fairness:	_____	_____
5. Credibility:	_____	_____
6. Reliability:	_____	_____
7. Respect for others:	_____	_____
8. Respect for state and federal laws:	_____	_____
9. Self discipline:	_____	_____
10. Self-evaluation:	_____	_____
11. Initiative:	_____	_____
12. Commitment to marriage and family therapy values/ethics:	_____	_____

C. Did the applicant complete all supervision goals and objectives? Yes____No___

D. Was the applicant's performance throughout the period of supervision consistently acceptable? Yes____No___

E. Do you recommend this applicant for licensure at the independent practice, clinical level in marriage and family therapy? Yes____No____ If **"no," attach a statement that explains your denial.**

VI. Attestation of the Supervisor:

I have personally known the above applicant that has made application to the BSRB for licensure as a clinical marriage and family therapist, and attest that said applicant has been practicing in the clinical setting as indicated, and has been supervised by me in that specialty.

In signing this form, I understand that I am attesting that all the information provided in this attestation form is true, accurate, and submitted in good faith. I understand that in accordance with Kansas statutes, anyone knowingly making a false statement on any form of the BSRB shall be guilty of a Class B misdemeanor.

_____

Signature Date

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Kansas
Behavioral Sciences
Regulatory Board

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Laura Kelly, Governor

Appendix A

Payment Instructions

1. Individuals wishing to submit payments to the BSRB using a credit card or electronic check should:

(1) visit the BSRB website at ksbsrb.ks.gov
(2) select the "SERVICES" drop-down tab from the top of the home screen, and
(3) click on the "Make A Payment" link. From this page, you will be asked to provide information allowing us to identify the applicant, select the item you wish to pay for, and you will be able to make a payment for that item.

For use of the secure payment platform, the state of Kansas charges a 2.5 percent processing fee for credit card payments or a $1.50 flat fee for use of an electronic check. After completing payment, you will receive a confirmation e-mail to confirm your payment.

2. Individuals wishing to submit payments to the BSRB office using a check-by-mail or with a money order may continue to mail payments to the Behavioral Sciences Regulatory Board, 700 SW Harrison St., Ste. 420, Topeka, KS 66603. There is no additional fee for processing checks-by-mail or money orders sent to the BSRB office.

The application fee may be paid before or after you submit your application. The application will not be processed until the fee has been received.