

STATE OF KANSAS

BEHAVIORAL SCIENCES REGULATORY BOARD
700 SW HARRISON ST.
SUITE 420
TOPEKA, KS 66603-3929



PHONE: (785) 296-3240
FAX: (785) 296-3112
bsrb@ks.gov
www.ksbsrb.ks.gov

GOVERNOR JEFF COLYER, M.D.
MAX FOSTER, EXECUTIVE DIRECTOR

INSTRUCTIONS FOR MARRIAGE AND FAMILY THERAPY LICENSURE LMFT

1. Before you begin to complete the application please read all instructions and review the statutes and regulations so that you will understand what information is being requested. The statutes and regulations can be found on our website, www.ksbsrb.org.
2. Answer all questions completely and accurately. The burden of proof in satisfying to the Board that you are eligible for licensure is upon you. Thus, if you have been convicted of a felony or if there have been other past or current events that potentially raise questions about your ability to merit the public trust, you may be required to appear before the Board to explain these matters.
3. Type or print your responses in black ink.
4. The \$100.00 application fee must accompany your application. Your check or money order should be made payable to the "Behavioral Sciences Regulatory Board" or "BSRB". Credit cards are also accepted. **ALL FEES ARE NON-REFUNDABLE.**
5. 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. Please direct the school to send the transcript directly to the Board office. **We will not accept transcripts sent directly from the applicant.**
6. As part of your completed application packet you are required to submit three (3) completed Professional Reference Forms. After completing Section 1, mail these forms directly to each of the three individuals that 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 to the BSRB. NOTE: The individuals referencing you 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, all of 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. One of the references must be from the individual(s) that provided direct clinical supervision of your on-site graduate program practicum.
7. It is extremely important for you to understand that the Board cannot determine whether you are eligible to sit for the examination until all the key application materials have been received and approved by the BSRB.
8. Once you are eligible to sit for the examination, you will be provided information about scheduling for the exam and can contact the examination center for questions regarding the examination.
9. If you have met all the requirements for licensure except passage of the examination, you may request a temporary license. **NOTE: We must have your official transcript on file before we can issue a temporary license.**
10. 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 your former state Board. You will need to send the Out-of-State Clearance Form to the state(s) where you were licensed, registered, or certified as a marriage and family therapist. They should send the form directly to us.
11. Your completed application packet shall be submitted to the BSRB and should include ALL of the following:
 - The completed application form (please complete all pages so that your application will not have to be returned);
 - The correct application fee made payable to the BSRB by check, money order or credit card;
 - The three (3) completed Professional Reference Forms;
 - The Out-of-State Clearance Form, if you were licensed in another state;
 - Your official transcript;
 - 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;
 - Exam scores, if applicable.

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 "Applicants."

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APPLICATION FOR LICENSURE AS A LICENSED MARRIAGE AND FAMILY THERAPIST: LMFT

Application Fee: \$100.00 check, money order or credit card made payable to BSRB

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

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

Preferred E-Mail Address: _____ Preferred Mailing: Home _____ Business _____

Home Phone: _____ Cell Phone (optional): _____

Home Address: _____ Apartment Number: _____

City: _____ State: _____ Zip+4: _____

Business Phone: _____ Business Name: _____

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 one of 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: _____ What type of credential: _____

3. Which state of jurisdiction: _____

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 us.

III. Merit of the Public Trust:

A. Please answer the following questions. **Note: If the answer to any of the items 1 through 9 in this section is "Yes", submit as part of your application a signed, dated type-written explanation that gives specific details including disposition of the matter.**

1. Have you ever been charged with or convicted of a felony or misdemeanor other than a traffic violation?
Yes ___ No ___
2. 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 ___
3. Have you ever had disciplinary action taken against you for unethical behavior, unprofessional conduct or any other grounds?
Yes ___ No ___
4. 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 ___
5. 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 ___
6. 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 ___
7. Has any state, jurisdiction, providence, or professional organization denied your application for credentials or professional membership?
Yes ___ No ___
8. Have you ever been sued for malpractice, or agreed to pay a settlement in a malpractice suit?
Yes ___ No ___
9. 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 ___

B. 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 that provided the direct clinical supervision of your on-site graduate program practicum. The Professional References 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.

C. 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) that provided the direct supervision of your graduate program practicum.**

Name: _____

Address: _____

Name: _____

Address: _____

Name: _____

Address: _____

IV. Educational Qualifications:

A. Transcript(s): 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. 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 ____, 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.

V. 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 in order 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: _____

VI. 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 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 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.



APPLICATION FOR LICENSURE AS A LICENSED MARRIAGE AND FAMILY THERAPIST: LMFT

Graduate Practicum Review Form

This form is NOT required of applicants who 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. Date of Birth: _____ Social Security #: _____
- C. Degree and Graduation Date: _____
- D. Applicant's Mailing Address: _____
- E. Graduate Program Director: _____
- F. Educational Institution: _____
- 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 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*. In order for the Board to make a determination as to whether the applicant meets educational qualifications pursuant to K.S.A. 1996 Supp. 65-6404 (a) (2) as defined in K.A.R. 102-5-3, ***the items listed below need to be completed by the graduate program director and returned to the applicant for submission in the application packet.*** Please return this 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 500 hours of face-to-face client contact conducting therapy and assessment with individuals, couples, families, and/or groups: Yes ___ No ___
 - 3. 100 hours of clinical supervision inclusive of at least 50 hours of individual supervision and the remaining hours in group supervision with 6 or less supervisees, provided by the program's core faculty and off-site supervisors: Yes ___ No ___
 - 4. Individual supervision at least once a week over a period of one year: Yes ___ No ___

D. 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): _____
Graduate Program Dean or Director

Date: _____



APPLICATION FOR LICENSURE AS A LICENSED MARRIAGE AND FAMILY THERAPIST: LMFT

Academic Background Form

Name: _____ Date: _____

Social Security Number: _____ Date of Birth: _____

Date of Conferral of Graduate Degree(s): _____

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

University: _____ City/State: _____

In order 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 LCMFT 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 |



APPLICATION FOR LICENSURE AS A LICENSED MARRIAGE AND FAMILY THERAPIST: LMFT
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 marriage and family therapist in the State of Kansas and I am required to provide information to support that application. This form, bearing my 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 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 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: _____ Fax: _____

F. Professional Title: _____

G. Professional Reference's Graduate Degree: _____

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 that has aided you in forming an 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 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 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 that would reflect unfavorably on the applicant's character and fitness to practice marriage and family therapy? Yes ___ No ___

If your answer is "yes", please state these facts in detail on an attached statement.

C. Do you recommend the applicant for licensure to practice marriage and family therapy in Kansas? Yes ___ No ___

If not, please elaborate in detail in an attached statement.

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 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 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.

Printed Name: _____ Date: _____

Signature: _____

STATE OF KANSAS

BEHAVIORAL SCIENCES REGULATORY BOARD
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GOVERNOR JEFF COLYER, M.D.
MAX FOSTER, EXECUTIVE DIRECTOR

APPLICATION FOR LICENSURE AS A LICENSED MARRIAGE AND FAMILY THERAPIST: LMFT 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 of Issuance: _____ 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 of Issuance: _____ 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#: _____
- 4. Applicant's Score: Raw: _____ Scaled: _____ Percent: _____
Exam Mean: _____ Standard Deviation: _____ State Cutoff Score: _____

I. Did the applicant take another examination to qualify for the Lic/Reg/Cert? 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: _____

STATE SEAL

STATE OF KANSAS

BEHAVIORAL SCIENCES REGULATORY BOARD
700 SW HARRISON ST.
SUITE 420
TOPEKA, KS 66603-3929



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GOVERNOR JEFF COLYER, M.D.
MAX FOSTER, EXECUTIVE DIRECTOR

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