Sam Brownback
Governor

Max L. Foster, Jr.
Executive Director

Kansas
Behavioral Sciences
Regulatory Board

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TRANSITION FROM LICENSED MARRIAGE AND FAMILY THERAPIST TO LICENSED CLINICAL MARRIAGE AND FAMILY THERAPIST

(Only printed or typewritten form will be accepted. Fax copies will not be accepted.)

At the time of application, make sure you have all of the needed transcripts or forms returned to you and submit them in their sealed envelopes that have been signed across the seal.

The transition application fee is $100.00.

License Number:_____ Expiration Date:_____

Name to Appear on License:_____ Date of Application:_____

List Other Name(s) Used:_____ Title: Gender:_____

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.*

Date of Birth:_____ Preferred Mailing Address: ☐ Home ☐ Business

Home Address:_____
Street Apt # City State Zip+4

Home Phone Number:_____ E Mail:_____

Business Name:_____

Business Address:_____
Street Apt # City State Zip+4

Business Phone Number:_____

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.)*

Address of Record_____
Street Apt # City State Zip+4

SECTION 2. CLINICAL PRACTICE WITHIN LAST FIVE YEARS

To be eligible for consideration an applicant must be able to demonstrate that he/she has been actively engaged in the practice of marriage and family therapy within five years prior to July 1, 2000.

Applicant Name_____ Date_____

LMFT License # _____ Expiration Date_____

Instructions for Applicant: Please complete the following information and have your supervisor/employer attest that the information is accurate. **Return this form in the signed, sealed envelope at the time of making application.**

Employer: Address: Employment/Work Dates: From: To: Hours Per Week: Position Title: LMFT Supervisor's Name/Position Title:	Work Description:

I have been personally acquainted with the applicant for _____ years.

I attest that the applicant _____**did** _____**did not** engage in the practice of marriage and family therapy while employed or working at the above referenced site.

I attest that the foregoing information supplied by the applicant is true to the best of my knowledge. I believe the applicant to be of good professional character and worthy of confidence.

Name (Print) _____

Signature: _____ Date: _____

Title:_____

Return this completed form as soon as possible to the applicant after first signing along the seal on the back of the sealed envelope.

***This form may be copied if there has been more than one place of employment

SECTION 3. LICENSURE OPTIONS

In order for a licensee to transition to the LCMFT license, there must be provided a demonstration of competence to diagnose and treat mental disorders through **at least two** of the following areas acceptable to the board. Please indicate the areas applicable for your transition and complete the corresponding appendicies.

_____ (a) Graduate coursework **or** passing the Marriage and Family Therapy exam. (Complete Appendix A);

_____ (b) Three years of clinical practice in a community mental health center, its contracted affiliate or a state mental hospital **or** three years of clinical practice in other settings with demonstrated experience in diagnosing and treating mental disorders (Complete Appendix B); or

_____ (c) Attestation from one professional licensed to diagnose and treat mental disorders in independent practice or licensed to practice medicine and surgery that the applicant is competent to diagnose and treat mental disorders (Complete Appendix C).

APPLICANT'S ATTESTATION: **I certify the foregoing answers and information furnished are given in good faith with the understanding that it will be utilized for purposes of determining my eligibility for licensure in the State of Kansas. Any response or information I have provided is true and correct to the best of my knowledge and belief.**

_____ _____

Date of Application Signature of Applicant

APPENDIX A.

REQUIREMENT: Graduate coursework **or** passing a national, clinical examination.

GRADUATE COURSEWORK

Applicants must have a minimum of nine transcripted graduate credit hours of coursework addressing clinical theory, assessment, and treatment issues including three credit hours addressing psychopathology. Please request that an **original transcript** be sent to you upon completion of coursework. **The signed, sealed envelope must be submitted to BSRB along with your application.**

Course Number	Course Title	Semester and Year Completed	Credit Hours	University

Total _____

NATIONAL CLINICAL EXAMINATION

The board is currently using the National Marriage and Family Therapy clinical exam administered by the Professional Examination Service. If you have previously taken the exam, through the state of Kansas, your test scores are already on file in the BSRB office. If you have taken the exam through another state, please arrange for the board's receipt of the official test scores by requesting that the testing company (or the out of state credentialing board) **send the scores directly to you in an envelope that is signed (or officially stamped) across the sealed envelope.**

Name of the examination completed _____

Location and date exam was taken:_____ Score_____

APPENDIX B. CLINICAL PRACTICE AND EXPERIENCE IN DIAGNOSING OR TREATING MENTAL DISORDERS***

REQUIREMENT: either three years of clinical practice in a community mental health center, its contracted affiliate or a state mental hospital **or** three years of clinical practice in other settings with demonstrated experience in diagnosing or treating mental disorders. "Three years of clinical practice" is defined as at least eight hours of client contact per week for at least nine months a year. "Demonstrated experience" is defined as experience demonstrated by such items as a published job description, description of practice in a public information brochure, description of services in an informed consent document, other published statements, and/or attestation by applicant, employer or supervisor.

Applicant Name_____ Date_____

LMFT License # _____ Expiration Date_____

Instructions for Applicant: Please complete the following information and have your supervisor/employer attest that the information is accurate. **Return this form in the signed, sealed envelope at the time of making application.**

Employer: _____ Address: _____ Employment and/or Work Dates: From: To: _____ Hours Per Week: _____ Position Title: _____ LMFT Supervisor's Name/Position Title:	Work Description:

I have been personally acquainted with the applicant for _____ years.

I attest that the applicant _____**did** _____**did not** diagnose or treat mental disorders while employed and/or working at the above referenced site

I attest that the foregoing information supplied by the applicant is true to the best of my knowledge. I believe the applicant to be of good professional character and worthy of confidence. If the foregoing information is not true or if there are concerns you have regarding the applicant's request for transitional licensure, please attach a signed, dated statement providing your rationale.

Name (Print) _____ Title_____

Signature: _____ Date: _____

Return this completed form as soon as possible to the applicant after first signing along the seal on the back of the sealed envelope.

***This form may be copied if there has been more than one place of employment.

APPENDIX C. ATTESTATION OF CLINICAL COMPETENCE TO DIAGNOSE AND TREAT MENTAL DISORDERS

REQUIREMENT: attestation from one professional individual licensed to diagnose and treat mental disorders in independent practice or licensed to practice medicine and surgery that the applicant is competent to diagnose and treat mental disorders. Qualifying professionals include licensed psychologists, licensed clinical psychotherapists, licensed clinical professional counselors, licensed clinical marriage and family therapists, licensed specialist clinical social workers, and licensed physicians.

Instructions to Applicant: Please have qualified individual complete form and return to you. **At the time of application, submit to BSRB in the signed, sealed envelope.**

Name of Applicant:_____ Date:_____

Name of Referencing Individual (please print)_____

Degree and Title:_____

License #_____ State_____

The above named individual has applied for transition from Licensed Professional Counselor to Licensed Clinical Professional Counselor. The Behavioral Sciences Regulatory Board is asking that you provide a written response attesting to this individual's competency to diagnose and treat mental disorders. Please complete all information requested and return to the applicant in a sealed envelope that has been signed across the seal.

a) Are you related by blood or marriage to the applicant? If yes, state relationship:_____

b) How long have you known the applicant? (please include dates)_____

c) In what work setting have you known the applicant (Name of Agency) _____

d) What relationship (such as supervisor, co-worker) have you had with the applicant which has aided you in forming any opinion of his/her competence?_____

e) 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 as a Licensed Clinical Professional Counselor?_____
If yes, please state these facts as fully as possible on a separate sheet of paper.

f) In your opinion is the applicant competent to diagnose and treat mental disorders?_____

g) What evidence can you provide related to the applicant's competence to diagnose and treat mental disorders? Include amount and length of experience. (Feel free to expand on a separate sheet of paper if needed).

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 competence to diagnose and treat mental disorders 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.

_____ _____
(Date) Signature

_____ _____
Current Position & Title Agency Name and Address

_____ _____
Telephone #, Including Area Code City, State and Zip Code

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Credit Card Payment Form

Only complete when paying by credit card.

The credit cards accepted are American Express, Discover, MasterCard and Visa.

Amount of Purchase: $_____

Credit Card: American Express _____ Discover _____
MasterCard _____ Visa _____

Credit Card Acct. # __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Credit Card Expiration Date ___ ___ / ___ ___

Name as it appears on the card _____

Signature: _____ Date_____

For Office Use Only:

Approval Number _____ **Date _____**