Department of Health

Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling

MARRIAGE AND FAMILY THERAPY DUAL LICENSURE APPLICATION

Rule 64B4-3.010
DH-MQA 1177 (Revised 04/15)

Qualifications for Marriage and Family Therapy Dual Licensure

- Must hold a valid, active Florida license for at least 3 years in one of the following:
  - Licensed Clinical Social Worker under Chapter 491, Florida Statutes
  - Licensed Mental Health Counselor under Chapter 491, Florida Statute
  - Licensed Psychologist under Chapter 490, Florida Statutes
  - Advanced Registered Nurse Practitioner certified under Section 464.012, Florida Statutes, as a specialist in psychiatric mental health by the Board of Nursing
- Passing score on the national marriage and family examination

I. FEES

Marriage and Family Therapy Dual Licensure Fees: $205

Make cashier's check or money order payable to the Department of Health and attach to the application. The required fees include the application fee of $100 and the initial licensure fee of $105. After your application and fees are received, you will be notified within 30 days if documentation is needed to complete your application.

You may pay with a credit or debit card, if you submit your application online at www.flhealthsource.com and click on "Apply for a License".

II. EXAMINATION INFORMATION AND APPLICATION DEADLINES

Application deadlines, registration deadlines, and examination dates are available on our website at http://floridasmentalhealthprofessions.gov and click on "Licensing" then "Exam Services".

Approved candidates register at **https://secure.ptcny.com/apply/** . Complete the examination application using your confidential Florida Approval Code and submit examination/testing fee payment. Applications are not considered complete until all information has been provided and payment is received. Within six (6) weeks prior to the start of the testing period, Professional Testing Corporation (PTC) sends your Eligibility Notice via email. The Eligibility Notice includes an eligibility number and information on how to set up your examination location, date, and time through PSI. **Retain this document. A printed copy of the Eligibility Notice must be presented along with your current, driver's license or passport at the testing center at the time of your examination appointment**

The AMFTRB offers an online practice version of the national MFT exam for purchase at www.amftrb.org.

SPECIAL TESTING ACCOMMODATIONS

Candidates requiring special accommodations must submit an application for special testing accommodations to the Department of Health, Bureau of Operations, Examination Services Unit. The application can be downloaded from our website at http://floridasmentalhealthprofessions.gov and clicking on "Resources" then clicking on "Forms". If you do not have the ability to download the application, please contact the Operational Support Services Unit at 850-245-4252 to request a special testing accommodations application.

In accordance with Rule 64B-1.005, F.A.C., the Department will provide reasonable and appropriate special testing accommodations. Candidates requesting special testing accommodations must file a completed application (Part I and Part II) with Examination Services at least 60 days prior to the examination date for which the accommodation is requested. It is the responsibility of the candidate to provide adequate documentation of his/her disability.

III. COMPLETING THE FORMS (COMPLETED FORMS MUST BE ORIGINAL, INCLUDING SIGNATURES)
Complete all forms by printing neatly in ballpoint pen or typing the information on the forms.

MARRIAGE AND FAMILY THERAPY DUAL LICENSURE APPLICATION [5 pages]

1. Applicant Profile Data:
List your legal name as it should appear on your license. Your mailing address is used whenever you are sent documents, renewals, licenses, etc. from the Department of Health. When you become a dual licensee, your name, license number and practice location address will be shown on our Internet License Verification. If you do not want your mailing address on the website, fill in the "practice location address" on the dual licensure application as you want it to appear on the website. If you only provide one address, it will be used for both the mailing address and the practice location address. Please note that the practice location address must be a street address.

2. Applicant Licensure Status:
List all counseling related professional licenses, including inactive or expired licenses issued from any state, U.S. territory, or foreign country.

3. Applicant History – General:
If you answer "yes", you must provide complete details and certified copies of court records/dispositions.

4. Applicant History – Professional:
If you answer "yes" to any question in this section, you must provide complete details. A "yes" answer does not mean the application will be denied, however, failure to provide the correct information may result in licensure denial.

5. Applicant History – Pursuant to Section 456.0635, Florida Statutes:
IMPORTANT NOTICE: Applicants for licensure and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes.

6. Certification:
Your signature is required. By signing you are attesting that you have provided true and correct information on the application and supporting documents, as well as having read the laws and rules.

7 Social Security Number: Your social security number is required.

8. Applicant History – Health:
The Board reviews each applicant's history to determine that the applicant is able to practice the profession with reasonable skill and safety. If you answer "YES" to any of the questions in this section, you must submit a current mental health status report from a licensed mental health professional, wherein this professional practitioner opines that you are able to practice with reasonable skill and safety to patients or clients.

The report should include: a description and summary of the diagnosis, onset, course of treatment, medications, inpatient treatments, outpatient treatments, group settings, factors which have triggered setbacks, compliance with treatment, prognosis, and recommendations for continued treatment.

DEPARTMENT OF HEALTH BOARD OF CLINICAL SOCIAL WORK, MARRIAGE and FAMILY THERAPY & MENTAL HEALTH COUNSELING	**Marriage and Family Therapy Dual Licensure Application (5202)**

1. APPLICANT PROFILE DATA (PLEASE TYPE OR PRINT IN BLACK INK)

Name	Last	First	Middle
Mailing Address	Street and No.		Apt. No.
	City	State	Zip
*Practice Location Address	Street and No.		Apt. No.
	City	State	Zip

DO NOT WRITE IN THIS SPACE
FOR OFFICE USE ONLY

Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name? ❑YES ❑NO If "YES" list names and dates of changes below:

Home Telephone: area code ( )	Business Telephone: area code ( )
E-Mail Address: (Optional)	Date of birth: _____/_____/_____
Place of Birth: (City, Sate)	Gender: ❑ Male ❑ Female

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Race: ❑ Caucasian ❑ African-American ❑ Hispanic ❑ Asian ❑ Native American ❑Other _____

SPECIAL TESTING ACCOMMODATIONS-See Application Instructions

*Your Practice Location Address Will Show On The Internet License Verification Screen

Our Internet license lookup provides the public with information on licensed health care practitioners in the state of Florida, including an "address of record". The "location address" from the licensure database will show as the "address of record" on the Internet.

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APPLICANT NAME _____

2. APPLICANT LICENSURE STATUS

A. Do you hold or have you ever held a license to practice any counseling-related professions in any state, U.S. territory, or foreign country? ❑ YES ❑ NO
If YES, list all licenses and the issuing state, territory, or foreign country:

B. Do you have any applications for licensure in a counseling-related profession currently pending in any state (including Florida), U.S. territory, or foreign country? ❑YES ❑NO
If YES, list all pending applications and the issuing state, territory, or foreign country:

3. APPLICANT HISTORY – GENERAL

Have you ever been convicted of, or entered a plea of guilty or nolo contendere (no contest) to any crime in any jurisdiction, other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. ❑ YES ❑ NO

If you answer YES, you must explain in detail on a separate sheet. In your explanation, include all dates, jurisdictions, offenses, specific circumstances, and dispositions. You must include a certified copy of the court records/dispositions

4. APPLICANT HISTORY – PROFESSIONAL

A. Have you ever been denied a psychotherapy or counseling-related license or the renewal thereof in any state? ❑ YES ❑ NO

B. Have you ever been denied the right to take a psychotherapy or counseling-related licensure examination? ❑ YES ❑ NO

C. Have you ever had a license to practice any profession revoked, suspended, or otherwise acted against in a disciplinary proceeding in any state? ❑ YES ❑ NO

D. Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was alleged negligence, malpractice or lack of professional competence? ❑ YES ❑ NO

E. Is there currently pending, in any jurisdiction, a complaint against your professional conduct or competency in a psychotherapy or counseling-related profession? ❑ YES ❑ NO

F. Have you ever been involved in, reprimanded for or disciplined by an employer or educational institution for misconduct including:

1. Acts of dishonesty, fraud, or deceit 1.❑ YES ❑ NO
2. Lying on a resume or misrepresentation 2.❑ YES ❑ NO
3. Academic misconduct, including acts such as cheating or plagiarism 3.❑ YES ❑ NO
4. Theft 4.❑ YES ❑ NO
5. Sexual harassment 5.❑ YES ❑ NO

If you answered "YES" to any question in Section 5, you must provide the Board complete details.

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APPLICANT NAME _____

5. APPLICANT HISTORY – Pursuant to Section 456.0635(2), Florida Statutes,
IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation. Supporting documentation includes court dispositions or agency orders where applicable.

1.	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded "no", skip to # 2.)	❑YES ❑NO
a.	If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea or conviction, and completion of any sentence or subsequent period of probation?	❑YES ❑NO
b.	If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).	❑YES ❑NO
c.	If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?	❑YES ❑NO
d.	If "yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation).	❑YES ❑NO
2.	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	❑YES ❑NO
a.	If "yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?	❑YES ❑NO
3.	Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 3a.)	❑YES ❑NO
a.	If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?	❑YES ❑NO
4.	Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If "No", do not answer 4a or 4b.)	❑YES ❑NO
a.	Have you been in good standing with a state Medicaid program for the most recent five years?	❑YES ❑NO
b.	Did the termination occur at least 20 years before the date of this application?	❑YES ❑NO
5.	Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	❑YES ❑NO
6.	If "yes" to any of the questions 1 through 5 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? (If "yes", please provide official documentation verifying your enrollment status.)	❑YES ❑NO

APPLICANT NAME _____

6. CERTIFICATION

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all government agencies and instrumentalities (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals, and groups listed above any information which is material to my application.

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for examination or licensure. Such supplement is required by Sections 456.072, F.S. and 456.013(1)(2), F.S. Failure to do so may result in disciplinary action by the Board including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind. I declare that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to s. 456.067, F.S., or criminal penalties pursuant to s. 775.082, s. 775.083, or s. 775.085, F.S. Should I furnish any false information on this application, I hereby acknowledge that such act may constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida.

I hereby acknowledge that I have read the regulations in Chapter 491, F.S., and related rules. I understand that I am under a continuing obligation to keep informed of any changes to Chapter 491, F.S., and related rules.

I understand that pursuant to Section 456.013(1)(a), F.S., an incomplete application shall expire one (1) year after initial filing.

I further state that I will comply with all requirements for licensure renewal, including continuing education credits.

_____

Applicant’s Signature Date

CONFIDENTIAL AND EXEMPT FROM
PUBLIC RECORDS DISCLOSURE

DEPARTMENT OF HEALTH

Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling

Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 USCA § 666 (a)(13); and Sections 456.013, 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to assure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L 193, Section 317.

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

IX. Social Security Number: _____

X.	**APPLICANT HISTORY – HEALTH** **If you answer "YES" to any of the following questions, you must submit a current mental health status report from a licensed mental health professional, wherein this professional practitioner opines that you are able to practice with reasonable skill and safety to patients or clients.**	
A.	In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past 5 years?	❑ YES ❑ NO
B.	In the last 5 years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	❑ YES ❑ NO
C.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
D.	In the last 5 years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last 5 years?	❑ YES ❑ NO
E.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
F.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice your profession?	❑ YES ❑ NO

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MAKE COPIES OF ALL DOCUMENTS

(For your records) prior to mailing the originals to the board office.

MAIL APPLICATION PACKET AND FEE TO:

BOARD OF CLINICAL SOCIAL WORK,
MARRIAGE & FAMILY THERAPY, AND
MENTAL HEALTH COUNSELING
PO BOX 6330
TALLAHASSEE, FL 32314-6330

MAIL ANY OTHER CORRESPONDENCE TO:

BOARD OF CLINICAL SOCIAL WORK,
MARRIAGE & FAMILY THERAPY, AND
MENTAL HEALTH COUNSELING
4052 BALD CYPRESS WAY, BIN #C08
TALLAHASSEE, FL 32399-3258

If information is mailed from a source other than the applicant, the applicant's full name must appear on the correspondence or documentation.

If you have further questions you may contact the application reviewers at (850) 245-4474 between the hours of 8:00 AM and 5:00 PM EST.

PLEASE NOTE:
YOUR PRACTICE LOCATION ADDRESS WILL SHOW ON THE INTERNET LICENSURE LOOKUP SCREEN. Our licensure database requires two addresses for each licensee. One is the mailing address and the other is the practice location address. The "mailing address" is used whenever documents, newsletters, etc. are mailed to the applicant/licensee. Our Internet license lookup provides the public with information on licensed health care practitioners in the state of Florida, including an "address of record". The "practice location address" from the licensure database will show as the "address of record" on the Internet. If you only provide one address, it will be used for both the mailing address and the practice location address. Please note that the practice location address must be a street address.