APPLICATION FOR LICENSURE AS A MARRIAGE & FAMILY THERAPIST

GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS, AND MARRIAGE & FAMILY THERAPISTS
237 Coliseum Drive, Macon, Georgia 31217-3858
Phone (478) 207-2440 * www.sos.state.ga.us/plb/counselors

Please read the instructions carefully and be familiar with the laws and rules governing the practice of Marriage & Family Therapy in the State of Georgia. Visit the Board’s web site for information.

**Important**
The Board cannot process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board. Please review this application before you submit it to ensure that all information and documentation is complete and correct. Incomplete applications result in delayed processing. Incomplete applications are void after one year.

Application Checklist
The following checklist is an important part of your application. Please use this checklist to ensure that you submit a COMPLETE application.

The NON-REFUNDABLE APPLICATION FEE made payable to Georgia Professional Counselors, Social Workers, and Marriage & Family Therapists must be included with the application. (Please see Fee Schedule at the Board’s website)

Please access the Board Rules which includes licensure requirements from our website at www.sos.state.ga.us/plb/counselors

- NOTARIZED APPLICATION: The application must be mailed to the Board’s office at the address listed above; along with your FEE. All questions must be answered. Any question answered “yes” requires further documentation to be submitted. Request official court documents be submitted to the Board and provide a letter of explanation if you have had any arrests, criminal convictions, charges, or disciplinary actions, sanctions by another state licensing board. The Board, at their next scheduled meeting, will review the application with required documentation. Approval of licensure is at the Board’s discretion.

- NATIONAL BOARD SCORES: If you have not taken the MFT exam thru PES, you will receive the exam packet information after Board approval. All applicants are required to pass the Marriage & Family Therapy Examination/PES exam. If you have taken the MFT exam, please contact the National Board Administrative Offices at (212) 367-4389 and have them certify your scores to Georgia. If you have taken the MFT exam thru PES, you would apply for license by exam waiver. If you have not taken the MFT exam thru PES, you would apply for license by exam. If you have an Associate Marriage & Family Therapy license, your MFT application will be combined with your AMFT file and you will not need to submit another exam score.

- DEGREE TRANSCRIPT: All applicants for licensure must have earned a master’s degree in marriage & family therapy, counseling, social work, medicine, applied psychology, psychiatric nursing, pastoral counseling, applied child and family development, applied sociology, or from any program accredited by the Commission on
Accreditation for Marriage and Family Therapy Education. Such degree shall be from an educational institution accredited by a regional body recognized by the Council on Post Secondary Accreditation. An official college transcript certifying the grades, degree conferred and the date awarded must be received in this office directly from the Registrar of the college/school. If you have an Associate Marriage & Family Therapy license in Georgia, you will not need to submit another transcript unless you have obtained a higher degree.

- **NAME CHANGE**: If your name has changed since you attended school, please make a note on the application advising of your former name(s) so we can match-up the documents with your application.

- **FORM A/INTERNERSHIP VERIFICATION**: The instructor of record at the college or university or the Site Supervisor may be verified by the school as part of the master’s degree program which includes a graduate level course over 12 consecutive months, under supervision, minimum of 500 hours MFT clinical contact. If you have an Associate Marriage & Family Therapy license in Georgia, you will not need to submit Internship Verification again.

- **FORM B/PRACTICUM/INTERNERSHIP VERIFICATION**: Practicum/Internship must meet minimum requirements set out in Board Rule 135-5-.06. Complete a separate form for each Practicum/Internship listed on your application.

- **FORM D-DIRECT CLINICAL EXPERIENCE VERIFICATION**: Complete a separate form for each experience listed on your application. Documented experience must meet the minimum requirements set out in Board Rule 135-5-.06. The Director of Clinical experience must complete Part II. Direction means the ongoing administrative oversight by an employer or supervisor of a special practitioner’s work.

- **FORM E-SUPERVISION OF DIRECT CLINICAL EXPERIENCE VERIFICATION**: Complete a separate form for each Supervisor listed on your application. The number of hours and type of supervision required for licensure as an MFT depends upon the graduate degree that your hold. See Board Rule 135-5-.06.

- **OTHER STATE LICENSURE CERTIFICATION**: If you are or have ever been licensed in another State(s), please have that/those State(s) officially certify that license directly to the Board’s office.

- **ENDORSEMENT**: Marriage & Family Therapist licensure by Endorsement is considered on a state-by-state basis.

- **REFERENCES**: Please submit references from two (2) teachers or supervisors who are familiar with their experience in Marriage & Family Therapy.

- **CONSENT FORM**: Please sign the consent form giving permission for the board to receive any criminal history record information.

- **IMPORTANT**: Applicants, please note when accessing your application status on our website through the link “check the status of an application”, that checklist items moved over to the completed column only means that those documents have been received. Please allow several days following your submission of documents for their processing before you check the status link.

- Only the Georgia Composite Board of Professional Counselors, Social Workers and Marriage & Family Therapist have the authority to approve or deny an application for licensure. Every application file must be presented to the board for review.
APPLICATION FOR LICENSURE AS A MARRIAGE AND FAMILY THERAPIST

Application Fee $100 (NON-REFUNDABLE)

Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A. §16-9-20.

Applications valid for (1) one year

Method Obtained by:
Applicant is applying for license by:
( ) Examination
( ) Examination Waiver (only if you have already taken the MFT exam thru PES)
( ) Endorsement - The Board will determine if a state meets or exceeds the GA Board licensure requirements.

Name ____________________________

Name as shown on exam records or transcripts (If Different):

Social Security Number ____________ Date of Birth ____________

Male ___ Female ___

Physical Address ____________________________
Number and Street Apt. No City/State Zip

(P.O. Box not acceptable. If you are granted a license, your name, mailing address and license number are public information and your mailing address will appear on the internet. Your physical address is required, if different than the mailing address. You must immediately notify the Board in writing of an address change.)

Mailing Address (if different) ____________________________
(P.O. Box Acceptable) Number and Street Apt. No City/State Zip

Telephone Number Day ____________________ Telephone Number Evening ____________________

E-Mail Address* (Print Clearly Please)

*(Acknowledgement of your application will be sent by e-mail. Also, if any additional information is needed, e-mail is the most efficient way for the Board staff to contact you so that your application can be processed in the most efficient manner. Please notify the Board of any e-mail address change, YOUR E-MAIL ADDRESS WILL NOT BE SHARED WITH ANY THIRD PARTY).

Please check this box if you are a military spouse or a transitioning service member of the United States armed forces (including the National Guard).
**PROFESSIONAL BACKGROUND**

**ANSWER “YES” OR “NO” TO THE FOLLOWING QUESTIONS. IF “YES,” TO 1 THROUGH 9, ATTACH A DETAILED EXPLANATION.**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>1. Are you unable to practice safely as a result of the use of alcohol or other drugs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>2. Have you been denied professional licensure or renewal because of a license disciplinary proceeding?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>3. Have you ever had a license to practice social work, counseling, marriage and family therapy, or any other profession revoked, suspended or annulled or otherwise sanctioned, including by private order, by any board or agency in Georgia or any other state, territory, or country?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>4. Have you been subject to disciplinary action or had your membership revoked by any professional organization?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>5. Have you knowingly failed to renew a license during an investigation of a disciplinary matter against you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>6. To the best of your knowledge is there any disciplinary action or investigation pending against you by any licensing board, agency, or professional organization?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>7. Have you ever been convicted of any criminal offense? If yes, provide certified copies of the court disposition.</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>8. Have you ever been arrested, charged or sentenced for the commission of a felony, misdemeanor (other than minor traffic or parking violations) or any crime of moral turpitude, including the entry of a plea of nolo contendere or a plea entered pursuant to the provisions of the “Georgia First Offenders Act? You must respond, “yes” if you plead and completed probation as a First Offender. If yes, provide certified copies of the court disposition. DUI and DWI are not minor traffic offenses.</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Yes</td>
</tr>
</tbody>
</table>

If you answered “Yes” to questions 7 &/or 8, print out the “Background Investigation Consent” form found on the same webpage as this application. Failure to submit this form with application may result in delayed processing of the application.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>9. Have you been the defendant in a malpractice suit and either entered into a settlement agreement or paid court awarded expenses?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>10. Do you now hold or have you ever held a license as a professional counselor, social worker or marriage and family therapist in any jurisdiction? If “yes,” complete the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Yes</td>
</tr>
</tbody>
</table>

|   |   | Jurisdiction ____________________ License No._____________ Date Issued____________________ Expiration ______________ |
|---|---|---|---|---|

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>11. Have you previously applied for the same license for which you are currently applying? If “yes,” name under which application was submitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>12. Have you ever served on active duty in the Armed Forces, the Reserves or the National Guard during wartime or during any conflict when military personnel were committed by the President? If “Yes,” you may be eligible for Veterans’ Preference Points to be added to your examination score. Submit your DD214 Form to the Board office.</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Yes</td>
</tr>
</tbody>
</table>

---

**GRADUATE EDUCATION**

- If you are applying for Associate MFT Licensure, please complete the application for Associate MFT Licensure.
- If your degree is in Marriage and Family Therapy from a COAMFTE accredited program (whether applying for full or associate licensure), complete Part III – A of the application.
- If your degree is in MFT (not a COAMFTE program), Counseling, Social Work or an allied profession, complete Part III - B of the Application.
List any additional post degree courses you want considered as part of this Application.
Direct the Registrar of your institution(s) to send an official copy of your transcript directly to the Board office.

<table>
<thead>
<tr>
<th>QUALIFYING DEGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctorate: Specify</td>
</tr>
<tr>
<td>Masters: Specify</td>
</tr>
</tbody>
</table>

Name of Institution:
Street Address of Institution:

Is the program accredited by the Commission on Accreditation for MFT Education (COAMFTE)? □ Yes □ No

### POST DEGREE COURSEWORK TO BE CONSIDERED

<table>
<thead>
<tr>
<th>COURSE TITLE AND NUMBER</th>
<th>EDUCATIONAL OR TRAINING INSTITUTE</th>
</tr>
</thead>
</table>

### PART III – A – MFT COURSEWORK

#### THREE (3) GRADUATE LEVEL COURSES IN MARRIAGE AND FAMILY STUDIES

A “Marriage and Family Studies Course” includes the study of the principles, concepts, or history of marriage and family life, family systems, family relations and family development. Board Rule Chapter 135-5-.05(a)4.

1. 

2. 

3. 

#### THREE (3) GRADUATE LEVEL COURSES IN MARRIAGE AND FAMILY THERAPY

A “Marriage and Family Therapy Course” includes the study of the theory and practice of various treatment modalities in marriage and family therapy. Board Rule Chapter 135-5-.05(a)5.

1. 

2. 

3. 

#### THREE (3) COURSES IN HUMAN DEVELOPMENT

“Human Development Courses” encompass the study of all aspects of human development across the life span. Such courses include, but are not limited to, theories of individual development, theories of learning, theories of personality development, theories of normal and abnormal behavior, human sexuality, and psychopathology. Board Rule Chapter 135-5-.05(a)3.

1. 

2. 

3. 

#### ONE (1) COURSE IN MARRIAGE AND FAMILY THERAPY ETHICS

A course in “Marriage and Family Ethics” includes but is not limited to: state and federal laws, Rules of the Georgia Composite Board of PC, SW & MFT, professional ethics, legal responsibilities and liabilities, professional socialization, professional organization, interprofessional cooperation, licensure legislation and independent practice. Board Rule Chapter 135-5-.05(a)6.
# ONE (1) COURSE IN RESEARCH

A course in Research includes, but is not limited to, research design, methods, and statistics, but not credit received for thesis or dissertation. Board Rule Chapter 135-5-.05(a)(7).

## A ONE-YEAR PRACTICUM/INTERNSHIP UNDER SUPERVISION IN MARRIAGE AND FAMILY THERAPY

1. **Date Began:** 
   **Date Ended:** 
   **Total # Hours Clinical Experience:** 
   **Total # Hours of Supervision:**

   **Name of Supervisor:** 
   **MFT License #** 
   **State:**

   ☐ Georgia Board-Approved Supervisor  ☐ AAMFT-Approved Supervisor or Supervisor in Training  ☐ Not an Approved Supervisor

2. **Date Began:** 
   **Date Ended:** 
   **Total # Hours Clinical Experience:** 
   **Total # Hours of Supervision:**

   **Name of Supervisor:** 
   **MFT License #** 
   **State:**

   ☐ Georgia Board-Approved Supervisor  ☐ AAMFT-Approved Supervisor or Supervisor in Training  ☐ Not an Approved Supervisor

### PART III – B – MFT, COUNSELING, SOCIAL WORK, OR ALLIED PROFESSIONAL DEGREE COURSEWORK

#### RELATED PROFESSIONAL DEGREES

Check Applicable:  ☐ MFT  ☐ Professional Counseling  ☐ Social Work  ☐ Medicine  
☐ Psychiatric Nursing  ☐ Psychology  ☐ Pastoral Counseling  
☐ Other: Specify

### TWO (2) GRADUATE LEVEL COURSES IN MARRIAGE AND FAMILY STUDIES – LIST COURSE TITLE, NUMBER AND INSTITUTION

1. 
2. 

### TWO (2) GRADUATE LEVEL COURSES IN MARRIAGE AND FAMILY THERAPY – LIST COURSE TITLE, NUMBER AND INSTITUTION

1. 
2. 

### TWO (2) GRADUATE LEVEL COURSES IN CLINICAL CONTENT SUCH AS THE ETIOLOGY, DYNAMICS, EVALUATION, ASSESSMENT, OR TREATMENT OF EMOTIONAL OR BEHAVIORAL PROBLEMS

1. 
2. 

### ONE (1) GRADUATE LEVEL COURSE IN PROFESSIONAL ETHICS

1. 
**PRACTICUM/INTERNSHIP EXPERIENCE FOR ALLIED PROFESSIONS**

**INSTRUCTIONS**
- Applicants for licensure as an MFT may apply up to one (1) year of Practicum/Internship experience toward the experience requirements for licensure.
- List, in chronological order, each practicum/internship which you want the Board to consider toward the experience requirements
- Complete the appropriate verification forms.

☐ Yes ☐ No  I am applying my Practicum and/or Internship toward the experience requirements. If “Yes” complete below.

### A - PRACTICUM/INTERNSHIP COMPLETED AS PART OF A DEGREE PROGRAM

<table>
<thead>
<tr>
<th>(1) COURSE TITLE AND NUMBER:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PROGRAM:</td>
<td>DEGREE:</td>
</tr>
<tr>
<td>NAME OF SITE:</td>
<td></td>
</tr>
<tr>
<td>NAME OF ON-SITE SUPERVISOR:</td>
<td></td>
</tr>
<tr>
<td>STARTING DATE:</td>
<td>ENDING DATE:</td>
</tr>
</tbody>
</table>

☐ Georgia Board Approved Supervisor  ☐ AAMFT Supervisor or Supervisor in Training  ☐ Not Approved Supervisor

<table>
<thead>
<tr>
<th>(2) COURSE TITLE AND NUMBER:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PROGRAM:</td>
<td>DEGREE:</td>
</tr>
<tr>
<td>NAME OF SITE:</td>
<td></td>
</tr>
<tr>
<td>NAME OF ON-SITE SUPERVISOR:</td>
<td></td>
</tr>
<tr>
<td>STARTING DATE:</td>
<td>ENDING DATE:</td>
</tr>
</tbody>
</table>

☐ Georgia Board Approved Supervisor  ☐ AAMFT Supervisor or Supervisor in Training  ☐ Not Approved Supervisor

<table>
<thead>
<tr>
<th>(3) COURSE TITLE AND NUMBER:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PROGRAM:</td>
<td>DEGREE:</td>
</tr>
<tr>
<td>NAME OF SITE:</td>
<td></td>
</tr>
<tr>
<td>NAME OF ON-SITE SUPERVISOR:</td>
<td></td>
</tr>
<tr>
<td>STARTING DATE:</td>
<td>ENDING DATE:</td>
</tr>
</tbody>
</table>

☐ Georgia Board Approved Supervisor  ☐ AAMFT Supervisor or Supervisor in Training  ☐ Not Approved Supervisor

### B - PRACTICUM AND/OR INTERNSHIP(S) COMPLETED OTHER THAN PART OF A DEGREE PROGRAM

<table>
<thead>
<tr>
<th>(1) COURSE TITLE AND NUMBER:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>INSTITUTION NAME &amp; ADDRESS:</td>
<td></td>
</tr>
<tr>
<td>NAME OF SITE:</td>
<td></td>
</tr>
<tr>
<td>NAME OF ON-SITE SUPERVISOR:</td>
<td></td>
</tr>
<tr>
<td>STARTING DATE:</td>
<td>ENDING DATE:</td>
</tr>
</tbody>
</table>

☐ Georgia Board Approved Supervisor  ☐ AAMFT Supervisor or Supervisor in Training  ☐ Not Approved Supervisor
### PART IV – POST MASTERS DIRECT CLINICAL EXPERIENCE

#### INSTRUCTIONS:
- ☐ Yes ☐ No I am applying my Practicum and/or Internship toward the experience requirements.
- The number of years of experience that are required for licensure as an MFT depends upon the graduate degree you hold and whether you have completed a practicum and or internship.
- List in chronological order your post-master’s experience that you want to use to satisfy the experience requirements.
- Use additional sheets if necessary.
- Submit a separate Form D, Parts I and II- MFT Direct Clinical Experience Verification for each site listed below.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Date:</td>
<td>Ending Date:</td>
<td>Total On-Site Experience: YEARS:</td>
<td>MONTHS:</td>
<td></td>
</tr>
<tr>
<td>Name of Site:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td>Name of Director:</td>
<td>Your Position Title:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My Experience Was As: ☐ MFT ☐ PC ☐ SW</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Date:</td>
<td>Ending Date:</td>
<td>Total On-Site Experience: YEARS:</td>
<td>MONTHS:</td>
<td></td>
</tr>
<tr>
<td>Name of Site:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td>Name of Director:</td>
<td>Your Position Title:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My Experience Was As: ☐ MFT ☐ PC ☐ SW</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Date:</td>
<td>Ending Date:</td>
<td>Total On-Site Experience: YEARS:</td>
<td>MONTHS:</td>
<td></td>
</tr>
<tr>
<td>Name of Site:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td>Name of Director:</td>
<td>Your Position Title:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My Experience Was As: ☐ MFT ☐ PC ☐ SW</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PART V- SUPERVISION OF POST MASTERS DIRECT CLINICAL EXPERIENCE

#### INSTRUCTIONS:
- You must have obtained 200 hours of MFT supervision concurrent with your documented experience. At least 100 of the 200 hours must have been provided by an AAMFT approved supervisor, an AAMFT supervisor-in-training, or a Board approved supervisor. A minimum of 50 of these 100 hours must have been in individual supervision and a maximum of 50 may have been in group supervision.
- If you are using 100 hours from your approved practicum, be sure that you have completed Form B.
- Complete the following for each supervisor whose supervision you are using to fulfill this requirement.
- Submit a separate Form E - MFT Supervision of Direct Clinical Experience Verification for each supervisor listed below.
- Enclose the form from each supervisor with your application in a signed, sealed envelope.

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Supervisor’s Name:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credentials: ☐ MFT ☐ PC ☐ CSW ☐ Psychologist ☐ Psychiatrist ☐ GA Board-Approved MFT Supervisor or ☐ AAMFT-Approved Supervisor ☐ Supervisor-in-Training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>License Title &amp; #:</td>
<td>State:</td>
<td>Issue Date:</td>
<td>Expiration Date:</td>
</tr>
</tbody>
</table>
PART VI – APPLICANTS FOR LICENSURE BY ENDORSEMENT/RECIPROCITY

INSTRUCTIONS:
- The Board may license without examination any Marriage and Family Therapist currently licensed in another jurisdiction so long as that jurisdiction’s requirements are substantially equal to those of Georgia.
- Complete this part if you are applying for licensure by endorsement.

☐ I currently hold License # _____________________ from the State of ___________________ issued on ___________________.

☐ I have provided verification of this license to the Board by completing Form N and requesting that the above-referenced state return that Form to the Board office.
YOU MUST SIGN THIS AFFIDAVIT IN THE PRESENCE OF A NOTARY

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage & Family Therapists, and I agree to abide by these laws and rules.

By executing this affidavit under oath, as an applicant for a professional license, as referenced in O.C.G.A. § 50-36-1, administered by the Professional Licensing Boards Division, the undersigned applicant also verifies one of the following with respect to his/her application for a public benefit (check one):

1) _______ I am a United States citizen. **Please submit a copy of your current Secure and Verifiable Document(s) such as driver’s license, passport, or other document as indicated on the Board website listing.**

2) _______ I am **not** a United States citizen, but I am a legal permanent resident of the United States or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency. **Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number.**

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit.

In making the above representations under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute. I also understand that any failure to make full and accurate disclosures may result in disciplinary action by the Board for which I am applying for licensure.

______________________________________________          __________________________
Signature of Applicant                                                           Date

Sworn to and subscribed before me this

__________ day of ____________________ 20______

_______________________________________________                          ( Notary Seal)
Notary Public Signature

My Commission Expires: __________________________

NOTE to NOTARY: Application must be signed with Proper ID.
**MARRIAGE AND FAMILY THERAPY PRACTICUM/INTERNSHIP VERIFICATION**

**FORM A**

**INSTRUCTIONS:**
- Please type or print clearly. For additional forms, please photocopy.
- Practicum/Internship must meet the requirements set out in Board Rule 135-5-.06 [Graduate level course over 12 consecutive months, under supervision, minimum 500 hours MFT clinical contact.]
- **Applicant** – Complete Part I.
- **On-Site Coordinator of Practicum/Internship** - Complete Part II.

<table>
<thead>
<tr>
<th>PART I - TO BE COMPLETED BY APPLICANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Street</td>
</tr>
<tr>
<td>✔ Check applicable box and complete information below:</td>
</tr>
<tr>
<td>☐ Practicum/Internship which was <strong>part of my degree program</strong> OR</td>
</tr>
<tr>
<td>☐ Practicum/Internship <strong>after the master’s degree</strong>.</td>
</tr>
</tbody>
</table>
| ✔ Check Type of Practicum/Internship:  
| ☐ MFT  ☐ PC  ☐ SW |
| Institution: | Degree Awarded: |
| Course Title & Number: | Supervisor: |
| Practicum/Internship Site: |
| Address: |
| Position/Title: |
| Description of Responsibilities: |
| DATES: |
| FROM: |
| Month/Year | TO: |
| Month/Year |
| DURATION: |
| TOTAL YEARS: |
| TOTAL MONTHS: |
| TOTAL HOURS OF ON-SITE EXPERIENCE |
| Individuals: | Group: | Couples/Families: |
| OATH |
| I attest that the above information is a true and accurate representation of my Practicum/Internship. |
| _______________________________ | _______________________________ |
| Date | Signature of Applicant |
| Subscribed to and sworn before me _______________________________ |
| this __ day of ____________, 20__ |
| Printed Name: _______________________________ |
| Notary Public |
| My Commission Expires: _______________ |
| NOTARY SEAL |
## FORM A - PART II - TO BE COMPLETED BY THE ON-SITE COORDINATOR

**INSTRUCTIONS:**
- Please review the Applicant’s description of his/her Practicum/Internship experience. If you have any additional information that would assist the Board in making a decision on licensure for this Applicant, please provide that information below.
- Complete A or B below, as applicable.

## ADDITIONAL INFORMATION:

### A - ACTUAL ON-SITE COORDINATOR

**ATTESTATION:**
I attest that I served as the On-Site Coordinator for the Practicum/Internship described above and that this description is a true and accurate representation of this Applicant’s experience.

<table>
<thead>
<tr>
<th>Date</th>
<th>Signature of On-Site Coordinator</th>
<th>Printed Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Site:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street</td>
</tr>
<tr>
<td>--------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work Phone: ( )</th>
<th>Home Phone: ( )</th>
<th>Fax: ( )</th>
</tr>
</thead>
</table>

### B - CURRENT ON-SITE COORDINATOR

**ATTESTATION:**
I attest that the person who coordinated this Applicant’s Practicum/Internship cannot be located and that I am the current On-Site Coordinator and can verify this Applicant’s experience based upon a review of the available records. After a diligent and thorough search of available records, I attest that the Practicum/Internship described above is a true and accurate representation of this Applicant’s experience.

<table>
<thead>
<tr>
<th>Date</th>
<th>Signature of Current On-Site Coordinator</th>
<th>Printed Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Site:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street</td>
</tr>
<tr>
<td>--------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work Phone: ( )</th>
<th>Home Phone: ( )</th>
<th>Fax: ( )</th>
</tr>
</thead>
</table>
INSTRUCTIONS:  NO FAXED FORMS ACCEPTED

- Please type or print clearly.
- Practicum/Internship must meet minimum requirements set out in Board Rule 135-5-.06.
- Applicant – Complete Part I. For additional forms, please photocopy. Complete separate form for each Practicum/Internship listed on your Application.
- Practicum/Internship Supervisor - Complete Part II. After you have completed this form and it has been notarized, enclose it in a sealed envelope, sign your name over the flap and return it to the Applicant.

PART I - TO BE COMPLETED BY APPLICANT

Name:  Social Security #:  

PART II - TO BE COMPLETED BY THE PRACTICUM/INTERNSHIP SUPERVISOR

Name of Supervisor:  

Type of License:  
- MFT  
- PC  
- CSW  
- PSYCHOLOGIST  
- PSYCHIATRIST  

License #:  State:  Date Issued:  Expiration Date:  

CERTIFICATION:  
I hereby certify that I supervised the Internship/Practicum of the above-named Applicant who practiced:  
- Marriage and Family Therapy  
- Professional Counseling  
- Social Work  

Practicum/Internship Site:  

Address:  Street  City  State  Zip  

FROM:  Month/Year  TO:  Month/Year  TOTAL MONTHS:  

SUPERVISION:  
This Applicant received the following weekly supervision from me:  
INDIVIDUAL:  ______________ Hours/Week  
GROUP:  ______________ Hours/Week  

I hereby certify that at the time of the documented supervision I met one of the following criteria:  
- AAMFT Approved Supervisor  
- AAMFT Supervisor-in-Training  
- Georgia Board LMFT Approved Supervisor  

DESCRIPTION OF PRACTICE SUPERVISED:  

OATH  
I attest that the supervision described above is a true and accurate representation of this Practicum/Internship experience and supervision.  

Date Signature of Internship/Practicum Supervisor  

Subscribed to and sworn before me this _____day of __________, __________ Printed Name  

Notary Public  
My Commission Expires:  

NOTARY SEAL
**INSTRUCTIONS:** Please type or print clearly. NO FAXED FORMS ACCEPTED

**APPLICANTS:**
- Make every effort to locate the supervisor/s/instructor/s of record as necessary to document the required Practicum/Internship Experience.
- You may show your diligence with returned mail, copies of letters, and verifications from your academic institution, etc.
- If, however, after a diligent search you are unable to locate the supervisor/s, you may attest to undocumented supervision of Practicum/Internship by taking the oath below.
- The Board may require additional information upon review.

**OATH**

Under penalty of perjury, as provided in the Official Code of Georgia Annotated, I hereby aver and swear that I was unsuccessful, after I made a diligent effort, to locate:

Name of Supervisor: __________________________________________________________

who served as my Practicum/Internship Supervisor in the practice of Marriage and Family Therapy during the period of: _______________________________ to _______________________________

Month/Year Month/Year

and during that period he/she was licensed as a:

- [ ] Marriage and Family Therapist
- [ ] Professional Counselor
- [ ] Clinical Social Worker
- [ ] Psychologist
- [ ] Psychiatrist

License Number: __________________ In the State of: ________________________________

During that period he/she was:

(check one) [ ] AAMFT Approved Supervisor or Supervisor in Training [ ] GA Board Approved Supervisor

I have attached copies of letters and/or returned mail that demonstrates my attempt/s to reach this supervisor.

Date Signature of Applicant

Sworn to and subscribed before me this

________ day of ________________, ______. Printed Name

______________________________
Notary Public
My Commission Expires: Notary Seal
**INSTRUCTIONS:**
- Please type or print clearly. For additional forms, please photocopy.
- Complete a separate form for each experience listed on your Application.
- Documented experience must meet the minimum requirements set out in Board Rule 135-5-.06.
- **Applicant** – Complete Part I.
- **Director of Clinical Experience** - Complete Part II.

## PART I - TO BE COMPLETED BY APPLICANT

<table>
<thead>
<tr>
<th>Name:</th>
<th>Social Security #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Street</td>
</tr>
<tr>
<td>Employer:</td>
<td>Address:</td>
</tr>
<tr>
<td>Position/Title:</td>
<td></td>
</tr>
<tr>
<td>Description of Responsibilities:</td>
<td></td>
</tr>
</tbody>
</table>

The Clinical Experience was in the practice of: □ MFT □ PC □ SW

<table>
<thead>
<tr>
<th>DATES OF EXPERIENCE:</th>
<th>FROM:</th>
<th>TO:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month/Year</td>
<td>Month/Year</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DURATION OF EXPERIENCE:</th>
<th>TOTAL YEARS:</th>
<th>TOTAL MONTHS:</th>
</tr>
</thead>
</table>

### HOURS OF CLINICAL EXPERIENCE IN A TYPICAL WEEK

[Do not indicate a range of hours — e.g. 5 to 10]

<table>
<thead>
<tr>
<th>CLINICAL ACTIVITY (Weekly)</th>
<th>TYPE OF CLIENT</th>
<th>Individual</th>
<th>Couple/Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) Client contact as therapist or co-therapist</td>
<td># of Hours:</td>
<td># of Hours:</td>
<td></td>
</tr>
<tr>
<td>B) Case staffing or Case Consultation</td>
<td># of Hours:</td>
<td># of Hours:</td>
<td></td>
</tr>
<tr>
<td>C) Clinical Supervision (As a supervisee)</td>
<td># of Hours:</td>
<td># of Hours:</td>
<td></td>
</tr>
</tbody>
</table>

### ATTESTATION

I attest that the above information is a true and accurate representation of my Direct Clinical Experience.

______________________________
Date

______________________________
Signature of Applicant

______________________________
Printed Name
### INSTRUCTIONS:

- "Direction" means the ongoing administrative oversight by an employer or supervisor of a special practitioner's work. Direction may be provided by any person acceptable to the standards committee for that specialty in which the practitioner is working. The Director shall be responsible for assuring the quality of the services rendered by the practitioner and shall ensure that qualified supervision or intervention occurs in situations that require expertise beyond that of the practitioner.
- An “Employer” is a person who employs the services of others; one for whom employees work, who has the right to control and direct the person who performs services, and who pays their wages or salaries or other monetary consideration for their services.
- Please review the Applicant's description of his/her Directed Clinical Experience. If you have any additional information that would assist the Board in making a decision on licensure for this Applicant, please provide that information below.
- Complete A or B below, as applicable and **sign before a Notary Public**.

### ADDITIONAL INFORMATION:

#### A - ACTUAL DIRECTOR

**OATH:**
I attest that I provided the direction, as prescribed by law, of the Direct Clinical Experience described on this Application and that this description is a true and accurate representation of this Applicant's experience.

<table>
<thead>
<tr>
<th>Date</th>
<th>Signature of Director</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Printed Name**

Name of Site:

Address:

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

Work Phone: ( )

| Home Phone: ( ) | Fax: ( ) |

#### B - CURRENT DIRECTOR

**OATH:**
I attest that the person who provided this Applicant’s direction cannot be located, that I am the current Director and can verify this Applicant’s experience based upon a review of the available records. After a diligent and thorough search of available records, I attest that the description above of this experience is a true and accurate representation of this Applicant’s experience.

<table>
<thead>
<tr>
<th>Date</th>
<th>Signature of Current Director</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Name of Site:**

**Address:**

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

Work Phone: ( )

| Home Phone: ( ) | Fax: ( ) |

**Subscribed to and sworn before me**
this ___ day of __________, __________________.

______________________________

**Notary Public**

My Commission Expires: ___________________

**NOTARY SEAL**
MARRIAGE AND FAMILY THERAPY
VERIFICATION OF SUPERVISION OF DIRECT POST GRADUATE CLINICAL EXPERIENCE
FORM E

INSTRUCTIONS: NO FAXED FORMS ACCEPTED
- Please type or print clearly. For additional forms, please photocopy.
- Complete a separate form for each Supervisor listed on your Application.
- The number of hours and type of supervision required for licensure as an MFT depends upon the graduate degree that you hold. See Board Rule 135-5-.06.
- Applicant – Complete Part I.
- Supervisor of Direct Clinical Experience – Complete Part II.

PART I - TO BE COMPLETED BY APPLICANT

<table>
<thead>
<tr>
<th>Name:</th>
<th>Social Security #:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address:

Street | City | State | Zip
--------|------|-------|-----

Employer:

Address:

Street | City | State | Zip
--------|------|-------|-----

Name of Supervisor:

The Supervision was in the practice of: ☐ MFT ☐ PC ☐ SW

DATES OF SUPERVISION:

FROM: Month/Year TO: Month/Year

DURATION OF SUPERVISION:

TOTAL YEARS: TOTAL MONTHS:

DESCRIBE THE PRACTICE:

DESCRIBE THE SUPERVISION:

ATTESTATION

I attest that the above information is a true and accurate representation of my practice and supervision.

Date

Signature of Applicant

Printed Name
FORM E - PART II - TO BE COMPLETED BY THE SUPERVISOR OF CLINICAL EXPERIENCE

INSTRUCTIONS:

- “Supervision” means the direct, i.e., face to face, clinical review, for the purpose of training, teaching, and promoting the development of clinical skill by a supervisor of a supervisee’s interaction with client(s). Supervision may include, without being limited to, the review of case presentations, audio tapes, video tapes, and direct observations.

- Please review the Applicant’s description of his/her practice and supervision. If you have any additional information that would assist the Board in making a decision on licensure for this Applicant, please provide that information below.

Name of Supervisor:

Address:  
Street  
City  
State  
Zip

Type of License:  
☐ MFT  
☐ PC  
☐ CSW  
☐ PSYCHOLOGIST  
☐ PSYCHIATRIST

License #  State:  Date Issued:  Expiration Date:  Years of Practice:

ADDITIONAL INFORMATION:

SUPERVISION
THIS APPLICANT RECEIVED THE FOLLOWING SUPERVISION FROM ME:

I supervised the above-named Applicant in the practice of:

☐ Marriage and Family Therapy  
☐ Professional Counseling  
☐ Social Work

DATES OF SUPERVISION:  
FROM:  
Month/Year  
TO:  
Month/Year

DURATION OF SUPERVISION:  
TOTAL MONTHS:  
TOTAL YEARS:

INDIVIDUAL:  _________ Hours/Week  
GROUP:  ____________ Hours/Week  
TOTAL HOURS:

I hereby certify that at the time of the documented supervision, I met one of the following criteria:

☐ AAMFT-Approved Supervisor  
Term Expires On:  

☐ In Supervision of Supervision  
Date Supervision of Supervision Began:  

☐ Georgia Board Approved MFT Supervisor  
Date Approved:  

OATH

I attest that I served as this Applicant’s supervisor as prescribed by law, and the description of the supervision provided in this Application is a true and accurate representation of my supervision with this Applicant.

I ☐ RECOMMEND  ☐ DO NOT RECOMMEND this Applicant for licensure.

________________________  __________________________
Date  Signature of Supervisor

Subscribed to and sworn before me this _____day of ____________.

________________________
Notary Public
My Commission Expires:  __________________________  NOTARY SEAL
INSTRUCTIONS: NO FAXED FORMS ACCEPTED

Please type or print clearly.

The years and hours of supervision required for MFT licensure depend on the degree you hold.

The Directed Experience Supervisor must: Be a licensed: Professional Counselor, Clinical Social Worker, Marriage and Family Therapist, Psychologist, Psychiatrist and Meet the post-licensure experience requirements for the degree held. See Board Rule Chapter 135-5-06.

APPLICANT:

Make every effort to locate as many of the directors of Directed Experience as necessary to document the required Directed Experience Supervisor.

You may show your diligence with returned mail, copies of letters, verifications from your academic institution, etc.

If, however, you have obtained sufficient directed experience to meet licensure requirements, but after a diligent search you are unable to locate enough Supervisors to document the required time, you may attest to undocumented Supervision by taking the oath below.

The Board may require additional information upon review.

PART I - APPLICANT

NAME: ____________________________

SOCIAL SECURITY NUMBER: ____________________________

I hold a: Master's Degree: ☐ PC ☐ CSW ☐ MFT ☐ Rehabilitation Counseling ☐ Specialist

Allied Degree: ☐ Medicine ☐ Psychiatric Nursing ☐ Psychology ☐ Pastoral Counseling

☐ Child & Family Development ☐ Applied Sociology Doctorate Degree: ☐ Ph.D. ☐ Ed.D.

OATH

Under penalty of perjury as provided in the Official Code of Georgia Annotated, I hereby aver and swear that I was unsuccessful, after I made a diligent effort, to locate:

Name of Supervisor: ____________________________________________

who served as my supervisor while I worked under the direction of:

Name of Director: ____________________________________________

at: _________________________________________________________

Name of Agency or Organization: ____________________________ Address: ____________________________ City: ____________________________ State: ____________________________ Zip Code: ____________________________

and that this supervisor has the following credentials:

License Type: ☐ Professional Counselor ☐ Clinical Social Worker ☐ Marriage and Family Therapy

☐ Psychologist ☐ Psychiatrist

License #: ____________________________ State: ____________________________ Date Issued: ____________________________ Expir. Date: ____________________________

At the time the supervision took place the supervisor was (check one)

☐ AAMFT-Approved Supervisor ☐ AAMFT- Supervisor in Training ☐ Georgia Board Approved Supervisor

DATES OF SUPERVISION:

FROM: ____________________________ Month/Year TO: ____________________________ Month/Year

DURATION OF SUPERVISION:

TOTAL MONTHS: ____________________________ TOTAL YEARS: ____________________________

INDIVIDUAL: ___________ Hours/Week GROUP: ___________ Hours/Week TOTAL HOURS: ___________

I have attached copies of letters and/or returned mail that demonstrates my attempts to reach this supervisor.

__________________________________________ ________________________________

Date Signature of Applicant

Sworn to and subscribed before me this day of ____________, ______.

__________________________

Notary Public

My Commission Expires: ____________________________ NOTARY SEAL

Page 19 of 22 07-07-17
INSTRUCTIONS: NO FAXED FORMS ACCEPTED

- Please type or print legibly.
- Applicants must have references from two (2) teachers or supervisors who are familiar with their experience in Marriage and Family Therapy.
- **APPLICANT** - Complete Part I, give this form to your references with an envelope addressed to yourself. Retrieve the completed form from your reference for inclusion with your application.
- **REFERENCE** - Complete Part II, enclose this form in the envelope provided to you by the applicant, seal the envelope, sign your name across the envelope flap and return it to the applicant. The Board assumes that in recommending this applicant, references will interpret or substantiate to the Board your recommendation if the Board needs to contact you at a later date.

**PART I - APPLICANT**

Name: 

**PART II - REFERENCE**

Name: 

Address: 

Day Phone: ( ) Other Phone: ( )

Relationship to Applicant: ☐ Teacher  ☐ Supervisor

Dates of Teaching/Supervisory Relationship: FROM: Month/Day/Year TO: Month/Day/Year

PROFESSIONAL POSITION WHEN TEACHING OR SUPERVISING APPLICANT:

Title: 

Agency/Institution: 

Address: 

RECOMMENDATION:  I ☐ Recommend  ☐ Do Not Recommend the Applicant for licensure.

ADDITIONAL COMMENTS:
[Please write any comments that would assist the Board in making a decision on this Applicant for licensure.]

Date ________________ Signature of Reference ________________________
APPLICATION FOR MARRIAGE AND FAMILY THERAPIST
PERSONAL REFERENCE FORM
FORM G

INSTRUCTIONS: NO FAXED FORMS ACCEPTED

- Please type or print legibly.
- Applicants must have references from two (2) teachers or supervisors who are familiar with their experience in Marriage and Family Therapy.
- APPLICANT - Complete Part I, give this form to your references with an envelope addressed to yourself. Retrieve the completed form from your reference for inclusion with your application.
- REFERENCE - Complete Part II, enclose this form in the envelope provided to you by the applicant, seal the envelope, sign your name across the envelope flap and return it to the applicant.

The Board assumes that in recommending this applicant, references will interpret or substantiate to the Board your recommendation if the Board needs to contact you at a later date.

PART I - APPLICANT

Name:

PART II - REFERENCE

Name:

Address: __________________________________________________________

Day Phone: ( ) Other Phone: ( )

Relationship to Applicant: ☐ Teacher ☐ Supervisor

Dates of Teaching/Supervisory Relationship: FROM: ______________________ TO: ______________________

PROFESSIONAL POSITION WHEN TEACHING OR SUPERVISING APPLICANT:
Title: __________________________
Agency/Institution: __________________________________________________________
Address: __________________________________________________________

RECOMMENDATION: ☐ I Recommend ☐ Do Not Recommend the Applicant for licensure.

ADDITIONAL COMMENTS:
[Please write any comments that would assist the Board in making a decision on this Applicant for licensure.]

Date ______________ Signature of Reference _______________________

--End--
**INSTRUCTIONS**
- Please type or print legibly.
- **Applicant** - Complete Part I. Mail a form to the Board or Agency of each state or jurisdiction by which you are currently licensed or certified as a Professional Counselor, Social Worker (any level) or Marriage and Family Therapist.
- **State Licensure Board or Regulatory Agency** - Complete Part II and mail, fax or E-Mail to the GA Board:
  - MAIL: GA Composite Board, 237 Coliseum Drive, Macon, GA 31217
  - FAX: 866-888-7127 * E-Mail: ExamBoards-Healthcare@sos.state.ga.us

**PART I - APPLICANT**

| Full Name: | |
| Date of Birth: | Social Security #: |

**GEORGIA LICENSE APPLIED FOR**
- _CHECK ONLY ONE:_
  - ☐ Marriage and Family Therapist
  - ☐ Professional Counselor
  - ☐ Clinical Social Worker
  - ☐ Master Social Worker

| Jurisdiction: | License Number: |
| Title of License: | Date Issued: | Expiration Date: |

**TO WHOM IT MAY CONCERN**

I, the undersigned applicant, am applying for a license with the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists. I hereby consent to the release of any information, favorable or otherwise, which you may have concerning my license or practice. Please return the completed form directly to the Georgia Board at the above address.

___________________________ _______________________________
Date Signature of Applicant

**PART II - LICENSURE BOARD OR REGULATORY AGENCY CERTIFICATION**

I, _________________________________________________________________, Board Chair or Designated Official of the ________________________________________________________________

Name of Board or Regulatory Agency

I certify that the information provided above by this applicant ☐ does ☐ does not conform with that in our record.

If “does not”, please explain:

____________________________________________________________________

_____________________________________________________________________________________________

According to our record, the applicant ☐ has ☐ has not been disciplined by this or any other Board, state agency, or professional organization. If the applicant has been disciplined, please explain and attach a copy of the Order or Decree:

_____________________________________________________________________________________________

Date __________________________________________________________________________________________

Signature of Board Chair/Designated Official

___________________________ _______________________________
Title of Board Street Address

**BOARD SEAL**

MAIL: GA Composite Board, 237 Coliseum Drive, Macon, GA 31217

FAX: 866-888-7127 * E-Mail: ExamBoards-Healthcare@sos.state.ga.us