GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS, AND MARRIAGE & FAMILY THERAPISTS
237 Coliseum Drive, Macon, Georgia 31217 * Phone (404) 424-9966
ExamBoards-Healthcare@sos.ga.gov
Board of Professional Counselors, Social Workers, and Marriage & Family Therapists | Georgia Secretary of State (ga.gov)

APPLICATION FOR LICENSURE AS AN ASSOCIATE MARRIAGE & FAMILY THERAPIST

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 Incomplete applications are withdrawn after sixty (60) days.

Application Checklist

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

PLEASE ACCESS THE BOARD RULES WHICH INCLUDES LICENSURE REQUIREMENTS FROM OUR WEBSITE AT
Board of Professional Counselors, Social Workers, and Marriage & Family Therapists | Georgia Secretary of State (ga.gov)

- ❑ **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 AN EXPLANATION IF YOU HAVE HAD ANY CRIMINAL CONVICTIONS OR CHARGES, OR 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, YOU WILL RECEIVE THE EXAM PACKET INFORMATION AFTER BOARD APPROVAL. ALL APPLICANTS ARE REQUIRED TO PASS THE MARRIAGE & FAMILY THERAPY EXAMINATION. IF YOU HAVE TAKEN THE MFT EXAM, PLEASE CONTACT THE EXAM VENDOR AND HAVE THEM CERTIFY YOUR SCORES TO GEORGIA.
- ❑ **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.
- ❑ **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/INTERNSHIP 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.

- ❑ **FORM B/PRACTICUM/INTERNSHIP 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.

- ❑ **CONTRACT AFFIDAVIT:** YOU MUST COMPLETE AND SUBMIT ALL 4 PAGES OF THIS FORM IN ITS ENTIRETY. THE PURPOSE OF THE CONTRACT AFFIDAVIT IS TO DEFINE THE EMPLOYMENT RELATIONSHIP FOR THE PURPOSE OF ACQUIRING THE REQUIRED POSTMASTER'S EXPERIENCE UNDER SUPERVISION THAT WILL BE APPLICABLE FOR LICENSURE. INDEPENDENT PRIVATE PRACTICE IS NOT ACCEPTABLE AS "EMPLOYMENT" FOR THE PURPOSES OF OBTAINING DIRECTED EXPERIENCE UNDER SUPERVISION.

- ❑ **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 BY MAIL OR E-MAIL TO VERIFICATIONS@SOS.GA.GOV.

- ❑ **CONSENT FORM:** PLEASE SIGN THE CONSENT FORM GIVING PERMISSION FOR THE BOARD TO RECEIVE ANY CRIMINIAL 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 FROM THE SUBMISSION OF ANY FORMS, DOCUMENTS ETC TO BE PROCESSED BEFORE ACCESSING THE WEB LINK FOR A STATUS UPDATE.

- ❑ ONLY THE GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS AND MARRIAGE & FAMILY THERAPIST HAS THE AUTHORITY TO APPROVE OR DENY AN APPLICATION FOR LICENSURE. EVERY APPLICATION FILE MUST BE PRESENTED TO THE BOARD FOR REVIEW.

New – Effective July 1, 2022

NATIONWIDE FINGERPRINT BACKGROUND CHECK RESULTS:

Each applicant for licensure as an associate marriage and family therapist, by examination, examination waiver, endorsement or by reinstatement of this license type shall register and provide fingerprints for a nationwide criminal background check to be conducted at the applicant's expense. **The instructions and vendor** for the background check can be found in the document on the Board's website (same location you downloaded this application from) and linked to on the on the Board's homepage - "Background Fingerprint Instructions."

- **Do not register for the background check prior to submission of your application. Fees paid may not be refundable. Register a few days after submission of the application.**
- **This background check registration is NOT required for the renewal of any license.**
- **Notify the Board of your registration for the background check -ExamBoards-Healthcare@sos.ga.gov. Staff will be checking the website and approving applicants as quickly as possible.**

***NOTE:** This is a new requirement under O.C.G.A. 43-10A-5(i) and O.C.G.A. 43-10A-8(5) Failure to comply with this requirement will delay the processing of this application for licensure and may result in the application being denied.

FOR BOARD USE ONLY		FOR BOARD USE ONLY
Amount Submitted _____		Certificate Number _____
Date _____		Date Issued _____
Receipt # _____		Applicant No. _____

GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS AND MARRIAGE & FAMILY THERAPIST

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APPLICATION FOR LICENSURE AS AN ASSOCIATE MARRIAGE & FAMILY THERAPIST

Application Fee $110 (NON-REFUNDABLE)

(Application fee includes a $10 mail in application fee)

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

Additional License Types (currently or previously issued by any Georgia Professional Licensing Board): _____

Method Obtained by: Applicant is applying for above referenced license by:

( ) Examination

( ) Examination Waiver (Check only if you have already taken the MFT exam)

Name _____
Last First Middle

Name as shown on exam records or transcripts (If different than above):

_____
Last First Middle

_____ _____ Male ( ) Female ( )

Social Security Number **Date of Birth**

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* Please Print Clearly

(* 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).

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? ( ) Yes ( ) No - If yes, you may be eligible for veteran's preference points to be added to your licensure examination score. You may obtain the necessary forms and additional information from the Board website, or Board office.

☐ **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). If yes, submit military orders, identification cards or any documentation that indicates you are a military member or spouse.**

PART II - PROFESSIONAL BACKGROUND

❒ Yes ❒ No	1.	Are you unable to practice safely as a result of use of alcohol or other drugs?
❒ Yes ❒ No	2.	Have you been denied professional licensure or renewal because of a license disciplinary proceeding?
❒ Yes ❒ No	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?
❒ Yes ❒ No	4.	Have you been subject to disciplinary action or had your membership revoked by any professional organization?
❒ Yes ❒ No	5.	Have you knowingly failed to renew a license during an investigation of a disciplinary matter against you?
❒ Yes ❒ No	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?
❒ Yes ❒ No	7.	Have you ever been convicted of any criminal offense?
❒ Yes ❒ No	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 contender 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.
❒ Yes ❒ No	9.	Have you been the defendant in a malpractice suit and either entered into a settlement agreement or paid court awarded expenses?
❒ Yes ❒ No	10.	Do you now hold or have you ever held a license as a marriage and family therapist (or an Associate level MFT) in any jurisdiction? If "yes," complete the following: Jurisdiction _____ License No._____ Date Issued_____ Expiration _____
❒ Yes ❒ No	11.	Have you previously applied to the Board for the same license for which you are currently applying? If "yes," name under which application was submitted: _____
❒ Yes ❒ No	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.

PART III — GRADUATE EDUCATION

- For licensure as an Associate Marriage and Family Therapists, you must have satisfied one of three (3) educational requirements. See Board Rule 135-5-.05(b).
- Submit an official certified copy of your transcript, or direct the Registrar of your institution(s) to send an official copy of your transcript directly to the Board office: ExamBoards-Healthcare@sos.ga.gov **OR** 237 Coliseum Drive, Macon, GA 31217-3858.

A - EDUCATIONAL REQUIREMENTS

CHECK THE APPLICABLE EDUCATIONAL REQUIREMENTS YOU MEET:

❒ 1. I earned a master's degree from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). The program, at the time the degree was awarded, was fully approved by COAMFTE.

Date degree program was fully approved by COAMFTE:_____
❒ Letter of Verification **MUST BE** attached.

❒ 2. I earned a master's degree from a program in Marriage and Family Therapy, as specified in Board rules, from a recognized educational institution and will COMPLETE PART III - C.

❒ 3. I completed a program, including an earned master's degree and additional post-master's coursework, as specified in Board Rules. All coursework, including the master's degree and all post-graduate coursework, was earned from a recognized educational institution and will COMPLETE PART III - C.

B - MASTER'S DEGREE

Official Title of Program [As Listed on Transcript]:

Date Awarded:

Name of Institution:

Address: _____
Street City State Zip

C - MFT COURSEWORK

■ **Under Number 1** – If your master's degree was earned from a fully accredited COAMFTE approved program, you may go directly to part IV

If you meet the educational requirements listed in Number 2 or 3 above, complete this section.

■ **Under Number 2** — To qualify for licensure, at a minimum your master's degree program must have included all of the following courses. See Board Rule 135-5-.05(a)(4).

■ **Under Number 3** — You must have an earned master's degree and have completed additional post-graduate coursework in marriage and family therapy. Such coursework must have included, at a minimum, ALL of the following courses. See Board Rule 135-5-.05(a)(5).

Course Title and Number	**Institution**
THREE (3) COURSES IN MARRIAGE AND FAMILY STUDIES	
A "Marriage and Family Studies Course" includes the study of the theory and practice of the principles, concepts, or history of marriage and family life, family systems, family relations and family development. Board Rule 135-5-.05(a)(6).	
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 135-5-.05(a)(7).	
1.	
2.	
3.	

THREE (3) COURSES IN HUMAN DEVELOPMENT	
"Human development courses" encompass the study of all aspects of individual 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 135-5-.05(a)(8).	
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 135-5-.05(a)(9).	
1.	

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 135-5-.05(a)(10).	
1.	

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:

❒ Board-Approved Supervisor ❒ AAMFT-Approved Supervisor ❒ Not an Approved Supervisor

PART IV - POST-MASTER'S DIRECTED EXPERIENCE UNDER SUPERVISION

INSTRUCTIONS:

■ An applicant for licensure as an Associate Marriage and Family Therapist must submit to the Board the Post-Master's Experience under Direction and Supervision Contract Affidavit.

DATE ALL EDUCATIONAL REQUIREMENTS WERE COMPLETED: _____

DATE MFT EXAMINATION TAKEN AND PASSED (IF APPLICABLE):_____

❒ I have completed and am submitting as part of this application the Post-Master's Directed Experience under Supervision Contract Affidavit.

❒ I acknowledge that if I change work settings, contract terms, or supervisors, I must request and receive approval from the Board by completing a new Contract and submitting it to the Board for approval.

AFFIDAVIT REGARDING CITIZENSHIP

YOU MUST SIGN THIS AFFIDAVIT IN THE PRESENCE OF A NOTARY. Submit this document along with a copy of your secure and verifiable document to the Board with your application.

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, for which I am applying for licensure 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 Boards website.**

2) _____ I am **not** a United States citizen, but I am either 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.

Executed in _____ (City), _____ (State).

_____ _____

Signature of Applicant Printed Name of Applicant

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.

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MARRIAGE AND FAMILY THERAPY PRACTICUM/INTERNSHIP VERIFICATION
FORM A

- ■ Please type or print clearly. For additional forms, please photocopy. This is a 2-page form.
- ■ 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.

PART I - TO BE COMPLETED BY APPLICANT

Name:

Address:
Street City State Zip

√ Check applicable and complete information below:
- ❒ Practicum/Internship which was **part of my degree program** OR
- ❒ Practicum/Internship **before or after the master's degree**.

√ Check Type of Practicum/Internship: ❒ MFT ❒PC ❒SW

Institution: Degree:

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:

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_____
Printed Name
This_____day of _____,_____

_____
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.

Date _____ Signature of On-Site Coordinator _____

Printed Name _____

Name of Site:

Address:
Street City State Zip

Work Phone: ( ) Home Phone: ( ) Fax: ( )

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.

Date _____ Signature of Current On-Site Coordinator _____

Printed Name _____

Name of Site:

Address:
Street City State Zip

Work Phone: ( ) Home Phone: ( ) Fax: ( )

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MARRIAGE AND FAMILY THERAPY VERIFICATION OF PRACTICUM/INTERNSHIP SUPERVISION
FORM B

- 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 a 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

PRINT Name:_____ Social Security #:_____/_____/_____

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

Name of Supervisor:

Type of License: ❒MFT ❒LPC ❒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 supervision from me:

INDIVIDUAL:_____ Hours/Week _____ GROUP: _____ Hours/Week_____

Total Number of Hours: _____

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

❒ AAMFT Approved Supervisor ❒ AAMFT Supervisor In Training ❒ GA Board LMFT Approved Supervisor

DESCRIPTION OF PRACTICE SUPERVISED (Use a separate page if needed):

OATH

I attest that the supervision described above is a true and accurate representation of this Practicum/Internship experience and supervision.
_____(_____)
Signature of Internship/Practicum Supervisor Date (Please Print Name Clearly-Supervisor)

Subscribed to and sworn before me
this ____day of _____, 20____

_____
Notary Public
My Commission Expires:_____ *NOTARY SEAL*

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MARRIAGE AND FAMILY THERAPIST
PRACTICUM/INTERNSHIP - MISSING OR DECEASED SUPERVISOR AFFIDAVIT
FORM C

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, 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 the supervisor below.

Name of Supervisor: _____

who served as my Practicum/Internship Supervisor in the practice of Marriage and Family Therapy

during the period of : _____ to _____ For _____Total Number of Hours
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:
- ❒ AAMFT Approved Supervisor or Supervisor in Training
- ❒ Georgia Board Approved Supervisor

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

_____ _____
Printed Name of Applicant Signature of Applicant

_____
Sworn to and subscribed before me this Date

_____ day of _____, 20_____.

_____
Notary Public
My Commission Expires: Notary Seal

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POST-MASTER'S EXPERIENCE UNDER DIRECTION AND SUPERVISION

CONTRACT AFFIDAVIT

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- The purpose of this Contract Affidavit is to define the employment relationship for the purpose of acquiring the required post-master's experience under the direction and supervision that will be applicable for licensure pursuant to O.C.G.A. § 43-10A et. seq.
- For the specific definitions of terms pertaining to specific licenses, see the Rules of the Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists (Chapter 135-5).
- In addition to the above, all contractual parties are required to adhere to all local, state, and federal laws and regulations pertaining to all aspects of this contractual agreement whether written or implied. This includes, but is not limited to, the payment of local, state and federal taxes, minimum wage guidelines, assessment and collection of fees, insurance reimbursement claims, etc.
- Independent private practice or practice under O.C.G.A. § 43-10A-7, sections (9), (10), (13), (14), (15), (16) or (17) is **not** acceptable as "employment" for the purposes of obtaining directed experience under supervision.
- **NOTE: You must complete a separate Contract Affidavit for each directed experience site and /or supervisor.**
- **YOU MUST COMPLETE AND SUBMIT ALL 4 PAGES OF THIS FORM IN ITS ENTIRETY.**

PART I — APPLICANT

* * * TO BE COMPLETED BY THE APPLICANT * * *

NAME:
Last First Other[Middle/Maiden]

ADDRESS:
Street City State Zip

HOME TELEPHONE: ( ) OFFICE TELEPHONE: ( )

SOCIAL SECURITY NUMBER:
[Optional: For Identification, Law Enforcement, Statistical and Administrative Purposes]

LICENSE APPLIED FOR: ❒ LAPC ❒ LPC ❒ LMSW ❒ LCSW ❒ LAMFT ❒LMFT

EDUCATION

DEGREE EARNED: ❒ Master's ❒ Master's Specialist ❒ Doctorate: ❒ Ph.D. ❒ Ed.D.
(Transcript MUST indicate on the transcript the type of degree earned checked above)

PRACTICUM/INTERNSHIP
Did you complete a Practicum/Internship as part of your degree program? ❒ Yes ❒ No

If "Yes," Name of Site: _____

Start Date: _____ End Date: _____

Name of Practicum/Internship Supervisor who was Instructor of Record for the course: _____
_____LICENSED AS: ❒ LPC ❒ LCSW ❒ LMFT ❒ Psychologist ❒Psychiatrist

At the time of your practicum was your supervisor one of the following?
❒ AAMFT Approved Supervisor or Supervisor in Training ❒ GA Board Approved Supervisor

VERIFICATION

I attest that I have read and understand O.C.G.A. Title 43, Chapter 10A, and Chapter 135 of the Board's Rules and I agree to comply completely with all laws of the State of Georgia and the Rules of the Composite Board governing the practice of any specialty licensed by the Board. Furthermore, I understand that I may not practice without appropriate direction and supervision until licensed by the Board, nor engage in independent private practice or practice under O.C.G.A. § 43-10A-7 (9), (10), (11), (14), (15), (16) or (17) while obtaining the required experience for licensure.

_____ _____
Date Signature of Applicant

PART II - DIRECTED EXPERIENCE
* * * TO BE COMPLETED BY THE DIRECTOR * * *

- The purpose of DIRECTION is to provide ongoing administrative oversight by an employer or superior in the practitioner's area of specialty.
- The Director is responsible for assuring the quality of the services provided and ensuring that qualified clinical supervision or intervention occurs in situations that require expertise beyond that of the employee.
- The Director must be located on-site and is specifically responsible for ensuring regularly scheduled reviews of employee compliance with the Rules of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists (Chapter 135) and all relevant federal, state, and local laws and regulations.
- **NOTE: Director and applicant (employee) must describe the content of the training experience and complete Part IV, Plan for Direction Section, on page 4.**

DIRECTOR

NAME:

TITLE/POSITION:

IF APPLICABLE: ❒ LPC ❒ LCSW ❒ LMFT ❒ Psychologist ❒ Psychiatrist

Date License Issued: Expires: State: Highest Earned Degree:

HOME TELEPHONE: ( ) | OFFICE TELEPHONE: ( )

EMPLOYMENT SITE

NAME OF EMPLOYMENT SITE:

ADDRESS:_____

Street City State Zip

OTHER PROFESSIONAL STAFF AT EMPLOYMENT SITE (ATTACH A SEPARATE SHEET, IF NECESSARY):

1. _____
Name *Degree* *License (If Applicable)* *Job Title*

2. _____
Name *Degree* *License (If Applicable)* *Job Title*

3. _____
Name *Degree* *License (If Applicable)* *Job Title*

4. _____
Name *Degree* *License (If Applicable)* *Job Title*

5. _____
Name *Degree* *License (If Applicable)* *Job Title*

AFFIDAVIT AND SIGNATURES

I attest that I have read and understand O.C.G.A. Title 43, Chapter 10A and the Rules of the Board and I agree to comply completely with all laws of the State of Georgia and Rules of the Composite Board governing the practice of any specialty licensed by the Board. Furthermore, I understand that this individual may not practice without appropriate direction and supervision until licensed by the Board, nor engage in independent private practice, or practice under O.C.G.A. § 43-10A-7, Sections (9), (10), (11), (13), (14), (15), (16), or (17) while obtaining the required experience for licensure.

I do hereby affirm under penalty of perjury that all statements made, and information contained above are true and correct to the best of my knowledge and belief. Further, I hereby authorize the release of any information relating to information contained in this form that may be necessary to verify the accuracy of the information contained herein.

_____
Signature of Applicant (Employee) Printed Name Date

Signature of Director Printed Name Date

Subscribed and sworn before me this _____
day of _____, 20_____

_____
My Commission Expires:_____ *NOTARY SEAL*

PART III — SUPERVISION
* * * TO BE COMPLETED BY THE SUPERVISOR * * *

- "SUPERVISION" is the direct clinical review, for the purposes of training or teaching, by a supervisor of interaction with a client/s in order to promote the development of clinical skills. It may include, but is not limited to, the review of case presentations, audiotapes, videotapes, and direct observation.
- The supervisor assumes complete clinical responsibility for all clients.
- The supervisor **does not** have to be located on-site.
- IMPORTANT: The requirements to be eligible to serve as a supervisor differ for Professional Counseling, Social Work and Marriage and Family Therapy. The number of hours and type (individual and/or group) of supervision is also specific to each license. See Chapter 135-5, Rules of the Composite Board of Professional Counselors, Social Workers and Marriage and Therapists for the precise requirements.
- NOTE: SUPERVISOR and APPLICANT (Employee) must complete PART V, Plan for Supervision, on page 4.

SUPERVISOR

NAME OF SUPERVISOR:

TITLE/POSITION:
IF APPLICABLE: ❒ LPC ❒ LCSW ❒ LMFT ❒ Psychologist ❒ Psychiatrist
Date License Issued: Expires: State: Highest Earned Degree:

HOME TELEPHONE: ( ) | OFFICE TELEPHONE: ( )

SUPERVISOR'S EMPLOYMENT SITE:

ADDRESS: _____
Street City State Zip

Do you have any current or prior relationship with the applicant/employee? ❒ No ❒ Yes If "Yes," please explain:

MFT SUPERVISORS ONLY:

1. Do you intend to supervise this applicant for licensure as a Marriage and Family Therapist or Associate Marriage and Family Therapist? ❒ Yes ❒ No
2. If "Yes," have you obtained one of the following required designations?
   ❒ GA Board Approved MFT Supervisor ❒AAMFT Approved Supervisor
   Supervisor's Name: _____

See Board Rule 135-5-.06 for specific information.

AFFIDAVIT AND SIGNATURES

I attest that I have read and understand my responsibilities as a supervisor under O.C.G.A. § 43, Chapter 10A and the Rules of the Board and that I will assure complete compliance with all laws of the State of Georgia and the Rules of the Composite Board governing the practice of any specialty licensed by the Board. In addition, I assume full responsibility for all aspects of the clinical services provided by this individual. Furthermore, I have reviewed this Contract Affidavit and will ensure that this individual will not practice without appropriate direction, nor engage in independent private practice, or practice under O.C.G.A. §43-10A-7, Sections (9), (10), (11), (13), (14), (15), (16), or (17) while obtaining the required experience for licensure.

I do hereby affirm under penalty of perjury that all statements made and information contained above are true and correct to the best of my knowledge and belief. Further, I hereby authorize the release of any information relating to information contained in this form that may be necessary to verify the accuracy of the information contained herein.

_____
Signature of Applicant (Employee) Printed Name Date

_____
Signature of Supervisor Printed Name Date

Subscribed and sworn before me this _____
day of _____, _____.

_____
My Commission Expires: _____ **NOTARY SEAL**

PART IV — TRAINING EXPERIENCE AND PLAN FOR DIRECTION

- To be completed by the director and applicant (employee). Use additional sheets, if necessary.
- Describe in detail below the content of the training experience and the specific plan for "Direction."
- The plan must include, but is not limited to: 1) A description of the nature of the services being provided to the public; 2) **the wages, salaries or other monetary considerations**; and 3) a description of and declaration that both the direction and supervision occur on a regular basis.

PLAN FOR DIRECTION:

Signature of Director | Date | Signature of Applicant (Employee)

PART V — PLAN FOR SUPERVISION

INSTRUCTIONS:

- To be completed by the director and applicant (employee). Use additional sheets, if necessary.
- Describe the specific "Supervision Plan" for this applicant (supervisee).
- "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 a client/s. Supervision may include, but is not limited to, the review of case presentations, audiotapes, videotapes, and direct observations.
- **CONTRACT/AFFIDAVIT MUST SPECIFY THE NUMBER OF HOURS PER WEEK TO MEET THE 30 MINIMUM HOURS PER YEAR.**

PLAN FOR SUPERVISION

Signature of Supervisor | Date | Signature of Applicant (Employee)