STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
BOARD FOR PROFESSIONAL COUNSELORS, MARITAL & FAMILY THERAPISTS,
AND CLINICAL PASTORAL THERAPISTS
665 Mainstream Drive
NASHVILLE, TENNESSEE 37243
http://tennessee.gov/health/topic/pcmft-board
(800) 778-4123, ext. 741-5735 -- (615) 741-5735

UPGRADE APPLICATION FOR LICENSE AS A MARITAL AND FAMILY THERAPIST

NAME _____
Last First Middle Maiden (if not used as your middle name)

CURRENT HOME MAILING ADDRESS:

_____
_____
_____

CURRENT PRACTICE NAME AND ADDRESS

_____
_____
_____

*If you have no practice address, notify the Board of your practice address within 30 days of obtaining a practice address. If you have multiple practice address, please attach an additional page listing all practice addresses.

Home Phone # (____)_____ Work Phone # (____)_____

E-Mail Address:_____

Do you wish to receive notifications, including renewal notification, from the Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. Yes _____ No _____

Social Security No. _____-_____-_____ Birth Date: _____/_____/_____

Race:_____ Gender: Female _____ Male _____ U.S. Citizen: Yes_____ No_____

Entitled to Live and Work in the U.S. Yes ___ No___

COMPETENCY QUESTIONS

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "Yes" to any question, attach an explanation on a separate sheet. **In support of your explanation, the final documents or orders from the issuing states, courts and/or agencies must be submitted along with this application.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned judgments, to learn and keep abreast of medical developments;
   b. The ability to communicate those judgments and medical information to clients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
   c. The physical capability to perform required tasks and procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

3. **"Minor Traffic Offense"** generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g., heroin, or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:	**YES**	**NO**
1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated because of ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice?	_____	_____
2. Do you currently use any chemical substances with in any way impair of limit your ability practice your profession with reasonable skill and safety?	_____	_____

If so, please list:

_____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.]

3. At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances? _____ _____

4. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances? Are you currently engaged in the illegal use of controlled substances? _____ _____

5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? _____ _____

6. Have ever held or applied for a license or certificate to practice marriage and family therapy in any state, country, or province, that had been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? _____ _____

7. Have you ever held staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, or otherwise disciplined or voluntarily surrendered under threat of restriction or disciplinary action? _____ _____

8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, otherwise disciplined, or voluntarily under threat of investigation or disciplinary action? _____ _____

9. Have you ever been convicted (including a "nolo contendere" plea or guilty plea) of a felony or a misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?? _____ _____

10. Have you ever been rejected or censured by a professional association? _____ _____

11. In relation to the performance of your professional services in any profession:

    a. Have you ever had a final judgment rendered <u>against</u> you; _____ _____

    b. Have you ever had settlement of any legal action rendered <u>against</u> you; or _____ _____

    c. Are there any legal actions pending <u>against</u> you or to which you are a party? _____ _____

12. Have you ever held a license or certificate in any health care profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? _____ _____

13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state. _____ _____

AFFIDAVIT AND RELEASE

I, _____, of _____, being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a licensed marital and family therapist in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a marital and family therapist .

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith without malice concerning my competence, ethics, character, and/or other qualifications, for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____

SIGNATURE **DATE**

VERIFICATION OF SUPERVISED POST-MASTERS EXPERIENCE

PLEASE COMPLETE THIS FORM AND RETURN IT TO THE ADDRESS BELOW. ON YOUR LETTERHEAD STATIONERY DESCRIBE THE POST-MASTERS SUPERVISED CLINICAL EXPERIENCE, INCLUDING ALL LOCATIONS. **TYPE OR PRINT LEGIBLY.**

TO BE COMPLETED BY THE APPLICANT'S SUPERVISOR

APPLICANT'S NAME: _____

SUPERVISOR'S NAME: _____

SUPERVISOR'S LICENSE NUMBER: _____

SUPERVISOR'S ADDRESS: _____

THE SUPERVISOR MUST HAVE:

1. Been in clinical practice as a marital and family therapist at least five (5) years;
2. At least two (2) years experience supervising marital and family therapists;
3. Received at least 36 clock hours of supervision (by an approved supervisor) of his supervisory work by at least two (2) persons doing marital and family therapy; or
4. Completed training for supervision with an AAMFT approved supervisor.
5. **Please submit proof of qualifications.**

THE ABOVE APPLICANT HAS SUCCESSFULLY COMPLETED SUPERVISED CLINICAL TRAINING DURING THE PERIOD _____, _____ TO _____, _____, AS FOLLOWS:

1. Total hours of **CLINICAL CONTACT IN MARRIAGE AND FAMILY THERAPY** provided by the applicant during the time you supervised him/her.

   _____ hours

2. Total hours of **INDIVIDUAL SUPERVISION** of this work (200 are required).

   _____ hours

I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT AND THAT I MEET THE ABOVE SUPERVISOR QUALIFICATIONS.

_____ _____

SUPERVISOR'S SIGNATURE DATE

SEND TO: Board for PC/MFT/CPT
665 Mainstream Drive
Nashville, TN 37243

THIS PAGE MAY BE DUPLICATED IF NEEDED.