Application for countries	who license, cer	tify, or resist	ter Marriage and	Family Therapist
The following materials are required 1. Application 2. Reference Sheet 3. Supporting Documents 4. Type or print legibly in black ink 5. Fees are non refundable		n for certified fo	amily therapists:	
Part 1: Application Information				
CHECK BOX INDICATING THE APPROPRIA	TE INFORMATION REGAR	RDING YOUR APPLIC	CATION	
☐ This is the first time I have made ☐ I have previously made application reapplying ☐ My application for this profession requirements.	on for this certification had been previously	n before, howeve		•
Part II: Applicant Identifying Info	ormation			
1. NAME Last First Middle 2. TITLE (e.g., M.D., LMFT) 3. NATIONAL ID NO.				
4. PERMANENT ADRESS	STREET	CITY	STATE/COUNTRY	POSTAL CODE
5. BUSINESS ADDRESS	STREET	CITY	STATE/COUNTRY	POSTAL CODE
6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER NAME WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE) 7. MOTHER'S MAIDEN				
8. PLACE OF BIRTH CITY	STATE/COUNTRY	9. AGE Male Female	10. DATE OF BIRTH	
11. TELEPHONE NUMBER WHER Work:	E YOU MAY BE REA Home:	ACHED		
Fax:	Mobile/C	ell:		
12. EMAIL ADDRESS (Required)				

PART III: Education Information					
1. PRELIMINARY EDUCATION (Ele	ementary and High School or	G.E.D. Cir	cle number of years com	pleted)	
1 2 3 4 5 6 7 8 9 10 11 12 \(\sum Yes \) \(\sum No \)	Graduated High School	Yes		ed G.E.D	
2. NAME OF LAST PRELIMINARY SCHOOL ATTENTED	3. LAST PRELIMINARY SCHOOL LOCATION (City and Country)		4. DATE OF GRADUATION (Month/Year)		
5. COLLEGE OR UNIVERSITY (Circ	ele number of years complet	ted)			
	luated?				
6. COLLEGE/UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City/Country)	DATES OF ATTENDANCE (Month/Year) FROM TO		TYPE OF DEGREE EARNED	
Į	f additional space is needed,	attach a se	parate sheet.		
7. SPECIALIZED TRAINING (Reside	ncy, Professional Training,	Vocational	l Training, Practical or	Clinical Training)	
COLLEGE/UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City/Country)	DATES OF ATTENDANCE (Month/Year)		DID YOU COMPLETE TRAINING?	
		FROM	ТО	1	
				□Yes □No	
				□Yes □No	
				□Yes □No	
				□Yes □No	
				□Yes □No	
				□Yes □No	
				□Yes □No	
ļ	f additional space is needed,	attach a se	parate sheet.		

PART IV: RECORD OF LICENSURE INFORMATION If you are licensed (or are certified or registered) to practice as a Family Therapist and or hold a license as a psychiatrist, psychologist, social worker or counselor, complete the information requested below. Whenever the word (licensure) is used below, that is also defined to mean certified or registered. LICENSE STATUS **PROFESSION LICENSE COUNTRY** DATE OF ISSUANCE (Active, Lapsed, **NAME NUMBER** etc.) Country of Original Licensure Location of most Current Licensure where you most recently have been practicing Other Country Licensure, Certification or Registration

If additional space is needed, attach a separate sheet.

PART V: LICENSURE REQUIREMENTS

Every country that certifies, licenses or registers therapists whether they be psychiatrist, psychologists, social workers, counselors or family therapists, has a set of requirements for certification. For this Certified Family Therapy Certificate, the Commission needs to match the requirements of your country and your certification with its established requirements (www.)

1. COUNTRY OF LICENSURE (Note space if needed) 2. Academic Credit Hours Needed hours	
2. Academic Credit Hours Needed hours	
3. Clinical Hours for Licensurehours	
4. Supervision Hours for Licensurehours	
5. Master's Degree Obtained?	
5a. College or University Where Master's Degree was Obtained	
6. License or Certificate Have you attached a copy in English?	
If additional space is needed, attach a separate sheet.	

PART VI: PERSONAL HISTORY INFORMATION (This part must be completed by all applicants)					
	YES	NO			
1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole officer. In general, a criminal conviction by itself does no usually result in denial of licensure.					
2. Have you been convicted of a felony? In general, a felony conviction by itself does not usually result in denial of licensure.					
3. Do you have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? <i>If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.</i>					
4. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in the United States or elsewhere? <i>If yes, attach a detailed explanation</i> .					
5. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? <i>If yes, attach a detailed explanation</i> .					
PART VII: CERTIFYING STATEMENT					
Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.					
Signature of Applicant Date					
I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater that \$50.					

CERTIFICATIO	ON BY LICE	ENSING AGENCY/BOARD			
APPLICANT: Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. You are authorized to photocopy this form as necessary.					
	Middle	2. DATE OF BIRTH	3. NATIONAL ID NO.		
4. ADDRESS STREET, CITY, STATE, POSTAL CODE		5. PROFESSION AND CODE: If your country uses a specific name for your profession and uses a governmental code, please provide them below.			
		Profession Name	Profession Code		
6. MAIDEN OR GIVEN SURNAME		7. APPLICANT TELEPHONE NUMBER (Daytime)			
8. RECORD PROFESSION NAME AS IT APPEAR YOUR LICENSE FROM THE JURISDICTION TO THIS FORM IS BEING FORWARDED. (If applica) WHICH	8b. LICENSE NUMBER (If applicable)	8c. ISSUANCE DATE OF LICENSE (If applicable)		
I hereby authorize					
Signature:		Date:			
RETURN COMPLETED FORM TO APPLICANT LICENSING AGENCY: The International Family Therapy Association will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas, which are not applicable. This form is to be returned directly to the applicant to be forwarded to the Commission.					
CERTI A. NAME OF PROFESSION AS IT APPEARS ON		OF LICENSURE B. LICENSE NUMBER			
	ETCEITOE	Bi Bi Bi Bi (ii) I (ii) I Bi Bi			
C. ISSUANCE DATE OF LICENSE		D. EXPIRATION DATE O	F LICENSE		
☐ Other (Name) ☐ Endorsement of License (Country) Acceptance of Examination Results (Administered in Another Country)					
F. CURRENT LICENSURE STATUS □ Active □ Other (Explain) □ Inactive □ Lapsed	G. ENDORSEMENT: I attest to this record indicate certification of the applicant.				
		Title	Date		