International Accreditation Commission
for Systemic Therapy Education

1800 3rd Avenue, Suite 512 • Rock Island, IL 61201 USA
Tele. +1-309-786-4491 • Fax. +1-309-786-0205 • Secretariat: wjhiebert@aol.com
www.ifta-familytherapy.org

Certified Systemic Therapy Supervisor Process

July 2019

The process of becoming a Certified Systemic Supervisor involves the following steps:

Please type in the forms. The forms are fillable PDFs.

1. Complete the Intent to Train Application - Before Training

This form is for those who are seeking training to become a Certified Systemic Supervisor. The form should be completed at the beginning of training and sent to the Secretariat.

The form provides the applicant with a grid to determine the applicant's background in terms of readiness to become certified. The form requests information on the applicant's college/university education, clinical training, licensure or registration as a systemic therapist.

2. Final Systemic Supervisor Application - After Training

Upon completion of all of the training, the applicant for Certified Systemic Supervisor must complete these forms:

- Application for Certified Systemic Supervisor

- Certification by Licensing Agency or Board (page 5)

- Supervision Training (Form ST-MFT)
(This form records the academic/didactic training, the systemic supervision training, and the trainees)

- Supervision of Supervision Worksheet (Form SOS- MFT)

- Supervisor's Report (Form SOSR-MFT)

- Trainee's Change Document (FORM SCD-MFT)

3. Acceptance and Fees

- Supervisor Fees (Form -MFT)

Upon acceptance of the application, the trainee will be notified by email together with an invoice for the fees. When the fees have been paid, IACSTE will issue a certificate.

International Accreditation Commission
for Systemic Therapy Education

1800 3rd Avenue, Suite 512 • Rock Island, IL 61201 USA
Tele. +1-309-786-4491 • Fax. +1-309-786-0205 • Secretariat: wjhiebert@aol.com
www.ifta-familytherapy.org

Application for Certified Systemic Supervisor

The following materials are required to make Application for certified family therapists:

1. Application
2. Pre-Requisites
3. Training Documents
4. Clinical Training Documents
5. Type
6. Fees are non refundable

PART 1: Application Information

CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

☐ This is the first time I have made application for certified systemic supervisor

☐ I have previously made application for this certification before, however my previous application expired and I am now reapplying

☐ My application for this profession had been previously denied. I am reapplying since I have fulfilled additional requirements.

PART II: Applicant Identifying Information

1. NAME Last First Middle	**2. TITLE (e.g., M.D., LMFT)**	**3. SOCIAL SECUTIRY NO.**
4. PERMANENT ADRESS STREET	**CITY STATE/COUNTRY**	**ZIP CODE COUNTY**
5. BUSINESS ADDRESSSTREET	**CITY STATE/COUNTRY**	**ZIP CODE COUNTY**
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 WHERE YOU MAY BE REACHED

Work: Home:

Fax: Fax:

12. EMAIL ADDRESS (Required)

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Check number of years completed)

1 2 3 4 5 6 7 8 9 10 11 12 ☐☐☐☐☐☐☐☐☐☐☐☐

Graduated High School ☐Yes ☐No *OR* Received G.E.D ☐Yes ☐No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENTED	**3. LAST PRELIMINARY SCHOOL LOCATION (City and State)**	**4. DATE OF GRADUATION (Month/Year)**

5. COLLEGE OR UNIVERSITY (Check number of years completed)

1 2 3 4 5 6 7 8 ☐☐☐☐☐☐☐☐

Graduated? ☐Yes ☐No

6. COLLEGE/UNIVERSITY NAME (Undergraduate and Graduate)	**LOCATION** (City/State/County)	**DATES OF ATTENDANCE** (Month/Year)		**TYPE OF DEGREE EARNED**
		FROM	**TO**	

If additional space is needed, attach a separate sheet.

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

COLLEGE/UNIVERSITY NAME (Undergraduate and Graduate)	**LOCATION** (City/State/County)	**DATES OF ATTENDANCE** (Month/Year)		**DID YOU COMPLETE TRAINING?**
		FROM	**TO**	
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

If additional space is needed, attach a separate sheet.

PART IV: RECORD OF LICENSURE INFORMATION

If you have ever been licensed to practice as a family therapist, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other states regarding possible fee).

COUNTRY/STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
Country/State of Original Licensure				
Country/State of Current Licensure where you most recently have been practicing				
Other Licensures				

If additional space is needed, attach a separate sheet.

PART V: RECORD OF EXAMINATION

If you have ever taken a licensure examination in a USA state for Marriage and Family Therapy, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	COUNTRY/STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)

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 state or in federal 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. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes attach a copy of the certificate.*		
4. 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? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		
5. 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? *If yes, attach a detailed explanation.*		
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		

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.

CERTIFICATION BY LICENSING 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.

1. NAME **Last** **First** **Middle**	**2. DATE OF BIRTH**	**3. SOCIAL SECURITY NO.**

4. ADDRESS STREET, CITY, STATE, ZIP CODE	**5. REFER TO REFERENCE SHEET. Record profession name and three-digit profession code for which you are making this application.**
	_____ _____ **Profession Name** **Profession Code**
6. MAIDEN OR GIVEN SURNAME	**7. APPLICANT TELEPHONE NUMBER (Daytime)**

8. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)	**8b. LICENSE NUMBER (If applicable)**	**8c. ISSUANCE DATE OF LICENSE (If applicable)**

I hereby authorize _____ to furnish to the International Family Therapy
Name of Licensing Agency or Board
Association or its designated testing service, the information requested below.

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.

PART I – CERTIFICATION OF EXAMINATION STATUS

A. The applicant ☐ has written ☐ is scheduled to write the following examination:

_____ _____
Name of Examination Date of Examination

B. The applicant has or will have written the above-named examination _____ number of times.

PART II – CERTIFICATION OF LICENSURE

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE	**B. LICENSE NUMBER**
C. ISSUANCE DATE OF LICENSE	**D. EXPIRATION DATE OF LICENSE**

E. LICENSURE METHOD

☐ Examination (Administered in Your State)
- ☐ National (Name) _____
- ☐ State Constructed _____
- ☐ Other (Name) _____

☐ Endorsement of License (State) _____
Acceptance of Examination Results (Administered in Another State) _____

☐ Reciprocity with (State) _____
- ☐ Waiver/Grandfather
- ☐ Credentials
- ☐ Other (Describe) _____

F. CURRENT LICENSURE STATUS	G. IF LICENSED BY EXAMINATION, RECORD SCORES
☐ Active ☐ Other (Explain) _____ ☐ Inactive _____ ☐ Lapsed _____	Type of Examination Score Written _____ Practical _____ Other (Describe) _____ Received no Grade Below _____ Examination Period _____ days _____ hours

International Accreditation Commission
for Systemic Therapy Education

1800 3rd Avenue, Suite 512 • Rock Island, IL 61201 USA
Tele. +1-309-786-4491 • Fax. +1-309-786-0205 • Secretariat: wjhiebert@aol.com
www.ifta-familytherapy.org

IMPORTANT NOTICE: Completion of this form is necessary for consideration for certification. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.	**SUPERVISION TRAINING**	SUPPORTING DOCUMENT **ST-MFT**

APPLICANT: You may copy this form as needed.

☐ I have completed an Intent to Train Application. Date:_____

Attach a copy of the application that you sent to the IACSTE office.

ACADEMIC TRAINING (30 Hours): List the courses or workshops you have received in systemic supervision. *Please attach certificates or verifications of attendance at the below courses or workshops.*

COURSE TITLE	INSTITUTION WHERE OFFERED	DATE	HOURS

SYSTEMIC SUPERVISION HOURS (30 Hours): List at lease one trainee and the location where you provided a student or trainee systemic supervision.

TRAINEE	LOCATION	DATES OF SUPERVISION	HOURS

Name(s) of the trainees who are applying for certification that you have provided systemic supervision of their supervision.

NAME	ADDRESS	EMAIL

	SUPERVISION OF SUPERVISION WORKSHEET	SUPPORTING DOCUMENT **SOS-MFT**

APPLICANT: Complete and return this form to IACSTE.

1. Last Name First Middle	2. Date of Birth	3. Social Security Number
4. Address (Street, City, Country, Postal Code)	5. REFER TO REFERENCE SHEET: Record profession name and three-digit profession code for which you are making this application.	
6. Maiden or Given Surname	_____ Profession Name	_____ Profession Code

CLINICAL SUPERVISION (30 Hours)

1	Supervisor Name, Degree, Institution Address, Phone	Supervision Hrs	Pre or Post Degree	MFT or MH Sup.
		Total Sup. Hours Start Date: End Date:	Supervision Occurred: ☐ During my first qualifying degree OR ☐ After completion of first qualifying degree	
2	Supervisor Name, Degree, Institution Address, Phone	Supervision Hrs	Pre or Post Degree	MFT or MH Sup.
		Total Sup. Hours Start Date: End Date:	Supervision Occurred: ☐ During my first qualifying degree OR ☐ After completion of first qualifying degree	
3	Supervisor Name, Degree, Institution Address, Phone	Supervision Hrs	Pre or Post Degree	MFT or MH Sup.
		Total Sup. Hours Start Date: End Date:	Supervision Occurred: ☐ During my first qualifying degree OR ☐ After completion of first qualifying degree	
4	Supervisor Name, Degree, Institution Address, Phone	Supervision Hrs	Pre or Post Degree	MFT or MH Sup.
		Total Sup. Hours Start Date: End Date:	Supervision Occurred: ☐ During my first qualifying degree OR ☐ After completion of first qualifying degree	

TOTALS OF THE CLNICAL SUPERVISION RECORDED ON THIS PAGE:

TOTAL supervision of supervision Hours provided for this Student/Trainee applicant:	TOTAL **Marriage and Family Therapy** supervision of supervision hours recorded on this page:

IMPORTANT! PLEASE HAVE EACH SUPERVISOR LISTED ABOVE COMPLETE AN SOSR-MFT FORM

THIS FORM MAY BE DUPLICATED AS NEEDED

IMPORTANT NOTICE: Copy as many of these forms as you had had supervisors.	**SUPERVISOR'S REPORT**	SUPPORTING DOCUMENTS **SOSR-MFT**

APPLICANT: Complete section 1-10 and forward this form to supervisor for completion.

1. Last Name First Middle	2. Date of Birth	3. Social Security Number
4. Address (Street, City, Country, Postal Code)	5. REFER TO REFERENCE SHEET: Record profession name and three-digit profession code for which you are making this application. _____ _____ Profession Name Profession Code	
6. Maiden or Given Surname		
7. Supervisor Name	8. Supervisor's Business Phone	
9. Supervisor's Institution or Agency Name	10. Supervisor's Address (Street, City, Country, Postal Code)	

SUPERVISOR: Complete the remainder of this form. Return the completed form directly to IACSTE, 1800 3rd Avenue, STE 512, Rock Island, IL 61201 USA or by fax at +1-309-786-0205 or by email, wjhiebert@aol.com.

PART I – Supervisor Information

A. Supervisor Name/Degree	B. Supervisor's License No.	C. State & Date of Issuance
D. Supervisor's Agency/Institution Name and Address	E. Supervisor's Work Phone	
	F. Starting Date of Supervision	G. Ending Date of Supervision

H. Please check the (one) box that accurately reflects your training, experience, certification, and/or licensing at the time supervision took place and provide supporting documentation as indicated. See Instruction Sheet for definition of terms.

The supervision you provided may count as marriage and family therapy (MFT) supervision if **one** of the following is true (Check **only** one box):

☐ I am certified as an Approved Supervisor or Supervisor-in Training by the American Association. (Please enclose a photocopy of proof of certification.)

☐ I am a licensed, certified or registered marriage and family therapist, social works or other mental health professional.

a) What is your license, registration or certification called (e.g. social worker)? _____

b) In what country is your license, registration or certification? _____

* *Please attach a copy of your license, registration or certification.*

☐ I have

a) an active license as a psychiatrist, licensed clinical psychologist, licensed clinical social worker, or licensed clinical professional counselor and
b) 5 years clinical experience providing marriage and family therapy and
c) provided at least 1,000 hours of conjoint therapy and
d) either 2 years experience providing clinical supervision of marriage and family therapy (including the supervision of conjoint therapy) or have completed a 1-semester hour graduate course in marriage and family therapy supervision (at least 15 contact hours) or the equivalent prior to or during the supervision provided the applicant. (Please enclose a written statement attesting to how you have met requirements b through d.)

NOTE: An applicant must have a supervisor qualified to provide systemic (marriage and family therapy) supervision as defined above for at least 50 hours of supervision of supervision in order to meet the certified supervision requirements.

PART II – Supervision Information

I. This supervision experience occurred (Please select one):

☐ during the applicant's 1st qualifying degree ☐ after completion of the applicant's 1st qualifying degree

J. Indicate your overall evaluation of the applicant's performance as a Marriage and Family Therapist.

Excellent		Satisfactory		Poor
5 ◯	4 ◯	3 ◯	2 ◯	1 ◯

K. COMMENTS: Include any comments regarding the applicant's job performance:

L. COMPLETE THE FOLLOWING:	M. Formats of Supervision (Check All that Apply):
Frequency of Supervision Appointments:	☐ Live Supervision
Duration of Each Supervision Appointment:	☐ Co-Therapy
Total Hours of Clinical Supervision:	☐ Video Tape Review ☐ Audio Tape Review ☐ Case Notes and Consultation

N. I have read the guidelines regarding supervision established for the marriage and family therapy license and certify that the supervision conducted with this application complies with these standards.

☐ Yes ☐ No

Under the penalties of perjury, I certify that the information provided regarding the supervision provided to the applicant and my training, experience, certification and/or licensing is true and correct.

Signature: _____ Date: _____

Title: _____