Virginia Department of Health Professions
Board of Counseling

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
www.dhp.virginia.gov/counseling

Email: coun@dhp.virginia.gov
(804) 367-4610 (Tel)
(804) 767-6225 (Fax)

APPLICATION INSTRUCTIONS
TEMPORARY LICENSURE AS A RESIDENT IN MARRIAGE AND FAMILY THERAPY

☐ Completed Application: The application must have an *original signature*. To avoid delays, please provide a complete application packet. Incomplete packets will not be evaluated by the Credential Reviewer.

☐ Application Fee: A fee of $65.00 is required for an application to be processed. All fees must be paid by check or money order made payable to the "Treasurer of Virginia". This fee is non-refundable. The application is valid for one year from date of receipt.

The below supplemental documentation must accompany your application and fee in one packet:

☐ Verification of Education: An official graduate degree transcript with conferral date is required. Electronic transcripts must be emailed directly to the Board from the school.

☐ Verification of Required Coursework and Internship: To be completed by your graduate program and sent to the Board within your application packet.

☐ Supervisor Contract: Signed contract that outlines the expectations and responsibilities of the supervisor and resident in accordance with the regulations of the Board. (Supervisor contract example can be found on the Board's website)

☐ Supervisor must be a LMFT or LPC with Evidence of Supervision Training: If your supervisor is **not** listed on the Supervisor Registry, you must submit evidence that your supervisor received professional training in supervision, consisting of three credit hours or 4.0 quarter hours in graduate-level coursework in supervision or at least 20 hours of continuing education in supervision offered by a provider approved under 18VAC115-50-96.

☐ Name Change: If applicable, documentation must be provided if your name has legally changed by marriage, divorce, or a court order. A photocopy of your marriage license or a copy of the court order must be provided.

☐ NPDB Self-Query: A current report from the U.S. Department of Health and Human Services National Practitioners Data Bank (NPDB) must be included. A self-query request can be obtained at https://www.npdb.hrsa.gov. Copies of the completed self-report result can be considered.

☐ Out-of-State Licensure Verification(s): If you hold or have ever held a licensure, certification, or registration as a mental health or health professional, whether current or expired, you must submit a license verification from the issuing jurisdiction. This verification is to be completed by the issuing jurisdiction and mailed back to you and included in your application packet, or can be provided through an online verification printed from the issuing jurisdiction's website if the verification indicates that you have no disciplinary actions listed.

☐ Degree Information: If applicable, you will need to submit the following information if your degree is **not** CACREP or COAMFTE accredited or your degree is **not** specifically in the practice of marriage and family therapy:

1. Evidence (letter or printed information from website) that degree program had the express intent to prepare students to practice marriage and family therapy.
2. Evidence that degree program had an identifiable counselor training faculty (licensed LMFT faculty) with an identifiable body of students.
3. Degree program had clear authority and primary responsibility for the core and specialty areas.

Please note:

In order to be considered for residency, all education requirements outlined in Regulations 18VAC115-50-50 and 18VAC115-50-55 must be met. Once approved you will be required to renew the Resident in Marriage and Family Therapy License each year and complete the continuing education requirements.

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INITIAL APPLIATION FOR TEMPORARY LICENSURE AS A RESIDENT IN MARRIAGE AND FAMILY THERAPY - PAGE 1

Military/Military Spouse

Are you active duty military personnel? ☐ Yes ☐ No

Are you the spouse of a member of the U.S. military who has been transferred to Virginia and who had to leave employment to accompany your spouse to Virginia? ☐ Yes ☐ No

(PLEASE PRINT IN BLUE OR BLACK INK)

FIRST NAME	MIDDLE NAME	LAST NAME AND SUFFIX
DATE OF BIRTH _____ _____ _____ MM DD YY	SOCIAL SECURITY NO. OR VA CONTROL NO.*	

ADDRESS OF RECORD**: STREET	CITY	STATE	ZIP CODE
ALTERNATE PUBLIC ADDRESS***: STREET	CITY	STATE	ZIP CODE

HOME PHONE:	WORK PHONE:	MOBILE PHONE:
E-MAIL ADDRESS		

DEGREE EARNED	DATE DEGREE RECEIVED	MAJOR	INSTITUTION NAME/STATE

*In accordance with §54.1-116 Code of Virginia, you are required to submit your Social Security Number or your control number issued by the Virginia Department of Motor Vehicles. If you fail to do so, the process of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other state agencies for child support enforcement activities. NO LICENSE WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FAILED TO DISCLOSE ONE OF THESE NUMBERS.

**The address information you provide is your address of record with the Board. Please be advised that all notices from the board, to include renewal notices, licenses, and other legal documents, will be sent to the address of record provided. If you provided a different public address, this information is not subject to public disclosure under the Freedom of Information Act and will not be sold or distributed for any other purpose.

***This address is subject to public disclosure under the Freedom of Information Act. You may provide an address other than a residence, such as a Post Office Box or a practice location if you wish.

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INITIAL APPLIATION FOR TEMPORARY LICENSURE AS A RESIDENT IN MARRIAGE AND FAMILY THERAPY - PAGE 2

If you answer "yes" to any question, **include a detailed explanation AND supporting documentation.**

Refer to Guidance Document 115-2 for detailed information on the requirements with a criminal conviction, past actions or possible impairment.

1. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? If yes, please provide a full explanation. ☐ Yes ☐ No

   (A) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? ☐ Yes ☐ No

2. Have you ever been censored, warned, terminated, or requested to withdraw from your employment with any health care facility, agency, or practice? If yes, provide a full description of the circumstances and any supporting documentation. ☐ Yes ☐ No

3. Within the past five years, have you been disciplined by any entity? Please provide a full explanation and any associated orders or letters from the entity. ☐ Yes ☐ No

   (A) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? ☐ Yes ☐ No

4. Have you voluntarily surrendered your license, certification or registration while under investigation? If yes, provide detail(s), jurisdiction(s), date(s), and supporting documentation. ☐ Yes ☐ No

5. Have you ever been denied the issuance of a license, certification, or registration, or denied the privilege of taking an occupational examination by a licensing agency. If yes, provide detail(s), jurisdiction(s) and date(s). ☐ Yes ☐ No

6. Have you ever been convicted of, pled Nolo Contendere to, or entered into a plea agreement for a violation of any federal, state or local statute, regulation, or ordinance? (This includes convictions for driving under the influence, but does not include other traffic violations).If yes, include an explanation of the charges/convictions, and attach documentation required in the Board's Guidance Document #115-2. ☐ Yes ☐ No

7. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing LPC. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.) ☐ Yes ☐ No

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INITIAL APPLIATION FOR TEMPORARY LICENSURE AS A RESIDENT IN MARRIAGE AND FAMILY THERAPY - PAGE 3

8. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing LPC. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.) ☐ Yes ☐ No

9. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing LPC. If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.) ☐ Yes ☐ No

10. Within the past 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? If yes, please provide a full explanation and any associated orders or letters from the entity. (NOTE: The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application, or have the program send this documentation directly to the Board.) ☐ Yes ☐ No

SUPERVISOR'S INFORMATION

The Board can only consider qualified LMFTSs or LPCs to supervise a resident in counseling.

SUPERVISOR'S NAME (LAST, FIRST)	LICENSE NUMBER	LICENSE TYPE
BUSINESS NAME OF SUPERVISOR'S WORKSITE	**ADDRESS** OF SUPERVISOR'S WORKSITE	
E-MAIL ADDRESS		
BUSINESS PHONE NUMBER		

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INITIAL APPLIATION FOR TEMPORARY LICENSURE AS A RESIDENT IN MARRIAGE AND FAMILY THERAPY - PAGE 4

WORKSITE INFORMATION **Please indicate the NAME and ADDRESS of the location where the RESIDENT will provide marriage and family therapy services.**
1st WORKSITE NAME
1st WORKSITE ADDRESS (Street and/or Box Number, City, State, Zip)
2nd WORKSITE NAME (if applicable)
2nd WORKSITE ADDRESS (Street and/or Box Number, City, State, Zip)(if applicable)
3rd WORKSITE NAME (if applicable)
3rd WORKSITE ADDRESS (Street and/or Box Number, City, State, Zip)(if applicable)

STATEMENT OF ASSURANCE AND ATTESTATION

- I have read, understand and intend to comply with the Regulations Governing the Practice of Marriage and Family Therapy.
- I understand that as a Licensed Resident in Marriage and Family Therapy, I must have a signed and executed supervisory contract for supervision before providing clinical marriage and family therapy services and before counting hours toward LMFT licensure.
- I attest that I will provide clinical marriage and family services as defined in the regulation during my residency.
- I acknowledge that the Board will conduct random audits to ensure that I am practicing in accordance with the regulations.
- I understand that as a Licensed Resident in Marriage and Family Therapy, I must renew my license each year and complete three hours of continuing education hours that emphasize ethics, standards of practice, or laws governing behavioral science professions in Virginia.
- I understand that I must complete all required residency requirements and pass the National MFT examination, administered by AMFTRB, within six years of the date of issuance of my resident in marriage and family license.

I ATTEST THAT THE INFORMATION CONTAINED WITHIN THE APPLICATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

APPLICANTS'S SIGNATURE:	DATE:

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VERIFICATION OF REQUIRED COURSEWORK AND INTERNSHIP FOR

LMFT LICENSURE

TO BE COMPLETED BY THE APPLICANT	
APPLICANT'S NAME (LAST, FIRST, MIDDLE)	
APPLICANT'S STUDENT ID NUMBER	APPLICANT'S SOCIAL SECURITY NUMBER OR VA DMV NUMBER

TO BE COMPLETED BY GRADUATE SCHOOL PROGRAM OFFICIAL OR ADMINISTRATION OFFICE

Please verify in the table below that the required coursework was successfully completed by the applicant by listing the relevant required core courses taken. All courses are required and must be graduate level from a college or university approved by a regional accrediting agency, CACREP or COAMFTE. Do not list courses that are not directly related to marriage and family therapy or counseling. If a course title is not clearly indicative on the transcript, please attach college catalog description(s) or course syllabi. **A graduate course cannot be counted for more than one core area.** All information provided is subject to Board review and approval. (See attached documents will not be considered)

1. **Marriage and Family Studies**. (marital and family development; family systems theory) These courses provide an overview of marriage and family systems theories and techniques. Courses in this area will enable students to conceptualize and distinguish the critical theories and practice in the profession of marriage and family therapy. Courses will be related conceptually to clinical concerns. **(A minimum of 6 semester or 8 quarter hours is required)**

Course Code	Course Title	Semester or Quarter Hours	College/University

2. **Marriage and Family Therapy**. (systemic therapeutic interventions and application of major theoretical approaches) These courses address contemporary issues, which include but are not limited to gender, violence, addictions and abuse in the treatment of individuals, couples and families from a relational/systemic perspective and application of major theoretical approaches. **(A minimum of 6 semester or 8 quarter hours is required)**

Course Code	Course Title	Semester or Quarter Hours	College/University

3. **Human Growth and Development.** This course provides an overview of contemporary theoretical perspectives regarding the nature of developmental needs and tasks from infancy through late adulthood, the influences of development on mental health and dysfunction and the promotion of healthy development across human life span.

Course Code	Course Title	Semester or Quarter Hours	College/University

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4. **Abnormal Behaviors**. This course provides students with an overview of the major categories of mental disorders including study of their etiology and progression, their prevalence and impact on individuals and society, their diagnosis according to the DSM-V and the use of diagnosis in treatment planning and counseling intervention.

Course Code	Course Title	Semester or Quarter Hours	College/University

5. **Diagnosis and Treatment of Addictive Behaviors**. This course provides students with an overview of addictive disorders including the study of contemporary theories of addictive behavior, pharmacological classification and addictive substances, assessment of addictive disorders and currently preferred models of addictions treatment.

Course Code	Course Title	Semester or Quarter Hours	College/University

6. **Multicultural Counseling.** This course provides students with an overview of the diverse social and cultural contexts that influence counseling relationships (e.g., culture, race, ethnicity, age, gender, SES, sexual orientation) including the study of current issues and trends in a multicultural society, contemporary theories of multicultural counseling, the impact of oppression and privilege on individual and groups and personal awareness of cultural assumptions and biases.

Course Code	Course Title	Semester or Quarter Hours	College/University

7. **Professional Identity and Ethics.** This course provides a foundation in professional counselor identity and ethical practice, including the study of the history and philosophy of the counseling profession, professional counselor function and credentialing and ethical standards for practice in the counseling profession.

Course Code	Course Title	Semester or Quarter Hours	College/University

8. **Research**. (research methods; quantitative methods; statistics) This course provides students with an overview of the principles and processes of performing counseling research including the study of quantitative and qualitative research designs and methods, methods of statistical analysis used in research, and reading and interpreting research results.

Course Code	Course Title	Semester or Quarter Hours	College/University

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9. **Assessment and Treatment.** (appraisal, assessment and diagnostic procedures) This course introduces students to the selection, administration; scoring and interpretation of contemporary psychological assessments used by professional counselor and includes the study of formal and information assessment procedures, basic test statistics, test validity and reliability, and the use of test finding in the counseling process.

Course Code	Course Title	Semester or Quarter Hours	College/University

10. **Supervised Internship.** This course provides students with a supervised internship of at least 600 hours to including (but not limited to) 240 hours of direct client contact, of which 200 hours must be with couples and families.

Course Code	Course Title	Semester or Quarter Hours	College/University

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VERIFICATION OF DEGREE AND INTERNSHIP FOR LMFT LICENSURE

TO BE COMPLETED BY STUDENT	
APPLICANT'S NAME (LAST, FIRST, MIDDLE)	
APPLICANT'S STUDENT ID NUMBER	APPLICANT'S SOCIAL SECURITY NUMBER OR VA DMV NUMBER

TO BE COMPLETED BY GRADUATE PROGRAM	
1. Is the college or university approved by a regional accrediting agency?	☐ Yes ☐ No
2. Did the graduate degree program prepare individuals to practice marriage and family therapy?	☐ Yes ☐ No
3. Was the applicant's graduate degree program CACREP or COMFTE accredited at the time of the applicant's graduation? (If yes, skip to question #7)	☐ Yes ☐ No
4. Did the graduate degree program have a sequence of academic study with the expressed intent to prepare students to practice marriage and family therapy?	☐ Yes ☐ No
5. Did the degree program have identifiable marriage and family therapy training faculty and an identifiable body of students who completed a counseling academic study?	☐ Yes ☐ No
6. Did the academic unit have clear authority and primary responsibility for the core and specialty areas?	☐ Yes ☐ No
7. Did internship begin after completion of 30 graduate semester hours?	☐ Yes ☐ No
8. **Total** number of supervised internship hours:	
9. Total **direct client contact** internship hours:	
10. Total **direct client contact** hours with couples and families:	
11. What type of licensure did the internship supervisor hold?	
12. Number of **individual** supervision hours during internship?	
13. Number of **group** supervision hours during internship?	
14. If applicable, total direct client contact hours treating **substance abuse-specific** treatment problems: (For LSATP licensure)	

NAME OF SCHOOL	
NAME OF PROGRAM OFFICIAL	TITLE
EMAIL ADDRESS OF SCHOOL OFFICIAL	PHONE NUMBER OF SCHOOL OFFICIAL
SIGNATURE OF SCHOOL OFFICIAL	DATE

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APPLICANT OUT-OF-STATE LICENSURE VERIFICATION/CERTIFICATION

PART I. TO BE COMPLETED BY THE APPLICANT:

NAME OF APPLICANT (LAST, FIRST, MIDDLE)

MAILING ADDRESS (STREET AND/OR BOX NUMBER, CITY, STATE, ZIP

APPLICANTS EMAIL ADDRESS	HOME AND/OR CELL TELEPHONE NUMBER

PART II. TO BE COMPLETED BY STATE LICENSING AUTHORITY:

TITLE OF LICENSE/CERTIFICATION	LICENSE/CERTIFICATION NUMBER
ISSUE DATE	EXPIRATION DATE

OBTAINED BY METHOD

☐ BY EXAMINATION ☐ BY WAIVER ☐ BY ENDORSEMENT ☐ BY RECIPROCITY

IS THERE ANY PUBLIC INFORMATION RELATING TO THIS LICENSE?

☐ YES (SPECIFY DETAILS ON A SEPARATE SHEET) ☐ NO

CERTIFICATION BY THE AUTHORIZED LICENSURE OFFICIAL OF THE STATE OF _____

☐ I CERTIFY THAT THE INFORMATION IS CORRECT.

AUTHORIZED LICENSURE OFFICIAL NAME AND TITLE _____

STATE SEAL

TITLE OF BOARD _____

TELEPHONE NUMBER _____

EMAIL ADDRESS _____

DATE _____

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QUARTERLY EVALUATION FOR LMFT LICENSURE

Section 115-50-60-D-1 of the Virginia LMFT regulations requires that the applicant's supervisor provide quarterly evaluations to the resident. This form must be signed and dated by the supervisor. **This form is to be completed by the supervisor each quarter and provided to the resident to be held in their possession until they are ready to submit their licensure application.**

NAME OF APPLICANT (LAST, FIRST, MIDDLE)	APPLICANT'S EMAIL ADDRESS

SUPERVISOR'S EVALUATION:

SUPERVISOR'S NAME (LAST, FIRST)	LICENSE NUMBER:	LICENSE TYPE:

BUSINESS NAME OF RESIDENCY WORK SITE WHERE CLINICAL HOURS WERE OBTAINED (ONE LOCATION ONLY)	**ADDRESS** OF RESIDENCY WORK SITE WHERE CLINICAL HOURS WERE OBTAINED (ONE LOCATION ONLY)

DATES OF SUPERVISION: FROM (MM/DD/YY): _____ TO (MM/DD/YY): _____

ALL COLUMNS MUST BE COMPLETED	**AVG HOURS PER WEEK**	**TOTAL HOURS (For this quarter only)**	**ARE HOURS DUPLICATED ON ANOTHER FORM**	
Total hours of supervised residency (Face-to-face client contact hour + ancillary hours)			☐ Yes	☐ No
How many face-to-face client contact hours did the resident provide?			☐ Yes	☐ No
How many number of face-to-face client contact hours with **couples and families or both?**			☐ Yes	☐ No
How many individual supervision hours did the resident receive?			**MUST HAVE A MIN. OF 1 AND MAX. OF 4 HOURS PER 40 HOURS OF EXPERIENCE.**	
How many group supervision hours did the resident receive?				
If applicable, total number of face-to-face client contact hours clinical substance abuse treatment services.			☐ Yes	☐ No

These areas are outlined in Section 18 VAC 115-50-55 of the LMFT Regulations. The resident must have supervised residency in the **role of a marriage and family therapist** in the below areas.

Did the applicant provide **marriage and family therapy** while under your direct supervision?	☐ Yes	☐ No
Did the applicant demonstrate minimum competencies in **human growth and development across the lifespan** under your supervision?	☐ Yes	☐ No
Did the applicant demonstrate minimum competencies in **abnormal behaviors** while under your supervision?	☐ Yes	☐ No
Did the applicant provide **diagnosis and treatment of addictive behaviors** while under your supervision?	☐ Yes	☐ No
Did the applicant demonstrate minimum competencies in **multicultural counseling** under your supervision?	☐ Yes	☐ No
Did the applicant demonstrate minimum competencies in **professional identity** while under your supervision?	☐ Yes	☐ No
Did the applicant demonstrate minimum competencies **research** while under your supervision?	☐ Yes	☐ No
Did the applicant demonstrate minimum competencies **assessments and treatment** under your supervision?	☐ Yes	☐ No
Do you have any **concerns about the competency** of the resident? If yes, explain on separate page.	☐ Yes	☐ No
COMMENTS:		

Resident's Signature:	Date:
Supervisor's Signature:	Date:

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TERMINATION OF SUPERVISION FOR A LICENSED RESIDENT

This form should be used to document termination of a supervisory contract between a supervisor and resident. At the conclusion of the supervised residency, the supervisor must provide the resident with a completed the Verification of Supervision form to be held in their possession until they are ready to submit their licensure application.

RESIDENT INFORMATION	
RESIDENT'S NAME (LAST, FIRST)	RESIDENT'S TELEPHONE NUMBER
RESIDENT'S EMAIL ADDRESS	
SUPERVISOR'S INFORMATION	
SUPERVISOR'S NAME (LAST, FIRST)	SUPERVISOR'S TELEPHONE NUMBER
SUPERVISOR'S EMAIL ADDRESS	SUPERVISOR'S LICENSE NUMBER:
SUPERVISED RESIDENCY WORKSITE INFORMATION	
NAME AND ADDRESS OF RESIDENCY WORKSITE(S):	
DATE OF TERMINATION:	
NAME AND SIGNATURE AND DATE OF INDIVIDUAL INITIATING TERMINATION OF SUPERVSION: PRINTED NAME: _____ SIGNATURE:_____ DATE:_____	