MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Board of Professional Counselors and Therapists
4201 Patterson Avenue, Suite 316
Baltimore, Maryland 21215
(410) 764-4732
www.dhmh.maryland.gov/bopc

NON-LCMFT MARRIAGE AND FAMILY THERAPY APPROVED SUPERVISOR
INSTRUCTIONS
PLEASE READ BEFORE COMPLETING APPLICATION

Documentation of a minimum of five (5) years experience for those wishing to provide 20% or 400 hours of the required supervision hours for Licensed Graduate Marriage and Family Therapists (LGMFTs).

QUALIFICATIONS:

As of May 1, 2014, to qualify as a Non-Marriage and Family Approved Supervisor, applicants must be licensed by the Board as a clinical professional counselor, a clinical alcohol and drug counselor, a clinical professional art therapist, or a mental health practitioner licensed under the Health Occupations Article, Annotated Code of Maryland **AND** have **5 years documented experience** in providing marriage and family therapy services. An Approved Marriage and Family Therapist Supervisor can **only provide up to 400 hours or 20%** of the required supervision for a licensed graduate marriage and family counselor (LGMFT).

SUPERVISEE:

Licensed Graduate Marriage and Family Therapists (LGMFTs)

*The following are **NOT ELIGIBLE** to provide supervision for the Licensed Graduate Marriage and Family Therapists:

1. Licensed Graduate Counselors (Ex: LGADC, LGPC, LGMFT, LGPAT, LGSW, etc);
2. A relative; or
3. An individual with whom there could be a conflict of interest, including, but not limited to, an employee supervising their employer or a student supervising their teacher.

NON-LCMFT MARRIAGE AND FAMILY THERAPY APPROVED SUPERVISOR

APPLICATION

SUBMIT NON-REFUNDABLE $75.00 APPLICATION FEE: CHECK OR MONEY ORDER MADE OUT TO "BOARD OF PROFESSIONAL COUNSELOR AND THERAPISTS" AND COMPLETE THE APPLICANT INFORMATION BELOW:

APPLICANT INFORMATION				
☐ Mr. ☐ Mrs. ☐Ms. ☐Dr.				
NAME (TYPE OR PRINT)	LAST NAME	FIRST NAME	MIDDLE INITIAL	MAIDEN NAME
DATE OF BIRTH	SOCIAL SECURITY #	PHONE NUMBER	EMAIL ADDRESS	
LICENSE NUMBER		ATTACH A COPY OF YOUR CURRENT LICENSE		

HOME ADDRESS					
STREET	CITY	COUNTY	STATE	ZIP CODE	

MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)				
STREET	CITY	COUNTY	STATE	ZIP CODE

CURRENT EMPLOYMENT INFORMATION					
PLACE OF EMPLOYMENT					
EMPLOYMENT ADDRESS					
	STREET	CITY	COUNTY	STATE	ZIP CODE
EMPLOYMENT PHONE NUMBER		EMPLOYMENT EMAIL			

CREDENTIALS AND EXPERIENCE:

AFTER DECEMBER 31, 2016 APPLICANTS MUST MEET specific supervision education requirements including completing a six (6) semester credit hours or 10 quarter credit hours of graduate-level academic training in *Theories of Couples and Families*.

PLEASE CHECK APPROPRIATE BOX AND ATTACH A COPY OF YOUR LICENSE AND REQUESTED DOCUMENTATION
SIGN AND DATE THE BOTTOM OF THIS FORM

☐ I hereby affirm that I am a (☐ LCPC, ☐ LCADC, ☐ LCPAT, Other (*LCSW-C, Psychologist, APRN, MD*) _____.
I attest that I have five (5) years experience providing Marriage and Family Therapy services.

APPLICANT SIGNATURE _____ **DATE**_____

BOARD OF PROFESSIONAL COUNSELORS AND THERAPISTS
NON-MARRIAGE AND FAMILY THERAPY APPROVED SUPERVISOR

Experience Verification

The person named below has applied to the Maryland Board of Professional Counselors and Therapists to become an **NON-Marriage and Family Therapist Approved Supervisor.** Your documentation of the applicant's marriage and family therapy experience will enable the Board to evaluate whether this applicant meets the requirements for "Approved Supervisor Status". **Please attest to the following statement and return the form to the applicant in a sealed envelope with the sealed flap signed.**

(*Print name of applicant*)_____ has a minimum of 5 years' experience in

marriage and family therapy with direct client contact while working at (*place of employment*)

_____ as a (*job title*) _____

from (*dates of experience*) _____ to _____.

I HEREBY AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE FOREGOING INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE, INFORMATION, AND BELIEF.

Check one: ☐ Applicant's supervisor ☐ Applicant's employer ☐ Applicant's colleague ***(****have colleague submit a copy of their mental health credential)*

Your Name: _____

Signature: _____

Date: _____

Business Address: _____

_____
(City) (State) (Zip code)

Daytime Contact Number: _____

Email: _____

PUBLICATION CONSENT

The Maryland Board of Professional Counselors and Therapists will maintain and post on its website a roster of Marriage and Family Therapy Approved Supervisors. The roster will list names of Approved MFT Supervisors and Non-LCMFT Approved Supervisors along with their contact information. Please indicate if you wish to be publically listed on the roster. Also, indicate if you want your name listed only or both your name and business contact information which may include a business number, address, and email address.

Do you wish to be publically listed as an Approved MFT Supervisor by the Board. Yes or No *(circle one)*
If you circle **Yes** please indicate the contact information you want published.

Contact Information: (Business Telephone #, Business email address, Business Address, etc.):

_____

_____

APPLICANT SIGNATURE _____ DATE_____