MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

TRANSFER FROM LGMFT to LCMFT

APPLICATION INSTRUCTIONS

** IMPORTANT **

This form is to be used ONLY if you are a Maryland Licensed Graduate Marriage and Family Therapist (LGMFT) with an active license in good standing and are seeking licensure as a Licensed Clinical Marriage and Family Therapist (LCMFT).

BEFORE submitting your application, please note the following:

□ Retain a copy of all documents for your records. Documents will not be returned once received by the Board.

□ Within 30 days after receipt of the application, the Board will determine if the application is complete. If the application is not complete, the Board will notify you, in writing, and you will have 90 days from the date of the notice to provide the requested documentation. If you do not provide the required information within 90 days, your application will be closed and all documents will be discarded. The Board does not retain incomplete applications. You will be required to submit a new application and pay the required application fee.

□ All forms must be legible, complete, signed, and dated or processing may be delayed.

□ Include a check or money order in the amount of $200 payable to: *Maryland Board of Professional Counselors and Therapists*.

A separate license fee of $150 will be due upon notification of eligibility from the Board. Fees are **non-refundable** and **non-transferable.**

□ Applications **may not** be submitted via fax, email, or in-person. Please mail to:

Board of Professional Counselors and Therapists
Attn: MFT Licensing Coordinator
4201 Patterson Avenue, Suite 316
Baltimore, MD 21215

If you would like confirmation that your application has been received, please send the application via certified mail, return receipt requested, or use another delivery method by which you may track your application. The Board cannot provide status updates on applications unless it has been 30 days or more since the date of receipt.

ELIGIBLITY/REQUIREMENTS: *The following is a summary only.* ***For complete requirements and definitions, see Md. Code Ann. Health Occ., §17-101, et. seq. and COMAR 10.58.08 and 10.58.15, which may be found on the Board's website, www.health.maryland.gov/bopc.***

□ **Applicant shall hold an active Maryland license as a graduate marriage and family therapist and be in good standing.**

□ **Clinical Supervision Requirements**: Applicant must have ***not less than two years with a minimum of 2,000 hours*** of supervised clinical experience in marriage and family therapy completed as a Maryland LGMFT and obtained under the supervision of a Board approved marriage and family therapy supervisor, as follows:

- At least 1,000 hours shall be face-to-face client contact hours; and
- 100 hours shall be face-to-face clinical supervision hours, of which:
  - 50 hours shall be individual face-to-face clinical supervision; and
  - A maximum of 50 hours may be face-to-face group clinical supervision.

See, COMAR 10.58.08.03C(2).

□ **Criminal History Records Check** (instructions and form attached). All applicants must complete a criminal history records check (CHRC). Applicant must include a **copy of the receipt** from the CHRC with this application. This allows the Board to access the report online from the Criminal Justice Information System.

Please note: A license will not be issued unless and until the Board determines that the applicant has completed **ALL** requirements including required coursework, examinations, CHRC, and any other requirements set by the Board in accordance with Maryland law.

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APPLICATION

Please type or print all information.

I. VETERANS AND SPOUSAL PREFERENCE

Are you an active service member or the spouse of any active service member? □ Yes □ No

Are you a veteran or the spouse of a veteran who was discharged from active duty under circumstances other than dishonorable within one year of filing this application? □ Yes □ No

II. DEMOGRAPHIC INFORMATION

Name: _____
Last *First* *MI* *Maiden*

SSN: _____ Date of Birth: _____ LGMFT Lic. # _____

Home Phone: _____ Work: _____ Cell: _____
Email: _____ *Email is the primary contact method by the Board.

Home Address: _____
Street *City* *State* *Zip*

Prior address: _____
(If less than 3 years at current address) *Street* *City* *State* *Zip*

Mailing Address: _____
(If different than above) *Street* *City* *State* *Zip*

Business: _____
Name *Street* *City* *State* *Zip*

Gender and Ethnicity: *This information is optional and may be used for statistical purposes by authorized personnel.*

Gender: □ Male □ Female

Ethnicity: Are you of Hispanic or Latino origin? □ Yes □ No

Check all that apply:

□ American Indian or Alaska Native □ Asian □ White

□ Black or African American □ Native Hawaiian or Pacific Islander

III. INFORMATION REGARDING BACKGROUND

Please answer Yes or No to each question.

YES NO

□ □ 1. Has any state licensing or disciplinary board ever taken any disciplinary action against your license or certification, including, but not limited to, charges, admonishment, reprimand, revocation, or suspension?

If yes, attach a separate page with a complete explanation of each occurrence (include date, time, location, disposition, etc.) and a copy of the disciplinary/court document from the issuing agency, if applicable.

□ □ 2. Have you pled guilty, nolo contender, or been convicted of, received probation before judgment or had a conviction set aside for any criminal act (excluding traffic violations)?

If yes, attach a separate page with a complete explanation of each occurrence (include date, time, location, disposition, etc.) and a ***certified*** copy of the disciplinary/court document from the issuing agency, if applicable. The failure to include this information will result in processing delays.

□ □ 3. Are you currently licensed or certified by another ***Maryland*** board in mental health therapy or other health occupation? *If so*, specify license/certificate (Ex: LCSW-C, Psychologist, Registered Nurse, etc.) _____.

IV. PROFESSIONAL REFERENCES (3): List at least 3 professional references who can attest to your therapy skills, professional standards of practice and supervised clinical work. You must include three (3) Professional Reference assessment forms in their original sealed envelopes with the application. Form is attached.

A. Name of Reference: _____

Degree: _____ Certification/License: _____

Position: _____ Business Name: _____

Business Address: _____

Business Phone: _____

Will this reference be verifying some or all of your supervised clinical experience? □ Yes □ No

B. Name of Reference:_____

Degree: _____ Certification/License: _____

Position: _____ Business Name: _____

Business Address: _____

Business Phone: _____

Will this reference be verifying some or all of your supervised clinical experience? □ Yes □ No

C. Name of Reference: _____

Degree: _____ Certification/License: _____

Position: _____ Business Name: _____

Business Address: _____

Business Phone: _____

Will this reference be verifying some or all of your supervised clinical experience? □ Yes □ No

V. SUPERVISED CLINICAL EXPERIENCE: I have:

□ completed a supervised internship course as part of my graduate program and have attained at least 2 years and 2000 hours of supervised clinical experience as a LGMFT as set forth below:

A. Practicum/Internship: Clinical therapy hours that were obtained as part of masters/doctoral program. Supervised clinical practice that included at least 60 hours of approved supervision and 300 hours of direct client contact with couples, families, and individuals, at least 100 hours of which were relational therapy.

1. Agency/school/organization where internship was obtained: _____
Name and credential of supervisor: _____
Inclusive dates of experience: from (mo. /yr.) _____ to (mo.yr.) _____
Total number of months worked: _____ Total number of hours per week: _____
Total number of hours worked during practicum/internship (No. of months x 4 x no. hours worked each week: _____
Direct clinical therapy services: _____ hours.
Supervision hours: _____

2. Agency/school/organization where internship was obtained: _____
Name and credential of supervisor: _____
Inclusive dates of experience: from (mo. /yr.) _____ to (mo.yr.) _____
Total number of months worked: _____ Total number of hours per week: _____
Total number of hours worked (No. of months x 4 x no. hours worked each week): _____;
Direct clinical therapy services: _____ hours.
Supervision hours: _____

And as further set forth in the attached Supervised Clinical Experience (Internship) Verification(s).

Summary of Internship/Practicum Hours:

Total number of **direct** clinical therapy services accrued during Internship/Practicum to be applied toward licensure: _____ hours.

Total number of **indirect** clinical therapy services accrued during Internship/Practicum to be applied toward licensure: _____ hours.

Total number of **supervision** hours: _____.

B. Clinical therapy experience obtained as a LGMFT under an approved supervisor:

1. Agency/ /organization name and address: _____
Name and credential of supervisor: _____ Phone: _____
Inclusive dates of experience: from (mo. /yr.) _____ to (mo.yr.) _____
Applicant's job title and duties: _____
Total number of months worked: _____ Total number of hours per week: _____
Total number of hours worked (No. of months x 4 x no. hours worked each week): _____;
Direct clinical therapy services _____ hours;
Indirect clinical therapy services _____ hours;
Supervision hours: _____.

2. Agency/ /organization name and address: _____
Name and credential of supervisor: _____ Phone: _____
Inclusive dates of experience: from (mo. /yr.) _____ to (mo. /yr.) _____
Applicant's job title and duties: _____
Total number of months worked: _____ Total number of hours per week: _____
Total number of hours worked (No. of months x 4 x no. hours worked each week): _____;
Direct clinical therapy services _____ hours;
Indirect clinical therapy services _____ hours;
Supervision hours: _____.

And as further set forth in the attached Supervised Clinical Experience (Post-Graduate) Verification(s).

Summary of Hours Accrued as a LGMFT:

Total number of post-graduate **direct** clinical therapy services to be applied toward licensure: _____ hours.

Total number of post-graduate **indirect** clinical therapy services to be applied toward licensure: _____ hours.

Total number of post-graduate supervision hours by a Board-approved supervisor:
Individual supervision: _____ hours.
Group supervision: _____ hours.

VI. AFFIDAVIT

In making this application to the Maryland Board of Professional Counselors and Therapists (the "Board") for the issuance of a Licensed Clinical Marriage and Family Therapist credential:

□ I agree to abide by the rules and regulations of the Board and to take all examinations necessary for the processing of my application;

□ I agree to abide by the Code of Ethics as set forth in COMAR;

□ I understand that the fee submitted with this application is **NON-REFUNDABLE**;

□ I agree to hold the Board, its members, officers, agents, and examiners free from any damage or claim of damage or complaint by reason of any action taken in connection with this application, the attendant examination, the grades with respect to any examination, and/or the failure or refusal of the Board to issue me a license or certificate.

□ I grant permission to the Board to seek any information or references it deems appropriate or necessary in verifying my credentials as it pertains to this application.

□ I understand, by law, it is my responsibility to notify the Board, in writing, of any change of contact information including address, phone number, and/or email address.

I do hereby affirm that all of the statements made herein are true and correct to the best of my knowledge and belief. I voluntarily consent to a thorough review of the information in this application and other activities for the purpose of verifying my qualifications for licensure.

_____ _____

Applicant's Signature Date

ATTACH
APPLICANT PHOTO

(Recent 2"x2")

NOTARY
State of _____
City/County of _____

I HEREBY CERTIFY that on this _____ day of _____, before me, a Notary Public of the State and City/County aforesaid, personally appeared _____ and made oath in due form that the contents of the foregoing Affidavit are true.

Notary Public _____Commission Expires: _____.

CLINICAL SUPERVISION EXPERIENCE VERIFICATION

(**Internship/Practicum S**upervised Clinical Experience)

***To Applicant*:** You must submit this form for each clinical therapy experience that you intend to apply toward the hours required for licensure. Please make additional copies as needed.

I hereby attest that, to the best of my knowledge, information, and belief, that

_____ obtained clinical experience under my supervision,
Applicant's Name

as part of his/her internship/practicum, from _____ to _____
mo./yr. *mo./yr.*

at _____
Name and Address Agency/Org.

as set forth below:

1. Direct Clinical Therapy Services*: _____ hours.
2. Direct Relational Clinical Therapy Services: _____ hours.
3. Indirect Clinical Therapy Services**: _____hours.
4. Direct Supervision: _____hours.

As the Board Approved Supervisor of this applicant, do you have any reservations about the applicant receiving a license for the independent practice of therapy?

□ Yes (please use additional sheets to explain) □ No

_____ _____
Name (printed) Lic. Type, Number and State of Issuance

_____ _____
Signature Date

Business Address: _____

Phone: _____ Email: _____

*"**Direct *Clinical Therapy Services"*** means the provision of face to face clinical professional therapy services to clients and their significant others that includes, but is not limited to, the following:

a. Individual therapy;
b. Group therapy;
c. Family therapy;
d. Couples therapy;
e. Evaluation;
f. Intake and assessment;
g. Diagnosis;
h. Treatment planning with client, and
i. Crisis management/intervention.

** ***"Indirect Clinical Therapy Services"*** means all case management and professional development activities related to the provision of clinical professional therapy services to a client that include, but are not limited to, the following:

a. Referral;
b. Intake or assessment by telephone or other means when client is not face to face;
c. Receiving individual or group supervision at site;
d. Consultation with other professionals;
e. Treatment planning with other professionals
f. Case staffing;
g. Staff meetings;
h. Related trainings and seminars;
i. Record keeping;
j. Report writing;
k. Case notes;
l. Telephone triage, and
m. Other clinical therapy administrative duties as required by the setting in which the clinical hours are accrued.

CLINICAL SUPERVISION EXPERIENCE VERIFICATION

(Supervised Clinical Experience as LGMFT)

***To Applicant*:** You must submit this form for each clinical therapy experience that you intend to apply toward the hours required for licensure. Please make additional copies as needed.

I hereby attest that, to the best of my knowledge, information, and belief, that

_____ obtained post-graduate clinical therapy experience
Applicant's Name

as a licensed graduate marriage and family therapist under my supervision, as a Board approved supervisor, from _____ to _____ at
(mo./yr.) *(mo./yr.)*

_____,
Name and Address Agency/Org.

as set forth below:

5. Direct Clinical Therapy Services*: _____ hours.
6. Indirect Clinical Therapy Services**: _____ hours.
7. Face to face*** Supervision between Board Approved Supervisor and Supervisee:
   a. Individual face to face supervision: _____ hours.
   b. Group face to face supervision: _____hours.

As the supervisor of this applicant, do you have any reservations about the applicant receiving a license for the independent practice of therapy?
□ Yes (please use additional sheets to explain) □ No

_____ _____
Name (printed) Lic. Type, Number and State of Issuance

_____ _____
Signature Date
Business Address: _____

Phone: _____ Email: _____

* **"Direct *Clinical Therapy Services"*** means the provision of face to face clinical professional therapy services to clients and their significant others that includes, but is not limited to, the following:

a. Individual therapy;
b. Group therapy;
c. Family therapy;
d. Couples therapy;
e. Evaluation;
f. Intake and assessment;
g. Diagnosis;
h. Treatment planning with client; and
i. Crisis management/intervention.

** ***"Indirect Clinical Therapy Services"*** means all case management and professional development activities related to the provision of clinical professional therapy services to a client that include, but are not limited to, the following:

a. Referral;
b. Intake or assessment by telephone or other means when client is not face to face;
c. Receiving individual or group supervision at site;
d. Consultation with other professionals;
e. Treatment planning with other professionals
f. Case staffing;
g. Staff meetings;
h. Related trainings and seminars;
i. Record keeping;
j. Report writing;
k. Case notes;
l. Telephone triage; and
m. Other clinical therapy administrative duties as required by the setting in which the clinical hours were accrued.

*** ***"Face-to-face"*** means in the physical presence of the individuals involved in the supervisory relationship during either individual or group supervision or using video conferencing which allows individuals to hear and see each other in actual points of time. It does not include telephone supervision; or internet communication that does not involve actual or real-time video conferencing such as instant messaging services and social networking sites. COMAR 10.58.15.02(5).

PROFESSIONAL REFERENCE ASSESSMENT

Three references are required. Please copy this form as necessary.

Applicant's Name: _____

The above-named individual has applied to the Board of Professional Counselors and Therapists to become a licensed clinical marriage and family therapist. Your assessment will help determine the applicant's eligibility for licensure. Please answer all questions to the best of your knowledge, information, and belief.

PLEASE RETURN THE COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPE.

Reference's Name: _____ Phone: _____

Business Address: _____

Degree: _____ Title: _____

Professional Certification/License: _____ State/Certifying Org.: _____

Relationship to Applicant: □ Educator □ Prof. Colleague □ Supervisor (must sign Supervision Verification form) □ Other: _____

Length of time you have known Applicant: From (mo./yr.) _____ To (mo./yr.) _____

Please rate the Applicant on the following skills/characteristics. Place a check √ in each category. *(Applicants who are counselor educators should be evaluated on the basis of their ability to train students in therapy skill areas).*	***Outstanding***	***Above Avg.***	***Average***	***Below Avg.***	***Poor***	***Cannot evaluate***
Individual therapy skills						
Appropriate referral making skills						
Group therapy skills						
Personal integrity						
Consulting skills						
Insight to client's problems						
Ability to relate to co-workers						
Objectivity on the job						
Ethical conduct						
Concern for welfare of clients						
Sense of responsibility						
Recognition of own limits						
Supervisory ability						
Ability to keep material confidential						

Additional Comments (optional): _____

_____

_____

I recommend this Applicant for licensure as a clinical marriage and family therapist: □ Yes □ No

The information provided above is based on my best knowledge, information, and belief. I agree to answer additional questions regarding this evaluation if requested by the Board.

_____ _____

Reference's signature Date

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NOTICE OF CRIMINAL HISTORY RECORDS CHECK

Effective January 1, 2014, the Maryland Board of Marriage and family therapists and Therapists (the "Board") requires that all applicants for licensure, certification, and trainee status complete a criminal history records check in accordance with §§17-501 and 17-501.1 of the Health Occupations Article, Annotated Code of Maryland.

A Criminal History Records Check includes a national and state criminal history background search. The criminal history records check requires you to be fingerprinted. In order to be fingerprinted, you will need to complete and present the Live Scan Pre-Registration Form. (Attached).

You must present this form to the fingerprinting site because it provides the Criminal Justice Information System (CJIS) authorization number **#1300005490** and the FBI ORI number **#MD920512Z** assigned specifically to the Board.

This allows the information to be forwarded directly to the Board.
For additional information contact CJIS at 410-764-4501. For current listings of fingerprinting providers please go to http: //www.dpscs.maryland.gov/publicservs/fingerprint.shtml.

FOR FAST AND ACCURATE SERVICE

1. When requesting a criminal history records check for licensing purposes you must have an agency name and authorization number (Listed above).

2. Your background check is being sent to the Board.

3. You must bring a valid form of government identification. (Examples: driver's license, Certificate of Naturalization, passport, Alien Registration Card, or Military Identification).

4. Complete the Live Scan Pre-registration Application and bring it to any fingerprinting center/provider.

5. Bring payment as indicated above. The Board will receive the results from the criminal history records check directly from CJIS within *5-7* business days. The Board will contact you if it has any questions regarding the report. Please do not contact the Board to check if the report has been received.

6. Please do not send the Live Scan Pre-registration Application to the Board. You must present it at the fingerprint center/provider location.