



**STATE OF MISSOURI**  
 DIVISION OF PROFESSIONAL REGISTRATION  
**REGISTRATION OF SUPERVISION**

STATE COMMITTEE OF MARITAL AND FAMILY THERAPISTS  
 3605 MISSOURI BOULEVARD  
 P.O. BOX 1335  
 JEFFERSON CITY, MO 65102  
 TELEPHONE (573) 751-0870 FAX (573) 751-0735  
 TDD (800) 735-2966

**INSTRUCTIONS**

- Please read this form and instructions before completing. This form must be typed or printed legibly in black ink.
  - Provide complete information. An incomplete form will delay review of the application.
  - Enclose the \$125 application fee made payable to the Missouri State Committee of Marital & Family Therapists. Payment must be made in the form of a check or money order.
  - Pursuant to §620.127, RSMo, disclosure of your social security number (SSN) is mandatory. The state committee will not publicly disclose your SSN without your consent, unless such disclosure is permitted by federal or state law. However, state law allows the state committee to disclose your SSN in connection with any civil, criminal, administrative or arbitral proceeding, in an investigation in anticipation of litigation, pursuant to a court order, and in the performance of a statutory or constitutional duty or power. The state committee can also disclose your SSN to another government agency (federal, state or local) and to a private person or entity acting on behalf of, or in cooperation with, a state entity. State law requires the state committee to provide your SSN to child support and tax compliance officials.
- \* ALL FEES ARE NONREFUNDABLE.**

**I. APPLICANT DATA**

1. NAME (LAST, FIRST, MIDDLE, MAIDEN)			E-MAIL ADDRESS		
2. OTHER NAME(S) YOU HAVE USED					
3. TELEPHONE HOME	TELEPHONE WORK	4. DATE OF BIRTH		5. SOCIAL SECURITY NUMBER (REQUIRED)	
6. MAILING ADDRESS (ACTUAL RESIDENTIAL ADDRESS, STREET, BOX NUMBER, CITY, STATE, ZIP CODE)					
7. GENDER (VOLUNTARY) <input type="checkbox"/> Female <input type="checkbox"/> Male		8. RACE (VOLUNTARY)		9. ETHNICITY (VOLUNTARY)	

**II. EDUCATIONAL**

10. GRADUATE DEGREE	DATES ATTENDED				DEGREE	CONFERRED	
	FROM		TO			MO	YR
	MON	YR	MON	YR			

11. LIST CORE COURSES TAKEN FOR GRADUATE CREDIT. (Official copies of all graduate degree transcripts must be sent to central office by the university/college.) If graduate course work is in quarter hours please check here . If graduate program is online or internet based, please check here .

**THIS SECTION MUST BE COMPLETED**

**A. THEORETICAL FOUNDATIONS OF MARRIAGE AND FAMILY THERAPY (3 SEMESTER HOURS REQUIRED)**

COURSE NO.	COLLEGE/UNIVERSITY	TITLE OF COURSE	CREDIT HOURS	DATE TAKEN

**B. PRACTICE OF MARRIAGE AND FAMILY THERAPY (12 SEMESTER HOURS REQUIRED)**

COURSE NO.	COLLEGE/UNIVERSITY	TITLE OF COURSE	CREDIT HOURS	DATE TAKEN

**C. HUMAN DEVELOPMENT AND FAMILY STUDIES (6 SEMESTER HOURS REQUIRED)**

COURSE NO.	COLLEGE/UNIVERSITY	TITLE OF COURSE	CREDIT HOURS	DATE TAKEN

**D. ETHICS AND PROFESSIONAL STUDIES (3 SEMESTER HOURS REQUIRED)**

COURSE NO.	COLLEGE/UNIVERSITY	TITLE OF COURSE	CREDIT HOURS	DATE TAKEN

**E. RESEARCH METHODOLOGY (3 SEMESTER HOURS REQUIRED)**

COURSE NO.	COLLEGE/UNIVERSITY	TITLE OF COURSE	CREDIT HOURS	DATE TAKEN

**F. DIAGNOSIS (EFFECTIVE AUGUST 28, 2008, 3 SEMESTER HOURS REQUIRED)**

COURSE NO.	COLLEGE/UNIVERSITY	TITLE OF COURSE	CREDIT HOURS	DATE TAKEN

**G. PRACTICUM IN MARRIAGE AND FAMILY THERAPY (6 SEMESTER HOURS REQUIRED)**

COURSE NO.	COLLEGE/UNIVERSITY	TITLE OF COURSE	CREDIT HOURS	DATE TAKEN

**III. SUPERVISOR DATA**

12. SUPERVISOR NAME (LAST, FIRST, MIDDLE, MAIDEN) DAYTIME TELEPHONE NUMBER

13. IS SUPERVISOR A RELATIVE OF APPLICANT?  
 YES     NO

14. ADDRESS (STREET, CITY, STATE, ZIP CODE)

15. DATE OF EMPLOYMENT IF NOT EMPLOYED BY INSTITUTION. CLEARLY INDICATE THE NATURE OF AFFILIATION WITH THE INSTITUTION

**14. PLEASE CHECK ALL THAT APPLY TO SUPERVISOR**

	LICENSE NUMBER	STATE
<input type="checkbox"/> AAMFT APPROVED SUPERVISOR		
<input type="checkbox"/> LICENSED MARITAL AND FAMILY THERAPIST		
<input type="checkbox"/> LICENSED PROFESSIONAL COUNSELOR		
<input type="checkbox"/> LICENSED PSYCHOLOGIST		
<input type="checkbox"/> LICENSED PSYCHIATRIST		
<input type="checkbox"/> LICENSED CLINICAL SOCIAL WORKER		

**IV. SUPERVISED PRACTICE SETTING**

17. INSTITUTION NAME

18. INSTITUTION ADDRESS

19. IS INSTITUTION A PRIVATE PRACTICE? IF YES, ANSWER QUESTION 19, 20 AND 21 BELOW

 YES  NO

20. LIST INFORMATION BELOW OF ALL INDIVIDUALS EMPLOYED BY OR AFFILIATED WITH THE PRIVATE PRACTICE. (ATTACH SEPARATE SHEET, IF NECESSARY.)

NAME	TITLE	LICENSE NUMBER	STATUS

21. IDENTIFY INDIVIDUAL(S) WHO HAVE AN OWNERSHIP INTEREST IN THE PRIVATE PRACTICE.

22. LIST THE INDIVIDUAL(S) ULTIMATELY RESPONSIBLE FOR THE PRIVATE PRACTICE.

**V. NATURE OF SUPERVISION**

CHECK THE APPROPRIATE BOX(ES) THAT DESCRIBE THE DUTIES TO BE PERFORMED BY THE APPLICANT. ATTACH ADDITIONAL SHEETS IF NECESSARY.

Assessment/Testing  Research  Other (please explain) \_\_\_\_\_

Marital & Family Therapy with (please specify)  Children  Adolescents  Adults  Family

BRIEFLY DESCRIBE JOB RESPONSIBILITIES/DUTIES.

CHECK THE APPROPRIATE BOX(ES) THAT APPLY TO THE NATURE OF THE SUPERVISION. ATTACH ADDITIONAL SHEETS IF NECESSARY.

Read all Reports/Case Notes  Cosign all Reports/Case Notes  Group Supervision Session

Observe Sessions  Review Audio/Visual Tapes  Review Treatment Plans

Seminars Weekly Meetings Other (please explain)

23. APPLICANT'S PROPOSED POSITION/TITLE

24. DATE OF APPLICANT'S INITIAL EMPLOYMENT

25. TOTAL NUMBER OF HOUR PER WEEK APPLICANT WILL BE WORKING

26. NUMBER OF HOURS PER WEEK OF INDIVIDUAL FACE-TO-FACE SUPERVISION

27. PLEASE ANSWER THE FOLLOWING QUESTIONS (Yes answers must be explained in writing and included with the application)	YES	NO
a. Have you, or any license or right to practice held by you, been restricted, disciplined, such a disciplinary action to include, but not be limited to, revocation, suspension, probation, censure, or reprimand, whether voluntarily agreed to or not, by any US state, territory, federal agency, Canadian province or foreign country?	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you ever taken an examination or been licensed by another professional licensing board? If yes, please list the board name, state, and license number.  _____	<input type="checkbox"/>	<input type="checkbox"/>
c. Are you presently being investigated or is any disciplinary action pending against any professional license, certification, registration or permit you hold?	<input type="checkbox"/>	<input type="checkbox"/>
d. Have you been arrested, charged, indicted, found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States whether or not sentence was imposed, including suspension imposition of sentence or suspended execution of sentence?	<input type="checkbox"/>	<input type="checkbox"/>
e. Have you been charged with or convicted of a violation of any federal or state drug laws or rules whether or not sentence was imposed or suspended?	<input type="checkbox"/>	<input type="checkbox"/>
f. Are you now being treated or have you in the last five years been treated through a drug or alcohol rehabilitation program?	<input type="checkbox"/>	<input type="checkbox"/>
g. Have you been convicted, arrested, charged, indicted, found guilty by a court, pled guilty or pled nolo contendere to any traffic offense resulting from or related to the use of drugs or alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
h. Have you had a judgment rendered against you based upon fraud, misrepresentation, or deception related to practicing marital and family therapy?	<input type="checkbox"/>	<input type="checkbox"/>
h. Have you been named as a defendant in a civil suit?	<input type="checkbox"/>	<input type="checkbox"/>

**VI. STATEMENT OF EMPLOYER**

(INSERT S-MFT NAME)	(SETTING)	(DATE OF EMPLOYMENT)
I hereby affirm that _____ is employed at _____ as of _____		
(INSERT SUPERVISOR NAME)	(SETTING)	(DATE OF EMPLOYMENT)
I hereby affirm that _____ is employed at or affiliated with _____ as of _____		
EMPLOYER SIGNATURE ▶		DATE

**VII. STATEMENT OF APPLICANT**

I affirm that I have read and understand the law and regulations regarding the licensure and practice of marital and family therapy. I understand I must practice marital and family under the supervision of a licensed marital and family therapist, clinical social worker, professional counselor, psychologist, or psychiatrist approved by the State Committee of Marital & Family Therapists, until I am licensed. I further understand that the minimum acceptable supervised experience shall be 3,000 hours and 24 months obtained within 24 - 60 calendar months for master's degree applicants or 1,500 hours and 12 months obtained within 12 - 24 calendar months for applicants with at least 30 hours post-master's degree course work in marital and family therapy. If, for any reason, the approved site or supervisor changes, I will notify the State Committee of Marital and Family Therapists and file a request to change of supervision. I understand that any supervision obtained without such notification will not be applicable toward licensure. I authorize the State Committee to release the results of this application to the licensure supervisor (see Section III or VIII) and my employer (see Section IV or VI).

I declare that all statements or representations contained in or attached to this form are made under oath or affirmation are true and correct to my best knowledge under penalty of 575.060 RSMo which specifies that anyone who makes a false statement in writing with intent to mislead a public official in the performance of his official duties is guilty of a class B misdemeanor. I understand that a violation of the practice act may subject the license to disciplinary action.

DATE	SIGNATURE OF APPLICANT ▶
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**VIII. STATEMENT OF SUPERVISOR**

I have reviewed this proposal for experience in marital and family therapy and accept full responsibility for the work this applicant will be performing under my supervision. This work will be performed pursuant to my order, control, oversight and guidance. If I am unable to complete this supervision arrangement I will advise the State Committee of Marital and Family Therapists in writing.

I hereby affirm under penalties of perjury that I am the supervisor named on this application. I declare that all statements or representations contained in or attached to this form are made under oath or affirmation and are true and correct to my best knowledge under penalty of section 575.060 RSMo which specifies that anyone who makes a false statement in writing with intent to mislead a public official in the performance of his official duties is guilty of a class B misdemeanor. I understand that a violation of the practice act may subject the license to disciplinary action.

DATE	SIGNATURE OF SUPERVISOR ▶
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