COMMONWEALTH OF VIRGINIA
Department of Health Professions
Board of Counseling

Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Email: coun@dhp.virginia.gov
Phone: (804) 367-4610 Fax: (804) 527-4435
Website: www.dhp.virginia.gov/counseling

LMFT APPLICATION INSTRUCTIONS
Initial Registration of Supervision for a Resident in Marriage and Family Therapy

Completed Application: The application must be signed by the resident and supervisor. To avoid delays, please provide a complete application packet. Incomplete packets will not be reviewed by the Credential Reviewer.

Application Fee: A fee of **$65.00** is required for an application to be processed. All fees paid by check or money order must be 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 transcript with conferral date is required.
- ☐ **Verification of Required Coursework and Internship**: To be completed by your graduate program and sent to the Board within your application packet.
- ☐ **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 through marriage, divorce, or a court order. A photocopy of your marriage license or a copy of the court order must be provided.

Please note:

In order to be considered for residency, all requirements outlined in Regulations 18VAC115-50-50 and 18VAC115-50-55 must be met.

Supervised work experience occurring in Virginia, in any setting, must be registered and approved by the Board prior to beginning that supervision. An applicant may not count hours towards licensure unless that supervised experience has been registered with the Board. Supervision that is not concurrent with a residency will not be accepted, nor will residency hours be accrued in the absence of board-approved supervision.

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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**

LMFT
Licensed Marriage and Family Therapist

Complete All Sections

Application Fee of $65.00 is Non-Refundable

Application forms lacking a Social Security or VA DMV number will not be processed.

Mail all required documentation and fee to:

Board of Counseling
9960 Mayland Dr., Suite 300,
Henrico,
Virginia 23233

All signatures must be original.

Legal Name (First, Middle, Last)

Other Names Used on Official Documents (i.e. transcripts)

Sex (Circle)
Male Female

Public Address (Street/Box Number, City, State, Zip)

Mailing Address (Street/Box Number, City, State, Zip)

Home Phone Cell Phone

Business Phone with extension

Email

Social Security Number (or VA DMV #) Date of Birth

Education/Training (List in chronological order all graduate schools attended. Include transcripts.)

Degree Earned	Date Degree Received	Major	Attendance Dates-mm/yr	Institution Name/State

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Initial Registration of Supervision for a Resident in Marriage and Family Therapy – Page 2

Ethics Attestation: Please answer the five questions below. **If you answer yes to any question, include a detailed explanation or supporting documentation. Refer to Guidance Document 115-2 for detailed information on the requirements with a criminal conviction.**

1. Have you ever been denied the privilege of taking an occupational license or certification examination? If yes, state what type of occupational examination and where: _____ □ **Yes** □ **No**

2. Have you ever had any disciplinary action taken against an occupational license to practice or are any such actions pending? If yes, explain in detail on a separate sheet of paper □ **Yes** □ **No**

3. Have you ever been convicted of a violation or pled nolo contendere to any federal, state or local statute, regulation or ordinance or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations and driving under the influence). If yes, explain in detail on a separate sheet of paper and provide court documents. □ **Yes** □ **No**

4. In the last twelve (12) months, have you been unable to practice counseling by reason of excessive use of alcohol, drugs, chemicals or any other type of material or as a result of any mental of physical condition? If yes, please provide an explanation on a separate sheet of paper. □ **Yes** □ **No**

5. Have you ever been censored, warned, or requested to withdraw from your employment, terminated from any health care facility, agency, or practice? If yes, provide an explanation on a separate sheet of paper. □ **Yes** □ **No**

6. Are you the respondent in any pending or unresolved board action in another jurisdiction or in malpractice claim? □ **Yes** □ **No**

Per the Regulations, only a qualified LMFT or LPC can supervise a resident in marriage and family therapy.

SUPERVISOR'S INFORMATION:		
Supervisor's Name: (Last, First)	License Number:	License Type:
Business Name and Address of Supervisor's worksite:		
Email Address:	Business Phone Number:	

Supervisors: If you are listed on the Supervisor registry on the Board's website, you are not required to complete this section. Otherwise, please provide the information requested below, along with certificates of completion or transcript.

Date	Organization that provided training	Title of the seminar/conference/workshop	Credit hours

Please indicate the NAME and ADDRESS of the location where the RESIDENT will provide clinical marriage and family therapy services. (one worksite)

Worksite Name:
Worksite Mailing Address (Street and/or Box Number, City, State, Zip

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Initial Registration of Supervision for a Marriage and Family Therapy – Page 3

Please indicate if the supervised experience during the residency will be in the role of a marriage and family as required by LMFT Regulations 18VAC115-50-60.

Does this worksite and position incorporate all of the below requirements? If not, explain on separate page. • Marriage and Family Studies • Marriage and Family Therapy • Human Growth and Development Across the Lifespan • Abnormal Behaviors • Diagnosis and Treatment of Addictive Behaviors • Multicultural Counseling • Professional Identity • Research • Assessments and Treatment	Yes No If no, explain on separate page
Will the supervisor be on-site in the same facility where the resident is providing services?	Yes No

Resident's Initial	Supervisor's Initial	Statement of Assurance
		I have read, understand and intend to comply with the regulations that govern the Virginia Board of counseling licensees and applicants.
		I understand that the Supervisor is prohibited from providing supervision to any individual whose relationship with the Supervisor would compromise objectivity.
		I understand that the Supervisor assumes full responsibility for the clinical activities of the Resident for the duration of the residency. The Supervisor is responsible for ensuring that the Resident does not practice outside of the scope of his/her education.
		I understand that the Supervisor shall complete evaluation forms to be given to the Resident at the end of each three-month period.
		I understand that the Supervisor must have two years of post-licensure marriage and family therapy experience prior to approval.
		I understand that the Supervisor shall report the total hours of residency by completing the verification of supervision form at the end of the residency.
		I understand that the Supervisor must immediately report to the Board any unethical practice performed by the Resident, in accordance with regulation 18VAC115-50-110.
		I understand that the Supervisor must ensure that all clients of the Resident are informed of the Resident's status and the Supervisor's contact information.
		I understand that the residency must be completed in no less than 21 months and no more than four years.
		I understand that the Resident may only use the title "Resident in Marriage and Family Therapy" and shall not present himself/herself in a way that may appear to be independent practice.
		I understand that the Supervisor will ensure that the Resident does not bill directly for services and that all payments, both cash and insurance, are paid to the Supervisor, or the Resident's employer.
		I understand that any violations of the regulations by the Supervisor or the supervisee, including but not limited to allowing unlicensed practice, misrepresenting the Resident's status to clients, allowing the Resident to bill directly, may result in disciplinary action before the Board of Counseling.

I attest that the information contained within the application is true and accurate to the best of my knowledge and belief.

Resident Signature:	Date:
Supervisor Signature:	Date:

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LICENSED MARRIAGE AND FAMILY THERAPIST (LMFT)

VERIFICATION OF REQUIRED COURSEWORK AND INTERNSHIP FORM

TO BE COMPLETED BY THE APPLICANT

Applicant's Name (Last, First, Middle)
Institution where internship took place (include city and state)
Name of Program
Applicant's Student ID Number Applicant's Social Security Number or 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 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 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.

DESIGNATE SEMESTER HOURS WITH AN "S" AND QUARTER HOURS WITH A "Q"

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.

Course Code	Course Title	S/Q Hours	College/University

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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.

Course Code	Course Title	S/Q 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	S/Q Hours	College/University

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	S/Q 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	S/Q 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	S/Q 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	S/Q Hours	College/University

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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	S/Q Hours	College/University

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	S/Q 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 shall be with couples and families.

Course Code	Course Title	S/Q Hours	College/University

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VERIFICATION OF INTERNSHIP FOR LMFT LICENSURE

USE THIS FORM TO DOCUMENT YOUR REQUIRED INTERNSHIP HOURS

Applicant's Name (Last, First, Middle)	
Applicant's Student ID Number	Applicant's Social Security Number or DMV Number

Is the college or university approved by a regional accrediting agency?	Yes	No
Is the college or university CACREP or COAMFTE accredited?	Yes	No
Did internship begin after completion of 30 graduate semester hours?	Yes	No
Total number of supervised internship hours:		
Total **direct client contact** internship hours:		
Total **direct client contact** with **couples and families**:		
What type of licensure did the supervisor hold?		
Number of **individual** supervision hours during internship?		
Number of **group** supervision hours during internship?		
If applicable, total direct client contact hours treating **substance abuse-specific** treatment problems:		

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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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 and 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	Hours per week	Total hours	Hours are duplicated on another supervisor's quarterly 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 face-to-face client contact hours were with Couples and Families or Both?			Yes No
How many Individual Supervision hours did the resident receive?			
How many Group Supervision hours did the resident receive?			
If applicable, Total number of face-to-face client contact hours in 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 clinical marriage and family services in the below core areas while under your direct supervision? • Marriage and Family Studies • Marriage and Family Therapy • Human Growth and Development Across the Lifespan • Abnormal Behaviors • Diagnosis and Treatment of Addictive Behaviors • Multicultural Counseling • Professional Identity • Research • Assessments and Treatment	Yes No If no, explain on a separate page.
Do you have any concerns about the competency of the resident? If yes, explain on separate page.	Yes No
Supervisor's Signature:_____	Date:_____

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REQUEST FOR TERMINATION OF SUPERVISION

This form should be used to notify the Virginia Board of Counseling of the termination of a board-approved supervisory contract between a supervisor and resident. At the conclusion of the supervised residency, the supervisor shall provide the resident with a completed Verification of Clinical 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 Information:

Name of Supervision Work Site:
Address of Supervision Work Site (Street, City, State, Zip):
Date of Termination:

Please email, fax or mail this completed form to:

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