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) 527-4435 (Fax

APPLICATION INSTRUCTIONS
Licensed Marriage and Family Therapist (LMFT) by Endorsement

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

Application Fee: A fee of **$175.00** 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 date of receipt.

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

☐ **Out-of-State Licensure Verification(s)**: If you have ever held or hold a licensure or certification as a mental health or health professional, whether current or expired, you must submit license verification. Please send the enclosed verification form to 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 you can provide an online verification printed from your licensure jurisdiction website if the verification indicates that you have no disciplinary actions.

☐ **Clinical Scores**: Clinical scores can be accepted by one of the following: (1) A notation on your official license verification form. (2) Submitting an exam score report within your certified copy of your application materials from the jurisdiction where you were originally licensed. (3) Transferring your official exam scores to VA by contacting AMFTRB.

☐ **NPDB Self-Query**: A current report from the U.S. Department of Health and Human Services National Practitioners Data Bank (NPDB) must be included. You may request a self-query at https://www.npdb.hrsa.gov.

☐ **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.

☐ **Verification of Education/Experience**: Submit all required documentation for **either** option 1 or option 2.

Option 1: **If you have 24 of the last 60 months of post-licensure active practice with an independent clinical marriage and family therapist license, then you must submit all of the following:**

- **Verification of Education**: An official graduate transcript with conferral date is required.
- **Original Application**: Provide a certified copy of your application materials from the jurisdiction where you were originally licensed.
- **Verification of Clinical Active Practice**: Provide evidence of post-licensure independent clinical active practice in marriage and family for 24 of the last 60 months immediately preceding your application in Virginia.

Option 2: **If you hold an independent clinical marriage and family therapist license but do NOT have 24 of the last 60 months of independent clinical active practice you must submit all of the following:**

- **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 in an envelope within your application packet.
- **Verification of Supervision**: The Verification of Supervision form should be completed by your supervisor, verifying hours obtained during your supervised residency. Original signatures are required. Note: *A separate verification of supervision form must be submitted for each supervisor and/or location.* If you are not in contact with your supervisor, you will need to provide a certified copy of your application materials (which must include your supervision documentation) from the jurisdiction where you were originally licensed.
- **Licensure Verification of Out-of-State Supervisor(s)**: If your supervision did not take place in Virginia, you must submit a verification of your supervisor's license. You may submit an online verification printed from the issuing license jurisdiction's website or you may submit the enclosed verification form. The supervisor's license verification must be included in your application packet.

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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 $175.00 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)

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

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

Home Phone | Cell Phone

Business Phone with extension | Fax

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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Licensed Marriage and Family Therapist (LMFT) Licensure by Endorsement Application - Page 2

Ethics Attestation: Please answer the ten questions below. **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.**

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? Yes No
   Please provide a full explanation and any associated orders or letters from the entity.

   (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? Yes No
   If yes, provide detail(s), jurisdiction(s), date(s), and supporting documentation.

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? Yes No
   (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.

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? Yes No
   "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing LMFT. 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.)

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 LMFT. 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 LMFT. 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

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Licensed Marriage and Family Therapist (LMFT) Licensure by Endorsement Application - Page 3

Licenses / Certifications: List all mental health or health professional licenses or certificates that you hold or have ever held.

State	State/License #	Current License Status	Issue Date	Type of License

Attestation of Accuracy & Review of Virginia Regulations & Statutes: *By signing this document, I hereby certify that the information provided in this application is true, accurate and complete to the best of my knowledge and belief. I also certify that I have carefully read, understand and agree to apply the Statutes and Regulations Governing the Practice of Marriage and Family Therapist. I understand that my signature below must be notarized.*

Signature of Applicant: _____ Date: _____

AFFIDAVIT: The following statement must be executed by a Notary Public.

State of _____, County of _____

Name _____, being duly sworn, says that he/she is the person who is referred to in the foregoing application for licensure as a professional counselor in the Commonwealth of Virginia; that the statements herein contained are true in every respect, that he/she has complied with all requirements of the law; and that he/she has read and understands this affidavit.

Subscribed to and sworn to before me this _____ day of _____, 20_____.

Signature of Notary: _____.

My commission expires on _____.

My Commission # (if applicable): _____. SEAL

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APPLICANT OUT-OF-STATE LICENSURE VERIFICATION

Part I. To be completed by the applicant:

PLEASE TYPE OR PRINT CLEARLY	
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:

PLEASE TYPE OR PRINT CLEARLY			
Title of License		License Number	
Issue Date		Expiration Date	
Obtained by Method ☐ By Examination **Date taken:** **Name of Exam:** **Score:**	☐ 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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VERIFICATION OF CLINICAL INDEPENDENT PRACTICE AS A LICENSED MARRIAGE AND FAMILY THERAPIST FOR 24 OF THE LAST 60 MONTHS IMMEDIATELY PRECEDING SUBMISSION OF APPLICATION FOR LICENSURE

The Virginia Board of Counseling, in its consideration of a candidate for licensure, depends on information from persons and institutions regarding the candidate's clinical independent practice for twenty-four of the last sixty months immediately preceding their licensure application in Virginia. Please complete this form to the best of your ability so the information you provide can be given consideration in the processing of this candidate's application in a timely manner.

By providing this form to references, the applicant authorizes past and present employers, businesses, professional associates and personal references to release to the Virginia Board of Counseling any information requested by the Board in connection with the processing of the application for licensure**.**

TO BE COMPLETED BY THE APPLICANT:

Last Name	First Name	M.I.
Street Address		
City	State	Zip Code
Email Address:	Phone Number:	

TO BE COMPLETED BY THE REFERENCE:

Last Name	First Name	M.I.
Street Address		
City	State	Zip Code
Email Address:	Phone Number:	

Relationship to Applicant:	

I certify that the above applicant for licensure in the Commonwealth of Virginia, was in active practice at:

Business Name of Agency or Private Practice:		
Street Address		
City	State	Zip Code
From: (mm/dd/yyyy)	To: (mm/dd/yyyyy)	
Reference Signature:		Date:

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VERIFICATION OF CLINICAL SUPERVISION FOR LMFT LICENSURE

GENERAL INFORMATION - PLEASE TYPE OR PRINT CLEARLY			
Name of Applicant (Last, First, Middle)	Applicant's Email Address		
SUPERVISOR'S EVALUATION:			
Supervisor's Name (Last, First)	License Number:	License Type:	Supervisor's Telephone Number
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): _____ Total Months:_____			
Did the resident receive a minimum of one (1) hour and a maximum of four (4) hours of in-person supervision per 40 hours of work experience while under your **direct supervision**?	Yes No If no, explain on separate page		
Total amount of in-person hours of supervision with the resident.	Individual Hours:	Group Hours:	
Did the applicant complete a minimum of 3,400 hours of supervised residency in the role of marriage and family therapist under your **direct supervision**? If not, how many? _____	Yes No		
Did the resident complete at least 2,000 hours of face-to face client contact in providing clinical marriage and family services under your **direct supervision**? If not how many? _____	Yes No		
Did the resident complete at least 1,000 hours of face-to face client contact with couples or families or both under your **direct supervision**? If not how many? _____	Yes No		
Did the applicant demonstrate minimum competencies in the following 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 separate page		
In your opinion has the applicant demonstrated competency sufficient for licensing and the independent practice in marriage and family services? If not, explain on separate page.	Yes No		
I declare that, to the best of my knowledge, the foregoing is true and correct. This evaluation has been discussed with the resident and a copy has been provided to the resident. 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

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

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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

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

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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	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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SUPERVISOR OUT-OF-STATE LICENSURE/CERTIFICATION VERIFICATION

Part I. To be completed by the applicant:

INSTRUCTIONS	**PLEASE TYPE OR PRINT CLEARLY**
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. Supervisor's information to be verified:

Last Name _____ First Name _____ M.I. _____

Part III. To be completed by state Licensing Authority:

INSTRUCTIONS	**PLEASE TYPE OR PRINT CLEARLY**
Title of License	License Number
Issue Date	Expiration Date

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 _____