INSTRUCTION SHEET

Licensed Marriage and Family Therapist

Examination
Acceptance of Examination
Endorsement of Licensure
Restoration

The requirements of licensure and practice for Illinois Licensed Marriage and Family Therapist (LMFT) licensure are provided by the ACT (225 ILCS 55/) and the RULES in Administrative Code (68 IAC Part 1283).

The ACT and RULES are available online at: www.idfpr.illinois.gov/profs/MarrFamTherapy.asp

STEP 1.

There are four (4) pathways (or LICENSURE METHODS) to Illinois LMFT licensure. Use the descriptions below to determine the appropriate LICENSURE METHOD for your situation.

ENDORSEMENT - The applicant in this situation is actively licensed as an LMFT (or equivalent license) in another state or US jurisdiction. This candidate has successfully completed the required licensure examination or will be required to complete it as part of the licensure process.

ACCEPTANCE OF EXAMINATION - The applicant in this situation is not actively licensed but has already successfully completed the required licensure examination.

EXAMINATION (or Pre-Examination Approval) - The applicant in this situation is not actively licensed and has not successfully completed the required licensure examination. An applicant in this situation is seeking approval from the Illinois Department of Financial and Professional Regulation (Department) and/or the Illinois Marriage and Family Therapy Licensing and Disciplinary Board (Board) to register and sit for the examination.

For more information about the required licensure examination please refer to RULES Section 1283.40.

RESTORATION - The applicant in this situation already holds an Illinois license as an LMFT but the license has been inactive or not renewed for five (5) years or more. Candidates seeking to reactivate a license that is not-renewed or inactive may contact the DPR call center 800/560-6420 to request instructions, forms and fees.

STEP 2.

Use the Licensure Method from STEP 1 and the chart below to complete **PART I** (Page 1), Box A., Items 1-4 of the application.

1. Profession Name	2. Profession Code	3. Licensure Method (From STEP 1)	4. Fee
Licensed Marriage and Family Therapist (LMFT)	166	ENDORSEMENT	$200
		ACCEPTANCE OF EXAMINATION	$100
		EXAMINATION	$100
		RESTORATION	$300

STEP 3.

Complete the rest of the 4-page application, noting the following:

PART IV: Record of Licensure Information (Page 3)
Applicants who have never held a marriage and family therapy or related license may mark N/A for "not available" or "not applicable" in this portion of the application.

PART V: Record of Examination (Page 3)
All attempts (pass or fail) of the Association of Marital and Family Therapy Regulatory Board's (AMFTRB) Examination in Marital and Family Therapy must be listed. Applicants should also list other state licensing or jurisprudence exams if different than the AMFTRB examination. Candidates who have never taken a licensure examination may mark N/A for "not available" or "not applicable" in this portion of the application.

PART VII: Examination Coding Information
This portion of the applicationis not used for LMFT or ALMFT applications. Please leave this part of the application blank or mark N/A for "not applicable". A separate examination registration process is followed when an applicant has been approved to take the exam.

STEP 4.

SUPPORTING DOCUMENTS - The following supporting documents may be required with your application. Read the instructions for each form thoughtfully.

Licensure Application fee (for your LICENSURE METHOD - please see STEP 2) - Please make your check or money order payable to IDFPR. DO NOT SEND CASH.

CCA form - This form is required to be completed by all applicants.

ED form(s) - This form is required for all applicants. The applicant completes the "APPLICANT" portion of the form, then arranges for his or her marriage and family therapy program college or university to complete the "SCHOOL OFFICIAL" portion of the form. The school official's original signature and seal is required, do not submit photocopies. Do not submit the form unless it has been completed by the marriage and family therapy program. A separate form is required for each college or university through which marriage and family therapy coursework was completed. Education requirements are detailed in RULES Section 1283.30.

Official Transcript(s) - Official final transcripts are required from each college or university through which marriage and family therapy coursework was completed.

AC-MFT form - This form is completed by the applicant. Applicants completing core area coursework at more than one college or university may use abbreviations to indicate the college or university where the coursework was completed.

Syllabi - A photocopy of the official syllabus is required for every course listed on the AC-MFT form(s). Candidates are encouraged to submit syllabi for every graduate level MFT course completed.

Illinois ALMFT license - An applicant whose education has already been approved as part of the Illinois ALMFT licensure process may submit a photocopy of his or her IL ALMFT license instead of the following documents: Official Transcript, AC-MFT form, and Syllabi.

COAMFTE accreditation - An applicant who has completed a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), or a marriage and family therapy program accredited by the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) may submit evidence of his or her program's accreditation instead of the following documents: Official Transcript, AC-MFT form, and Syllabi.

PCE-MFT - This form is completed by the applicant to document his or her post-masters professional and clinical work experience. Experiences should be listed in chronological order, with the most recent experience last. Professional Work Experience and Clinical Experience requirements are detailed in RULES Sections 1283.15 and 1283.20.

CSW-MFT - This form is completed by the applicant to list supervisory experiences. Experiences should be listed in chronological order, with the most recent experience last. Additional experiences may be listed on a separate page, following the same format. Clinical Supervision requirements are detailed in RULES Section 1283.25.

SR-MFT - A separate SR-MFT form must be submitted by each supervisor listed on the CSW-MFT form. The applicant completes the "APPLICANT" portion of the form, then arranges for each supervisor to complete the "SUPERVISOR" portion of the form. Each Supervisor's original signature is required-photocopies are not acceptable. Supervisor qualifications and other Clinical Supervision requirements are detailed in RULES Section 1283.25.

AAMFT Clinical Fellow Membership Certificate - This document is optional. An applicant who is a Clinical Fellow member of the American Association for Marriage and Family Therapy (AAMFT) may submit a photocopy of his or her membership certificate instead of the following documents: Official Transcript, AC-MFT form, Syllabi, PCE-MFT, CSW-MFT, SR-MFT.

CT form - A candidate who is licensed as an LMFT in another state or U.S. Jurisdiction must provide Certification of Licensure from his or her first state of marriage and family therapy licensure and the state in which she or he has most recently been practicing. The applicant must contact the appropriate Board or Agency in the other state(s) to arrange for an original Certification of Licensure to be sent directly to the Department.

An individual applying under the ENDORSEMENT licensure method who has been licensed at the independent level in another state or U.S. jurisdiction for 10 consecutive years without discipline may submit Certification of Licensure (CT forms) for each state in which the applicant practiced in the last 10 years instead of submitting the following documents: ED form, Official Transcript, AC-MFT form, Syllabi, PCE-MFT, CSW-MFT, SR-MFT.

Official Score Report - A candidate applying under the ACCEPTANCE OF EXAMINATION or ENDORSEMENT licensure methods must contact PTC (Professional Testing Corporation) or AMFTRB to arrange for an official, original licensure exam score report to be sent directly to the Department.

Personal History Documents - An applicant marking "YES" in response to any of the personal history questions in PART VI, page 4 of the application will need to provide a signed personal statement of explanation and corresponding documentation.

Proof of name change(s) - If any of the supporting documents listed above list a different first or last name than the name on the application, proof of name change(s) must be submitted. An applicant must document each step of each change. Examples of acceptable documentation include: Signed Marriage Certificates, Marriage Licenses, Divorce Decrees, Court orders showing change(s) of name.

RS form (Restoration Licensure Method only) - The RS form is not available online and must be obtained by contacting the Department. Candidates seeking to reactivate a license that is not-renewed or inactive may contact the DPR call center 800/560-6420 to request instructions, forms and fees.

Continuing Education (Restoration Licensure Method only) - Candidates seeking to reactivate a license may submit documentation of Continuing Education (CE) such as certificates of attendance. All CE must be completed in accordance with Marriage and Family Therapy Administrative Rules (68 IAC Section 1283.110). Candidates applying on the basis of the RESTORATION licensure method are NOT required to submit the following documents: ED form, Official Transcripts (unless as proof of continuing education), AC-MFT form, Syllabi, PCE-MFT, CSW-MFT, SR-MFT.

STEP 5.

The application, supporting documents, and application fee may be submitted with the application or to:
Illinois Department of Financial and Professional Regulation
Division of Professional Regulation
P.O. Box 7007
Springfield, Illinois 62791

An application is valid for 3 years from date it is received by the Department.

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.illinois.gov.

For assistance--Call one of the following numbers and state that you are applying to become licensed as a marriage and family therapist and need help with your application:
1-800-560-6420
TTY - 1-866-325-4949

Please allow 6 weeks from mailing your application before making an inquiry concerning its status.

IMPORTANT NOTICE

Elder and Child Abuse Reporting

"Pursuant to Public Act 91-0244, effective January 1, 2000, if you have reason to believe that an adult 60 years of age or older who resides in a domestic living situation who, because of dysfunction is unable to seek assistance for himself or herself has, within the previous 12 months been subject to abuse, neglect or financial exploitation, the mandated reporter shall, within 24 hours after developing such belief, report this suspicion to the Department on Aging. Reports should be made to **DEPARTMENT ON AGING AT 1-800-252-8966."**

"Public Act 91-0244 also requires that if you have reasonable cause to believe a child known to you in your professional capacity may be an abused or neglected child you are required to report such possible neglect or abuse to the **DEPARTMENT OF CHILDREN AND FAMILY SERVICES AT 1-800-25abuse."**

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APPLICATION FOR LICENSURE AND/OR EXAMINATION

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE and/or EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

A. **Check the box indicating the appropriate information regarding your application.** ☐ **Military** ☐ **Military Spouse** ☐ **Not Military** ☐ **Decline to Answer**
Military service member is defined as. "Service member means any person who, at the time of application under this Section, is an active duty member of the United States Armed Forces or any reserve component of the United States Armed Forces, the Coast Guard, or the National Guard of any state, commonwealth, or territory of the United States or the District of Columbia or whose active duty service concluded within the preceding 2 years before application." The following will be considered proof of you or your spouse's active military status: DD214, Letter of Service signed by Unit Commanding Officer, or Proof of Service document from the Servicemember's electronic personnel portal. Proof for Spouses: Military Permanent Change of Station Orders with the spouse identified by name; Official Notification of Change of Assignment with your marriage license, a certified DD1172 verifying marital status, or a letter signed by the commanding officer verifying change of assignment and the name of the military spouse.

B. SEE **REFERENCE SHEET, CHART I, OR INSTRUCTIONS** PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
	___ ___ ___		$

C. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

☐ This is the first time I have made application for this profession in Illinois.

☐ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.

☐ Other: _____

☐ My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.

☐ I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.

PART II: Applicant Identifying Information--You must notify the Department of Financial and Professional Regulation - Division of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST FIRST MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
		__ __ __ – __ __ – __ __ __ __

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY
__ __ __ __ __ – __ __ __ __

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY
__ __ __ __ __ – __ __ __ __

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)	7. MOTHER'S MAIDEN NAME

8. PLACE OF BIRTH CITY STATE/COUNTRY	9. DATE OF BIRTH	10. AGE
	__ __ / __ __ / __ __ __ __ (Month / Day / Year)	____ ☐ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED	12. **REQUIRED** E-MAIL ADDRESS
Work: (__ __ __) __ __ __ – __ __ __ __ (Area Code) Home: (__ __ __) __ __ __ – __ __ __ __ (Area Code)	
Fax: (__ __ __) __ __ __ – __ __ __ __ (Area Code) Fax: (__ __ __) __ __ __ – __ __ __ __ (Area Code)	

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.illinois.gov

NAME (Last, First, MI):

SS#:

Profession:

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)

1 2 3 4 5 6 7 8 9 10 11 12 Graduated High School? ☐ Yes ☐ No Received OR G.E.D.? ☐ Yes ☐ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION ___ ___ / ___ ___ ___ ___ (Month / Year)

5. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 5 6 7 8 Graduated? ☐ Yes ☐ No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	TYPE OF DEGREE EARNED

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	Did You Complete Training?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI):

SS#:

Profession:

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure				
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				

(If additional space is needed, attach a separate sheet.)

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS
			(Passed, Failed, Absent)

(If additional space is needed, attach a separate sheet.)

NAME (Last, First, MI):

PART VI: Personal History Information *(This part must be completed by all applicants)*	YES	NO
1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. *If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.*		
2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.*		
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		
4. Do you now have any disease or condition that presently limits your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		

PART VII: Examination Coding Information *(This part is for examination applicants only)*

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes

b) CHART III - Select the examination site you desire and enter Test Center Code:

c) CHART IV - Find your School of Graduation and enter school code:

d) Record the number of times you have taken this exam in Illinois or any other state:

SS#:

PART VIII: Child Support and Tax Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? Yes ☐ No ☐
   (NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 ILCS 2105-15(g), "The Department shall deny any license application or renewal authorized under any licensing Act administered by the Department to any person who has failed to file a return, or to pay the tax, penalty, or interest shown in a filed return, or to pay any final assessment of tax, penalty, or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirement of any such tax Act is satisfied."

   Are you delinquent in the filing of state taxes? Yes ☐ No ☐

Profession:

PART IX: Certifying Statement

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant _____ Date _____

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

HEALTH CARE WORKERS CHARGED WITH *OR* CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME LAST FIRST MIDDLE

2. ADDRESS STREET, CITY, STATE, ZIP CODE

3. PROFESSIONAL LICENSE NUMBER (if any)
__ __ __ - __ __ __ __ __ __

4. SOCIAL SECURITY NUMBER
__ __ __ - __ __ - __ __ __ __

Pursuant to 20ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding convictions pertaining to certain offenses. **Please check applicable profession.**

- ☐ Acupuncturists
- ☐ Advanced Practice Registered Nurses
- ☐ Advanced Practice Registered Nurse - Full Practice Authority
- ☐ Athletic Trainers
- ☐ Audiologists
- ☐ Clinical Psychologists
- ☐ Clinical Social Workers
- ☐ Dental Hygienists
- ☐ Dentists
- ☐ Genetic Counselors
- ☐ Licensed Clinical Professional Counselors
- ☐ Licensed Practical Nurses
- ☐ Licensed Social Workers
- ☐ Marriage and Family Therapists
- ☐ Medication Aide
- ☐ Naprapaths
- ☐ Nursing Home Administrators
- ☐ Occupational Therapists
- ☐ Occupational Therapy Assistants
- ☐ Optometrists
- ☐ Orthotists
- ☐ Pedorthists
- ☐ Perfusionists
- ☐ Pharmacists
- ☐ Physical Therapists
- ☐ Physical Therapy Assistants
- ☐ Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.)
- ☐ Physician Assistants
- ☐ Podiatrists
- ☐ Professional Counselors
- ☐ Prosthetists
- ☐ Registered Nurses
- ☐ Registered Surgical Assistants
- ☐ Registered Surgical Technologists
- ☐ Respiratory Care Practitioners
- ☐ Speech Pathologists

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

	Yes	No
1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *	☐	☐
2) Are you currently charged with or have you been convicted of a criminal battery against any patient *in the course of patient care or treatment*, including any offense based on sexual conduct or sexual penetration?	☐	☐
3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *	☐	☐
4) Are you currently charged with or have you been convicted of a forcible felony? *	☐	☐

*If **YES** to any of the above, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant _____ Email _____ Date _____

* DEFINITIONS

730 ILCS 150 et. seq:—Acts that require Sex Offender Registration:

(B) As used in this Article, "sex offense" means:

(1) A violation of any of the following Sections of the Criminal Code of 1961:

11-20.1 (child pornography),
11-20.3 (aggravated child pornography),
11-6 (indecent solicitation of a child),
11-9.1 (sexual exploitation of a child),
11-9.2 (custodial sexual misconduct),
11-9.5 (sexual misconduct with a person with a disability),
11-15.1 (soliciting for a juvenile prostitute),
11-18.1 (patronizing a juvenile prostitute),
11-17.1 (keeping a place of juvenile prostitution),
11-19.1 (juvenile pimping),
11-19.2 (exploitation of a child),
11-25 (grooming),
11-26 (traveling to meet a minor),
12-13 (criminal sexual assault),
12-14 (aggravated criminal sexual assault),
12-14.1 (predatory criminal sexual assault of a child),
12-15 (criminal sexual abuse),
12-16 (aggravated criminal sexual abuse),
12-33 (ritualized abuse of a child).

An attempt to commit any of these offenses.

(1.5) A violation of any of the following Sections of the Criminal Code of 1961, when the victim is a person under 18 years of age, the defendant is not a parent of the victim, the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act, and the offense was committed on or after January 1, 1996:

10-1 (kidnapping),
10-2 (aggravated kidnapping),
10-3 (unlawful restraint),
10-3.1 (aggravated unlawful restraint).

(1.6) First degree murder under Section 9-1 of the Criminal Code of 1961, when the victim was a person under 18 years of age and the defendant was at least 17 years of age at the time of the commission of the offense, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.7) (Blank).

(1.8) A violation or attempted violation of Section 11-11 (sexual relations within families) of the Criminal Code of 1961, and the offense was committed on or after June 1, 1997.

(1.9) Child abduction under paragraph (10) of subsection (b) of Section 105 of the Criminal Code of 1961 committed by luring or attempting to lure a child under the age of 16 into a motor vehicle, building, house trailer, or dwelling place without the consent of the parent or lawful custodian of the child for other than a lawful purpose and the offense was committed on or after January 1, 1998, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.10) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after July 1, 1999:

10-4 (forcible detention, if the victim is under 18 years of age), provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act,
11-6.5 (indecent solicitation of an adult),
11-15 (soliciting for a prostitute, if the victim is under 18 years of age),
11-16 (pandering, if the victim is under 18 years of age),
11-18 (patronizing a prostitute, if the victim is under 18 years of age),
11-19 (pimping, if the victim is under 18 years of age).

(1.11) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after August 22, 2002:

11-9 (public indecency for a third or subsequent conviction).

(1.12) A violation or attempted violation of Section 5.1 of the Wrongs to Children Act (permitting sexual abuse) when the offense was committed on or after August 22, 2002.

(2) A violation of any former law of this State substantially equivalent to any offense listed in subsection (B) of this Section.

(C) A conviction for an offense of federal law, Uniform Code of Military Justice, or the law of another state or a foreign country that is substantially equivalent to any offense listed in subsections (B), (C), (E), and (E5) of this Section shall constitute a conviction for the purpose of this Article.

* DEFINITIONS

A **"forcible felony"**, for the purposes of Section 2105-165 of the Code (section numbers are from the Criminal Code of 1961 [720 ILCS 5]) and 68 Illinois Administrative Code 1130.120 is one or more of the following offenses:

a) First Degree Murder (Section 9-1);
b) Intentional Homicide of an Unborn Child (Section 9-1.2);
c) Second Degree Murder (Section 9-2);
d) Voluntary Manslaughter of an Unborn Child (Section 9-2.1);
e) Drug-induced Homicide (Section 9-3.3);
f) Kidnapping (Section 10-1);
g) Aggravated Kidnapping (Section 10-2);
h) Unlawful Restraint (Section 10-3);
i) Aggravated Unlawful Restraint (Section 10-3.1);
j) Forcible Detention (Section 10-4);
k) Involuntary Servitude (Section 10-9(b));
l) Involuntary Sexual Servitude of a Minor (Section 10-9(c));
m) Trafficking in Persons (Section 10-9(d));
n) Criminal Sexual Assault (Section 11-1.20);
o) Aggravated Criminal Sexual Assault (Section 11-1.30);
p) Predatory Criminal Sexual Assault of a Child (Section 11-1.40);
q) Criminal Sexual Abuse (Section 11-1.50);
r) Aggravated Criminal Sexual Abuse (Section 11-1.60);
s) Aggravated Battery (Section 12-3.05);
t) Compelling Organization Membership of Persons (Section 12-6.5);
u) Compelling Confession or Information by Force or Threat (Section 12-7);
v) Home Invasion (Section 12-11);
w) Robbery (Section 18-1);
x) Armed Robbery (Section 18-2);
y) Vehicular Hijacking (Section 18-3);
z) Aggravated Vehicular Hijacking (Section 18-4);
aa) Aggravated Robbery (Section 18-5);
bb) Terrorism (Section 29D-14.9);
cc) Causing a Catastrophe (Section 29D-15.1);
dd) Possession of a Deadly Substance (Section 29D-15.2);
ee) Making a Terrorist Threat (Section 29D-20);
ff) Falsely Making a Terrorist Threat (Section 29D-25);
gg) Material Support for Terrorism (Section 29D-29.9);
hh) Hindering Prosecution of Terrorism (Section 29D-35);
ii) Boarding or Attempting to Board an Aircraft with Weapon (Section 29D-35.1);
jj) Armed Violence (Section 33A-2); and
kk) Attempt (Section 8-4) of any of the above specified offenses.

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IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION BY LICENSING AGENCY / BOARD

SUPPORTING DOCUMENT

CT

APPLICANT: Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. You are authorized to photocopy this form as necessary.

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. _____ Profession Name ___ ___ ___ Profession Code	
6. MAIDEN OR GIVEN SURNAME	7. APPLICANT TELEPHONE NUMBER (Daytime) Area Code (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___	
8a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)	8b. LICENSE NUMBER (If applicable)	8c. ISSUANCE DATE OF LICENSE (If applicable)

I hereby authorize _____ to furnish to the Illinois Department of
Name of Licensing Agency or Board
Financial and Professional Regulation or its designated testing service, the information requested below.

Signature _____ Date _____

RETURN COMPLETED FORM TO APPLICANT

LICENSING AGENCY: The Illinois Department of Financial and Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas which are not applicable.

PART I - CERTIFICATION OF EXAMINATION STATUS

A. The applicant ☐ has written ☐ is scheduled to write the following examination:

_____ Name of Examination _____ Date of Examination

B. The applicant has or will have written the above-named examination _____ number of times.

PART II - CERTIFICATION OF LICENSURE

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE	B. LICENSE NUMBER
C. ISSUANCE DATE OF LICENSE	D. EXPIRATION DATE OF LICENSE

E. LICENSURE METHOD

- ☐ Examination (Administered in Your State)
  - ☐ National (Name) _____
  - ☐ State Constructed _____
  - ☐ Other (Name) _____
- ☐ Endorsement of License (State) _____
- Acceptance of Examination Results _____ (Administered in Another State)
- ☐ Reciprocity with (State) _____
- ☐ Waiver/Grandfather
- ☐ Credentials
- ☐ Other (Describe) _____

F. CURRENT LICENSURE STATUS

- ☐ Active
- ☐ Inactive
- ☐ Lapsed
- ☐ Other (Explain) _____

G. IF LICENSED BY EXAMINATION, RECORD SCORES

Type of Examination	Score
Written	_____
Practical	_____
Other (Describe) _____	
Received no Grade Below	_____

Examination Period _____ days _____ hours

NAME (Last, First, MI):

SS#:

Profession:

PART III - CERTIFICATION OF EXAMINATION SCORES

A1. National or other Profession Specific Examination — Date of Examination _____

(Record all available information)

Scaled Score	_____	Raw Score	_____
Standard Deviation	_____	Corrected Score	_____
National Mean	_____	Percent Score	_____

A 2.

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

B. State Constructed Examination

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

PART IV - FORMAL ACTIONS

A. Is there now or has there ever been any formal action commenced against the applicant? ☐ Yes ☐ No

B. Have there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? **(If yes, attach a certified copy of disciplinary action.)** ☐ Yes ☐ No

PART V - RECIPROCAL REGISTRATION

This state ☐ does ☐ does not grant the same privilege of reciprocal registration to Illinois registrants.

I certify that the information contained herein is true and correct according to the official records of the State.

SEAL

Print Name

Title

Signature

Agency/Board Street Address

Date

City, State, ZIP Code

Area Code ( )

Telephone Number

Attention Licensing Agency/Board: RETURN THIS FORM TO THE APPLICANT.

Attention Applicant: FOR INCLUSION WITH APPLICATION PACKET.

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF EDUCATION

SUPPORTING DOCUMENT

ED

APPLICANT: Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form.

1. NAME LAST FIRST MIDDLE

2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ (Month Day Year)

3. SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __

4. ADDRESS STREET, CITY, STATE, ZIP CODE

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.

Profession Name _____ Profession Code ___ ___ ___

6. MAIDEN OR GIVEN SURNAME

7. NAME OF INSTITUTION ATTENDED

8. DATE OF GRADUATION / COMPLETION __ __ / __ __ / __ __ __ __ (Month Day Year)

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below.

Date _____ Signature of Applicant _____

SCHOOL OFFICIAL: Complete the bottom portion of this page and the reverse side. RETURN THE COMPLETED FORM TO THE APPLICANT.

A. NAME OF INSTITUTION

B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE

C. DEPARTMENT OF INSTITUTION

D. SPECIFIC PROGRAM OR CURRICULUM CONCENTRATION OF APPLICANT

E. MAJOR AREA OF STUDY OF THE APPLICANT

F. APPLICANT WAS (CHECK ONE): ☐ Full-time ☐ Part-time ☐ Co-op

G. CREDIT HOURS EARNED (CHECK ONE AND COMPLETE)
☐ _____ Semester Hours
☐ _____ Quarter Hours
☐ _____ Course Hours

H. DATES OF ATTENDANCE
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

I. Total academic years attended _____ Years _____ Months _____ Days
OR
Total calendar years attended _____ Years _____ Months _____ Days

J. TYPE OF DEGREE OR CERTIFICATE AWARDED (e.g., B.A., M.A., M.D., Ph.D.)

K. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET __ __ / __ __ / __ __ __ __ (Month Day Year)

L. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED __ __ / __ __ / __ __ __ __ (Month Day Year)

M. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE

☐ Applicant has graduated on __ __ / __ __ / __ __ __ __ (Month Day Year)

☐ Applicant has completed program on __ __ / __ __ / __ __ __ __ (Month Day Year)

☐ Applicant will graduate on __ __ / __ __ / __ __ __ __ (Month Day Year)

☐ Applicant will complete program on __ __ / __ __ / __ __ __ __ (Month Day Year)

N. IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN THE NORMALLY REQUIRED TIME, PLEASE EXPLAIN:

O. USE THIS SPACE TO RECORD ANY OTHER INFORMATION THAT YOU FEEL WOULD ASSIST THE DEPARTMENT IN EVALUATING THE APPLICANT'S EDUCATIONAL EXPERIENCES.

NAME (Last, First, MI):

SS#:

Profession:

I certify that the information recorded herein is true and correct according to the official records of this institution.

Print Name of School Official

Signature of School Official

Title

Date

SCHOOL SEAL OR NOTARY SEAL

NOTE: If the institution does not have a school seal, this form must be notarized.

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

Date of Expiration

Signature of Notary Public

SCHOOL OFFICIAL: RETURN THIS FORM TO APPLICANT

ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 55/1 et. seq.(Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.	**ACADEMIC CRITERIA**	SUPPORTING DOCUMENT **AC-MFT**

APPLICANT: Complete a separate form for each institution in which you have completed graduate coursework. You may copy this form as needed.

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. ☐ Associate Licensed Marriage and Family Therapist (208) ☐ Licensed Marriage and Family Therapist (166)	
6. MAIDEN OR GIVEN SURNAME		
7. NAME OF COLLEGE/INSTITUTION	8. DEPARTMENT	
9. ADDRESS OF COLLEGE/INSTITUTION	10. PROGRAM (AREA OF SPECIALIZATION AS IT APPEARS ON TRANSCRIPT.)	

A. ACADEMIC COURSEWORK: Indicate which specific courses or equivalent experiences you believe to meet the course areas listed below. Course descriptions and syllabi are required for courses whose titles do not reflect the content area listed below.

AREA	COURSE TITLE	COURSE NO.	YEAR	CREDITS	SEMESTERS OR QUARTERS
Individual Development and Family Studies 1 course: 3 semester hours					
Theoretical Foundations and Clinical Practice[1] 6 courses: 18 semester hours					
Professional Studies and Ethics 1 course: 3 semester hours					
Research 1 course: 3 semester hours					

[1] **The course work in this subsection must balance methods for working individually (one client in a therapy session), and for working conjointly with at least two clients present in therapy sessions who are in significant relationships with each other outside the therapy context, and must include methods for working with groups.**

NAME (Last, First, MI):

SS#:

Profession:

B. PRACTICUM OR INTERNSHIP (300 hours)

This practicum or internship occurred ☐ during my 1st qualifying degree ☐ after completion of 1st qualifying degree

SITE NAME		SUPERVISOR NAME/DEGREE	
SITE ADDRESS		SUPERVISOR'S BUSINESS/INSTITUTION NAME/ADDRESS	
TOTAL HOURS WORK EXPERIENCE	TOTAL FACE-TO-FACE CONTACT HRS	STARTING DATE	ENDING DATE

C. MANDATORY TOPICS:

Indicate which specific courses or equivalent experiences you believe meet the mandatory topic areas listed below. Please note that the same course may be used to cover more than one mandatory topic area.

MANDATORY TOPICS	LIST AT LEAST ONE COURSE WHERE TOPIC WAS COVERED	COURSE NO.	YEAR
Historical Development, Theoretical and Empirical Foundations, and Contemporary Directions			
Overview of the Major Clinical Theories of Marital and Family Therapy			
Assessment and Evaluation of Individuals, Couples and Families			
Treatment and Intervention Methods for Working with Individuals, Couples, Families, and Groups in Therapy			
Assessment and Treatment of Mental, Emotional, Behavioral and Interpersonal Disorders and Psycopathology			
Contemporary Issues			
Crisis Intervention			

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 55/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

PROFESSIONAL/CLINICAL EXPERIENCE

SUPPORTING DOCUMENT

PCE-MFT

APPLICANT: You are authorized to photocopy this form if additional space is required.

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. _____ ___ ___ ___ Profession Name Profession Code	
6. MAIDEN OR GIVEN SURNAME	8. DATE FORM COMPLETED	

A. NAME OF AGENCY / INSTITUTION	JOB TITLE
ADDRESS STREET, CITY , STATE, ZIP CODE	DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME	

PROFESSIONAL WORK EXPERIENCE (3000 HOURS REQUIRED)

☐ FULL-TIME POSITION ☐ PART-TIME POSITION	EMPLOYMENT STARTING DATE	EMPLOYMENT ENDING DATE	TOTAL HOURS WORK EXPERIENCE

CLINICAL EXPERIENCE (350 HOURS CONJOINT, 350 HOURS WITH INDIVIDUALS; TOTAL OF 1000 HOURS)

TOTAL HOURS OF CLIENT CONTACT **REGARDLESS OF THERAPY FORMAT**	NUMBER OF THESE HOURS PROVIDING **INDIVIDUAL** THERAPY	NUMBER OF THESE HOURS PROVIDING **CONJOINT** THERAPY

B. NAME OF AGENCY / INSTITUTION	JOB TITLE
ADDRESS STREET, CITY , STATE, ZIP CODE	DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME	

PROFESSIONAL WORK EXPERIENCE (3000 HOURS REQUIRED)

☐ FULL-TIME POSITION ☐ PART-TIME POSITION	EMPLOYMENT STARTING DATE	EMPLOYMENT ENDING DATE	TOTAL HOURS WORK EXPERIENCE

CLINICAL EXPERIENCE (350 HOURS CONJOINT, 350 HOURS WITH INDIVIDUALS; TOTAL OF 1000 HOURS)

TOTAL HOURS OF CLIENT CONTACT **REGARDLESS OF THERAPY FORMAT**	NUMBER OF THESE HOURS PROVIDING **INDIVIDUAL** THERAPY	NUMBER OF THESE HOURS PROVIDING **CONJOINT** THERAPY

NOTE: This form must be completed by all applicants.

NAME (Last, First, MI):

SS#:

Profession:

C. NAME OF AGENCY / INSTITUTION			JOB TITLE
ADDRESS STREET, CITY , STATE, ZIP CODE			DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME			
PROFESSIONAL WORK EXPERIENCE (3000 HOURS REQUIRED)			
☐ FULL-TIME POSITION ☐ PART-TIME POSITION	EMPLOYMENT STARTING DATE	EMPLOYMENT ENDING DATE	TOTAL HOURS WORK EXPERIENCE
CLINICAL EXPERIENCE (350 HOURS CONJOINT, 350 HOURS WITH INDIVIDUALS; TOTAL OF 1000 HOURS)			
TOTAL HOURS OF CLIENT CONTACT **REGARDLESS OF THERAPY FORMAT**	NUMBER OF THESE HOURS PROVIDING **INDIVIDUAL** THERAPY	NUMBER OF THESE HOURS PROVIDING **CONJOINT** THERAPY	

D. NAME OF AGENCY / INSTITUTION			JOB TITLE
ADDRESS STREET, CITY , STATE, ZIP CODE			DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME			
PROFESSIONAL WORK EXPERIENCE (3000 HOURS REQUIRED)			
☐ FULL-TIME POSITION ☐ PART-TIME POSITION	EMPLOYMENT STARTING DATE	EMPLOYMENT ENDING DATE	TOTAL HOURS WORK EXPERIENCE
CLINICAL EXPERIENCE (350 HOURS CONJOINT, 350 HOURS WITH INDIVIDUALS; TOTAL OF 1000 HOURS)			
TOTAL HOURS OF CLIENT CONTACT **REGARDLESS OF THERAPY FORMAT**	NUMBER OF THESE HOURS PROVIDING **INDIVIDUAL** THERAPY	NUMBER OF THESE HOURS PROVIDING **CONJOINT** THERAPY	

E. NAME OF AGENCY / INSTITUTION			JOB TITLE
ADDRESS STREET, CITY , STATE, ZIP CODE			DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME			
PROFESSIONAL WORK EXPERIENCE (3000 HOURS REQUIRED)			
☐ FULL-TIME POSITION ☐ PART-TIME POSITION	EMPLOYMENT STARTING DATE	EMPLOYMENT ENDING DATE	TOTAL HOURS WORK EXPERIENCE
CLINICAL EXPERIENCE (350 HOURS CONJOINT, 350 HOURS WITH INDIVIDUALS; TOTAL OF 1000 HOURS)			
TOTAL HOURS OF CLIENT CONTACT **REGARDLESS OF THERAPY FORMAT**	NUMBER OF THESE HOURS PROVIDING **INDIVIDUAL** THERAPY	NUMBER OF THESE HOURS PROVIDING **CONJOINT** THERAPY	

PLEASE SUM THE TOTALS INCLUDED ON THIS FORM

GRAND TOTAL PROFESSIONAL WORK EXPERIENCE HOURS RECORDED ON THIS FORM	GRAND TOTAL HOURS OF CLINICAL FACE-TO-FACE CLIENT CONTACT **REGARDLESS OF THERAPY FORMAT** RECORDED ON THIS FORM	GRAND TOTAL HOURS OF CLINICAL FACE-TO-FACE CLIENT CONTACT PROVIDING **INDIVIDUAL** THERAPY RECORDED ON THIS FORM	GRAND TOTAL HOURS OF CLINICAL FACE-TO-FACE CLIENT CONTACT PROVIDING **CONJOINT** THERAPY RECORDED ON THIS FORM
3000 HOURS REQUIRED	1000 HOURS REQUIRED	350 HOURS REQUIRED	350 HOURS REQUIRED

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 55/1 et. seq.(Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CLINICAL SUPERVISION WORKSHEET

SUPPORTING DOCUMENT

CSW-MFT

APPLICANT: Complete and return this form to the Department of Professional Regulation.

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.	
6. MAIDEN OR GIVEN SURNAME	**Licensed Marriage & Family Therapist** (Profession Name)	**1 6 6** (Profession Code)

CLINICAL SUPERVISION (200 HOURS)

	SUPERVISOR NAME, DEGREE, INSTITUTION ADDRESS, PHONE	SUPERVISION HOURS	PRE OR POST DEGREE	MFT OR MH SUPERVISION
1.		Total Supervision Hours Starting Date Ending Date	This supervision occurred (pick one): ☐ During my first qualifying degree OR ☐ After completion of first qualifying degree	Please count this supervision as part of the hours required for (pick one). ☐ MFT Supervision OR ☐ MH Supervision
2.	SUPERVISOR NAME, DEGREE, INSTITUTION ADDRESS, PHONE	SUPERVISION HOURS	PRE OR POST DEGREE	MFT OR MH SUPERVISION
		Total Supervision Hours Starting Date Ending Date	This supervision occurred (pick one): ☐ During my first qualifying degree OR ☐ After completion of first qualifying degree	Please count this supervision as part of the hours required for (pick one). ☐ MFT Supervision OR ☐ MH Supervision
3.	SUPERVISOR NAME, DEGREE, INSTITUTION ADDRESS, PHONE	SUPERVISION HOURS	PRE OR POST DEGREE	MFT OR MH SUPERVISION
		Total Supervision Hours Starting Date Ending Date	This supervision occurred (pick one): ☐ During my first qualifying degree OR ☐ After completion of first qualifying degree	Please count this supervision as part of the hours required for (pick one). ☐ MFT Supervision OR ☐ MH Supervision
4.	SUPERVISOR NAME, DEGREE, INSTITUTION ADDRESS, PHONE	SUPERVISION HOURS	PRE OR POST DEGREE	MFT OR MH SUPERVISION
		Total Supervision Hours Starting Date Ending Date	This supervision occurred (pick one): ☐ During my first qualifying degree OR ☐ After completion of first qualifying degree	Please count this supervision as part of the hours required for (pick one). ☐ MFT Supervision OR ☐ MH Supervision

TOTALS OF THE CLINICAL SUPERVISION RECORDED ON THIS PAGE:

TOTAL SUPERVISION HOURS THAT ARE RECORDED ON THIS PAGE AND WERE COMLETED **DURING** MY FIRST QUALIFYING DEGREE.	TOTAL **MARRIAGE AND FAMILY THERAPY** SUPERVISION HOURS RECORDED ON THIS PAGE
TOTAL SUPERVISION HOURS THAT ARE RECORDED ON THIS PAGE AND WERE COMLETED **AFTER** MY FIRST QUALIFYING DEGREE.	TOTAL **MENTAL HEALTH** SUPERVISION HOURS RECORDED ON THIS PAGE

NOTE: This form is not necessary if one is a Clinical Member of the American Association for Marriage and Family Therapy. An applicant may accumulate up to 100 hours of the required 200 hours of clinical supervision during graduate training for the first qualifying degree. Regardless of whether the supervision took place prior to or after graduation, the applicant must have at least 100 hours of supervision with a supervisor qualified to provide marriage and family therapy supervision as defined by this license. To determine if your supervisor is qualified to provide marriage and family therapy supervision, refer to the act and rules then complete form SR-MFT for each supervisory experience.

IMPORTANT! PLEASE HAVE EACH CLINICAL SUPERVISOR LISTED ABOVE COMPLETE AN SR-MFT FORM.

THIS FORM MAY BE DUPLICATED IF NEEDED.

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IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 55/1 et. seq.(Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

SUPERVISOR'S REPORT

SUPPORTING DOCUMENT

SR-MFT

APPLICANT: Complete section 1-10 and forward this form to supervisor for completion.

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. **Licensed Marriage & Family Therapist** (Profession Name) **1 6 6** (Profession Code)	
6. MAIDEN OR GIVEN SURNAME		
7. SUPERVISOR NAME	8. SUPERVISOR'S BUSINESS PHONE	
9. SUPERVISOR'S INSTITUTION OR AGENCY NAME	10. SUPERVISOR'S ADDRESS, STREET, CITY, STATE, ZIP CODE	

SUPERVISOR: Complete the remainder of this form. Return the completed form directly to the Department of Financial and Professional Regulation, ATTN: Division of Professional Regualtion, 320 West Washington - HSS1, Springfield, IL 62786.

PART I - SUPERVISOR INFORMATION

A. SUPERVISOR NAME/DEGREE	B. SUPERVISOR'S LICENSE NO.	C. STATE & DATE OF ISSUANCE
D. SUPERVISOR'S AGENCY OR INSTITUTION AND ADDRESS	E. SUPERVISOR'S WORK PHONE	
	F. STARTING DATE OF SUPERVISION	G. ENDING DATE OF SUPERVISION

H. Please check the (one) box below that accurately reflects your training, experience, certification, and/or licensing at the time supervision took place and provide supporting documentation as indicated. See Instruction Sheet for definition of terms.

The supervision you provided may count as marriage and family therapy (MFT) supervision if **one** of the following is true (Check **only** one box):

- ☐ I am certified as an Approved Supervisor or Supervisor-in Training by the American Association for Marriage and Family Therapy. (Please enclose a photocopy of proof of certification.)
- ☐ I hold an active license as a licensed marriage and family therapist with 5 years clinical experience after my first qualifying degree.
- ☐ I have held an active clinical membership certification with the American Association for Marriage and Family Therapy for at least 5 years. (Please enclose a photocopy of proof of clinical membership.)
- ☐ I have
  - a) an active license as a psychiatrist, licensed clinical psychologist, licensed clinical social worker, or licensed clinical professional counselor and
  - b) 5 years clinical experience providing marriage and family therapy and
  - c) provided at least 1000 hours of conjoint therapy and
  - d) either 2 years experience providing clinical supervision of marriage and family therapy (including the supervision of conjoint therapy) or have completed a 1-semester hour graduate course in marriage and family therapy supervision (at least 15 contact hours) or the equivalent prior to or during the supervision provided the applicant. (Please enclose a written statement attesting to how you have met requirements b through d.)

The supervision you provided may count as mental health (MH) supervision if the following is true:

- ☐ I am a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker, or a licensed clinical professional counselor with 5 years experience in my discipline.

NOTE: An applicant must have a supervisor qualified to provide marriage and family therapy supervision as defined above for at least 100 of the 200 hours of supervision in order to meet the supervision requirements of this license.

PART II - SUPERVISION INFORMATION

I. This supervision experience occurred:
(Please select one.) ☐ during the applicant's 1st qualifying degree ☐ after completion of the applicant's 1st qualifying degree.

J. INDICATE YOUR OVERALL EVALUATION OF THE APPLICANT'S PERFORMANCE AS A MARRIAGE AND FAMILY THERAPIST.

EXCELLENT		SATISFACTORY		POOR
5	4	3	2	1

K. COMMENTS - INCLUDE ANY COMMENTS REGARDING THE APPLICANT'S JOB PERFORMANCE.

L. COMPLETE THE FOLLOWING:	M. FORMATS OF SUPERVISION (CHECK ALL THAT APPLY):
FREQUENCY OF SUPERVISION APPOINTMENTS	☐ LIVE SUPERVISION
DURATION OF EACH SUPERVISION APPOINTMENT	☐ CO-THERAPY
TOTAL HOURS OF CLINICAL SUPERVISION	☐ VIDEO TAPE REVIEW ☐ AUDIO TAPE REVIEW ☐ CASE NOTES AND CONSULTATION

N. I have read the guidelines regarding supervision established for the marriage and family therapy license and certify that the supervision conducted with this application complies with these standards. ☐ Yes ☐ No

Under the penalties of perjury, I certify that the information provided regarding the supervision provided to the applicant and my training, experience, certification and/or licensing is true and correct.

Signature: _____

Title: _____ Date: _____

NAME (Last, First, MI):

SS#:

Profession: