



STATE OF ARIZONA
 BOARD OF BEHAVIORAL HEALTH EXAMINERS
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 PHOENIX, AZ 85007
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 Board Website: www.azbbhe.us
 Email Address: information@azbbhe.us

DOUGLAS A. DUCEY
 Governor

TOBI ZAVALA
 Executive Director

APPLICATION FOR MARRIAGE AND FAMILY THERAPIST LICENSURE (LMFT) FOR APPLICANTS WITHOUT AN AZ ASSOCIATE MFT LICENSE

PART I. PERSONAL INFORMATION

SALUTATION <input type="checkbox"/> MR. <input type="checkbox"/> MS. <input type="checkbox"/> MRS. <input type="checkbox"/> DR.	LEGAL NAME (FIRST NAME MI LAST NAME)			PREVIOUS LAST NAMES (IF APPLICABLE)
DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER		CURRENT AZ BOARD LICENSE (IF APPLICABLE)	
HOME ADDRESS				PREFERRED PHONE
CITY	STATE	ZIP CODE	ALTERNATIVE PHONE	
PREFERRED EMAIL (FOR APPLICATION/LICENSE UPDATES)			ALTERNATIVE EMAIL	

APPLICATION UPDATES AND RENEWAL NOTIFICATIONS WILL BE SENT VIA EMAIL, SO AT LEAST ONE EMAIL MUST BE PROVIDED.

EMPLOYER INFORMATION

PRIMARY EMPLOYER NAME			CURRENT TITLE
EMPLOYER ADDRESS			
CITY	STATE	ZIP CODE	EMPLOYER PHONE

NOTE: THE BOARD WILL USE YOUR HOME ADDRESS, PHONE NUMBER AND EMAIL FOR COMMUNICATION REGARDING YOUR APPLICATION. UPON LICENSURE, YOUR PRIMARY EMPLOYER INFORMATION (ABOVE) WILL BE VISIBLE TO THE PUBLIC ON THE BOARD'S LICENSE VERIFICATION SCREEN. IF YOU DO NOT PROVIDE EMPLOYER INFORMATION, YOUR HOME CITY, STATE AND ZIP WILL BE PUBLIC INFORMATION. APPLICANTS AND LICENSEES SHOULD REPORT NAME AND ADDRESS CHANGES (INCLUDING EMPLOYMENT CHANGES) WITHIN 30 DAYS OF THE CHANGE. PLEASE LIST ADDITIONAL EMPLOYERS IN THE EMPLOYMENT HISTORY SECTION OF THE APPLICATION.

PART II. UNITED STATES LEGAL PRESENCE

Arizona Revised Statutes § 41-1080 requires, in general, that a person applying for a license must submit documentation to the licensing agency that satisfactorily demonstrates that the applicant is lawfully present in the United States.

Section 1. Citizenship or national status declaration

1. Are you a citizen or national of the United States? Yes No (if no, complete Section 2)
- If yes, attach a legible copy of your proof of citizenship document. See List A for [acceptable documents](#).
NOTE: An Arizona issued driver’s license provides acceptable proof, as do driver’s licenses issued by other states verifying lawful presence in the US.
 - Name of document provided: _____ Expiration Date: _____

Section 2. Alien status declaration

For applicants who are NOT citizens or nationals of the United States, please indicate alien status by checking the appropriate box below. Attach a legible copy of the front and back (if applicable) of a document that evidences your status. See List B for [acceptable documents](#).

- Name of document provided: _____ Expiration Date: _____

“Qualified Alien” Status (8 U.S.C. §§ 1621(a)(1), -1641(b) and (c))

- 1. An alien lawfully admitted for permanent residence under the Immigration and Nationality Act (INA).
- 2. An alien who is granted asylum under Section 208 of the INA.
- 3. A refugee admitted to the United States under Section 207 of the INA
- 4. An alien paroled into the United States for at least one year under Section 212(d)(5) of the INA.
- 5. An alien whose deportation is being withheld under Section 243(h) of the INA.
- 6. An alien granted conditional entry under Section 203(a)(7) of the INA as in effect prior to April 1, 1980.
- 7. An alien who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980).
- 8. An alien who is, or whose child or child’s parent is a “battered alien” or an alien subjected to extreme cruelty in the United States.

Nonimmigrant Status (8 U.S.C. § 1621(a)(2))

- 9. A nonimmigrant under the Immigration and Nationality Act [8 U.S.C. § 1101 et seq.] Nonimmigrants are persons who have temporary status for a specific purpose. See 8 U.S.C. § 1101(a)(15).

Alien Paroled into the United States For Less Than One Year (8 U.S.C. § 1621(a)(3))

- 10. An alien paroled into the United States for less than one year under Section 212(d)(5) of the INA

Other Persons (8 U.S.C. § 1621(c)(2)(A) and (C))

- 11. A nonimmigrant whose visa for entry is related to employment in the United States, or
- 12. A citizen of a freely associated state, if section 141 of the applicable compact of free association approved in Public Law 99-239 or 99-658 (or a successor provision) is in effect [Freely Associated States include the Republic of the Marshall Islands, Republic of Palau and the Federate States of Micronesia, 48 U.S.C. § 1901 *et seq.*];
- 13. A foreign national not physically present in the United States.

Otherwise Lawfully Present (A.R.S. § 41-1080)

- 14. A person not described in categories 1–13 who is otherwise lawfully present in the United States.
PLEASE NOTE: The federal Personal Responsibility and Work Opportunity Reconciliation Act may make persons who fall into this category ineligible for licensure. See 8 U.S.C. § 1621(a).

PART III. EDUCATION INFORMATION

Starting with your undergraduate education, list **all** colleges and universities attended, whether completed or not, in chronological order.

COLLEGE OR UNIVERSITY (undergraduate and graduate)	LOCATION (City, State or Country)	DATES ATTENDED (Month/Yr to Month/Yr)	DEGREE EARNED (and date earned)	MAJOR

PART III, Section 1. OFFICIAL TRANSCRIPTS

You must include an official transcript for the education being submitted to meet requirements in a **SEALED** envelope from the educational institution. Transcripts submitted in open envelopes will not be accepted. If the institution provides certified electronic transcripts, please have them emailed to applications@azbbhe.us.

A. REQUIRED DEGREE CREDIT HOURS

Applicants for marriage and family therapist licensure shall have a master’s or higher degree from a regionally accredited college or university in a behavioral health science program.

My graduate program consisted of (choose one): _____ semester credit hours _____ quarter credit hours

College or University: _____

Degree Title (as indicated on transcript): _____

Date degree awarded: _____

B. ACCREDITATION OF GRADUATE MARRIAGE AND FAMILY THERAPY PROGRAM

NOTE: Complete for the behavioral health science degree listed above.

Please select which of the following designations your graduate program held on the date your degree was awarded:

- 1. Accreditation from the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE)
- 2. A Board approved curriculum pursuant to A.R.S. § 32-3253(14) as indicated on the Board’s website
- 3. Neither of the above

What is the approval/accreditation date for the designation indicated in (B)(1-2) above? _____



APPLICANTS SELECTING (B)(1-2) ABOVE PROCEED TO PART IV - BACKGROUND INFO.

APPLICANTS SELECTING (B)(3) ABOVE PROCEED TO PART III, Section 2. – CURRICULUM.

PART III, Section 2. CURRICULUM

Not required for applicants whose graduate degree held a designation indicated in (B)(1-2) in Section 1 above at the time of graduation. For curriculum requirements, please see R4-6-601.

Part A: TO BE COMPLETED BY APPLICANT

Indicate all courses taken that fulfill the requirements for the six core content areas as defined in R4-6-601(B). For each core content area, list ALL courses that meet the requirement. However, each course may only be used to meet a single area. Do not list the same course in more than one area unless indicating embedded coursework.

Please submit published college or university course descriptions for the year and semester you were enrolled for every course you submit to meet the curriculum requirements. Please highlight the courses you are using to meet curriculum requirements. To assist in the review process, applicants are strongly encouraged to include syllabi for the core content area coursework from the year/semester attended.

A course must be a 3-semester or 4-quarter credit hour course to count for licensure purposes.

					FOR COMMITTEE USE ONLY.			
CORE CONTENT AREA	COURSE NO.	COURSE NAME	TERM/ YEAR CMPL	CREDITS (Sem / Qtr)	ELEMENTS COVERED	Review #1	Review #2	Curriculum Requirement Met?
Marriage and Family Studies - Three courses from a family systems theory orientation that collectively contain at minimum the following elements: a. Introductory family systems theory b. Family development c. Family systems, including marital, sibling, and individual subsystems, and d. Gender and cultural issues					a b c d			
					a b c d			
					a b c d			
					a b c d			
					a b c d			
Marriage and Family Therapy - Three courses that collectively contain at minimum the following elements: a. Advanced family systems theory and interventions b. Major systemic marriage and family therapy treatment approaches c. Communications, and d. Sex therapy					a b c d			
					a b c d			
					a b c d			
					a b c d			
					a b c d			
Human development - Three courses that may integrate family systems theory that collectively contain at minimum the following elements: a. Normal and abnormal human development b. Human sexuality, and c. Psychopathology and abnormal behavior					a b c			
					a b c			
					a b c			
					a b c			
					a b c			

					FOR COMMITTEE USE ONLY.			
CORE CONTENT AREA	COURSE NO.	COURSE NAME	TERM/ YEAR CMPL	CREDITS (Sem / Qtr)	ELEMENTS COVERED	Review #1	Review #2	Curriculum Requirement Met?
Professional Studies - One course including at minimum: a. Professional ethics as a therapist, including legal and ethical responsibilities and liabilities, and b. Family law					a b			
					a b			
					a b			
					a b			
					a b			
					a b			
Research - One course in research design, methodology, and statistics in behavioral health science								
Supervised Practicum - Two courses that supplement the practical experience requirements								
In addition to required practicum course work, the supervised practicum must provide an enrolled student the opportunity to provide marriage and family therapy services to individuals, couples and families in an educational or professional setting under the direction of a faculty member or supervisor designated by the college or university. It must include 300 client-contact hours provided under direct supervision by a licensed marriage and family therapist. Please complete Parts 2 and 3 below with this information.								

Part B: VERIFICATION OF PRACTICUM

NOTE: Applicant must mail this form to the college/university for verification before submission to the Board.

TO BE COMPLETED BY THE APPLICANTTo: _____ Applicant's SSN: _____
University (please print)From: _____ Telephone _____
Applicant's name (please print)

Applicant's Address _____

Briefly describe practicum setting and your activities: _____

_____Supervision of the practicum must have been done under the direction of a college/university designated faculty member or supervisor with an active Marriage and Family Therapist license.¹ Please indicate the faculty member or supervisor providing supervision and their license below:Practicum Supervisor: _____ Faculty member Site SupervisorMFT license number²: _____

I am applying to the Arizona Board of Behavioral Health Examiners for licensure as a behavioral health professional. I hereby authorize you to release the information requested below.

Applicant's signature _____

Date _____

TO BE COMPLETED BY THE COLLEGE/UNIVERSITY

NOTE: After completing this verification form, college/university personnel must send this verification form back to the applicant for submission with their application.

Applicant's Name: _____

College/University Verification

I attest that the applicant completed a supervised practicum, field work experience, or internship in a professional setting under the direction and supervision of a faculty member and/or site supervisor holding a Marriage and Family Therapist license, and approved by the college/university as follows:

Dates of participation: From _____ To _____

Total hours of client contact during practicum: _____

Name _____

Title _____

Signature _____

Date _____

College/University name _____

Telephone number _____

College/University seal _____

¹ If the practicum supervisor was not a licensed MFT, applicant must submit a written request for an exemption and attach the proposed practicum supervisor's transcript, curriculum vitae, and Verification of Credential form (see page 7) if the supervisor was not licensed by the Board.² If the MFT license is held in a state OTHER than Arizona, please provide a Verification of Credential form (see page 7).

Part C. VERIFICATION OF PRACTICUM SUPERVISOR’S CREDENTIALS
 (Not required if the Practicum Supervisor held an active license from the Board)

If your Practicum Supervisor did not hold an active license by the Arizona Board of Behavioral Health Examiners, you must submit verification of their credential(s) from the regulatory entity in which they are licensed or certified.

Title of Practicum Supervisor’s Credential Held	State	Date Issued	Expiration Date	Credential #	Current Status

For all credentials listed above, attach a verification from the regulatory entity issuing the credential. The verification must include the following information:

- Professional’s name
- Credential title and number (if applicable)
- Credential issue and expiration date
- Credential status
- Past disciplinary actions

Applicants may use an online verification if it contains all required items above and is printed from the regulatory entity’s official website. If not, applicant must request an official verification from the regulatory entity and attach it to this application.

PART IV. BACKGROUND QUESTIONNAIRE

If the answer to any of the questions below is "YES", provide a complete explanation below.

QUESTIONS		
1.	Have you ever been denied a license, certificate, registration or membership by any state regulatory board, any professional or occupational credentialing authority or any professional association in Arizona or any other state?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.	Other than complaints filed by this Board, have you ever been or are you currently the subject of any complaint, investigation or disciplinary action against your license, certificate, registration or membership by any state regulatory board, any professional or occupational credentialing authority or any professional association in Arizona or any other state? If yes, please provide copies of the complaint and all final actions.	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.	Have you ever voluntarily surrendered, allowed to lapse, canceled or resigned your license, certificate, registration or membership in lieu of disciplinary proceedings or sanctions of any kind by any state regulatory board, any professional or occupational credentialing authority or any professional association in Arizona or any other state?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4.	Have you ever been arrested, charged with, convicted of or pled nolo contendere to a criminal offense, other than a minor traffic violation (DUI history must be reported), in any city, county, state, federal or tribal court, or in any other country? If yes, please provide copies of the police and court documents such as the police narrative, complaint, the pleadings and final order(s). <u>You must answer "yes" even if you received a pardon, the charges were dropped, the conviction was set aside, the records were expunged, or your civil rights were restored.</u>	<input type="checkbox"/> YES <input type="checkbox"/> NO
5.	Have you ever entered into any type of pretrial diversion or deferred prosecution agreement with a state or federal government? If yes, please provide a copy of your pretrial diversion agreement.	<input type="checkbox"/> YES <input type="checkbox"/> NO
6.	Have you ever been or are you currently a defendant in any type of civil or criminal action related to any professional services (i.e., malpractice)? If so, indicate whether you entered into a settlement agreement or were ordered to pay damages and whether such a suit is currently pending. Provide copies of the original complaint and response, any judgment entered and any settlement agreements.	<input type="checkbox"/> YES <input type="checkbox"/> NO
7.	Have you ever had any disciplinary action or sanctions of any kind taken against you by any behavioral health related employer in Arizona or any other state? If yes, please provide the name, address and telephone number of the employer, the name of your immediate supervisor and a description of the cause for disciplinary action or sanction.	<input type="checkbox"/> YES <input type="checkbox"/> NO
8.	Have you ever been involuntarily terminated or resigned in lieu of termination from any behavioral health position or related employment? If yes, please provide the name, address and telephone number of the employer, the name of your immediate supervisor and a description of the cause for the termination. If the cause of termination was due to a reduction in force, please include a copy of the letter advising you of the layoff.	<input type="checkbox"/> YES <input type="checkbox"/> NO
CONFIDENTIAL QUESTION		
9.	Have you received treatment within the last five years for use of alcohol or a controlled substance, prescription-only drug, or dangerous drug or narcotic, or a physical, mental, emotional, or nervous disorder or condition that currently affects your ability to competently and safely perform the essential functions of your profession? If so, provide the following: a. A detailed description of the use, disorder, or condition; and b. An explanation of whether the use, disorder, or condition is reduced or ameliorated because you're receiving ongoing treatment and if so, the name and contact information for all current treatment providers and for all monitoring or support programs in which you are currently participating. c. A copy of any public or confidential agreement or order relating to the use, disorder, or condition, issued by a licensing agency or health care institution within the last five years, if applicable.	<input type="checkbox"/> YES <input type="checkbox"/> NO

PART IV. BACKGROUND QUESTIONNAIRE – (cont’d)

Use the space below to provide a complete explanation for any “YES” answers above. Use additional paper if necessary, and include copies of relevant documents, including court and/or regulatory agency documents showing the disposition of disciplinary and court-related matters.

PART V. EMPLOYMENT HISTORY

Provide all employment for the previous seven years. Copy sheet as needed. **IMPORTANT:** include an explanation of any breaks in employment of greater than one month.

PRESENT EMPLOYMENT	JOB TITLE	MM/DD/YY TO MM/DD/YY
NAME OF BUSINESS OR INSTITUTION (AGENCY OR ORGANIZATION) <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> INDEPENDENT CONTRACTOR <input type="checkbox"/> OTHER _____		
ADDRESS		
CITY, STATE, ZIP		TELEPHONE
NAME AND TITLE OF SUPERVISOR		
DESCRIPTION OF DUTIES PERFORMED		
REASON FOR LEAVING:	<input type="checkbox"/> RESIGNED – NEW POSITION	<input type="checkbox"/> RESIGNATION – OTHER (EXPLAIN)
<input type="checkbox"/> TERMINATION (EXPLAIN)	<input type="checkbox"/> RESIGNED IN LIEU OF TERMINATION (EXPLAIN)	
PRIOR EMPLOYMENT	JOB TITLE	MM/DD/YY TO MM/DD/YY
NAME OF BUSINESS OR INSTITUTION (AGENCY OR ORGANIZATION) <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> INDEPENDENT CONTRACTOR <input type="checkbox"/> OTHER _____		
ADDRESS		
CITY, STATE, ZIP		TELEPHONE
NAME AND TITLE OF SUPERVISOR		
DESCRIPTION OF DUTIES PERFORMED		
REASON FOR LEAVING:	<input type="checkbox"/> RESIGNED – NEW POSITION	<input type="checkbox"/> RESIGNATION – OTHER (EXPLAIN)
<input type="checkbox"/> TERMINATION (EXPLAIN)	<input type="checkbox"/> RESIGNED IN LIEU OF TERMINATION (EXPLAIN)	
PRIOR EMPLOYMENT	JOB TITLE	MM/DD/YY TO MM/DD/YY
NAME OF BUSINESS OR INSTITUTION (AGENCY OR ORGANIZATION) <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> INDEPENDENT CONTRACTOR <input type="checkbox"/> OTHER _____		
ADDRESS		
CITY, STATE, ZIP		TELEPHONE
NAME AND TITLE OF SUPERVISOR		
DESCRIPTION OF DUTIES PERFORMED		
REASON FOR LEAVING:	<input type="checkbox"/> RESIGNED – NEW POSITION	<input type="checkbox"/> RESIGNATION – OTHER (EXPLAIN)
<input type="checkbox"/> TERMINATION (EXPLAIN)	<input type="checkbox"/> RESIGNED IN LIEU OF TERMINATION (EXPLAIN)	

PART V. EMPLOYMENT HISTORY (cont'd)

Provide all employment for the previous seven years. Copy sheet as needed. **IMPORTANT:** include an explanation of any breaks in employment of greater than one month.

PRESENT EMPLOYMENT	JOB TITLE	MM/DD/YY TO MM/DD/YY
NAME OF BUSINESS OR INSTITUTION (AGENCY OR ORGANIZATION) <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> INDEPENDENT CONTRACTOR <input type="checkbox"/> OTHER _____		
ADDRESS		
CITY, STATE, ZIP		TELEPHONE
NAME AND TITLE OF SUPERVISOR		
DESCRIPTION OF DUTIES PERFORMED		
REASON FOR LEAVING:	<input type="checkbox"/> RESIGNED – NEW POSITION	<input type="checkbox"/> RESIGNATION – OTHER (EXPLAIN)
<input type="checkbox"/> TERMINATION (EXPLAIN)	<input type="checkbox"/> RESIGNED IN LIEU OF TERMINATION (EXPLAIN)	
PRIOR EMPLOYMENT	JOB TITLE	MM/DD/YY TO MM/DD/YY
NAME OF BUSINESS OR INSTITUTION (AGENCY OR ORGANIZATION) <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> INDEPENDENT CONTRACTOR <input type="checkbox"/> OTHER _____		
ADDRESS		
CITY, STATE, ZIP		TELEPHONE
NAME AND TITLE OF SUPERVISOR		
DESCRIPTION OF DUTIES PERFORMED		
REASON FOR LEAVING:	<input type="checkbox"/> RESIGNED – NEW POSITION	<input type="checkbox"/> RESIGNATION – OTHER (EXPLAIN)
<input type="checkbox"/> TERMINATION (EXPLAIN)	<input type="checkbox"/> RESIGNED IN LIEU OF TERMINATION (EXPLAIN)	

PLEASE USE THE SPACE BELOW TO EXPLAIN GAPS IN EMPLOYMENT OF GREATER THAN A MONTH:

PART VI. WORK EXPERIENCE AND CLINICAL SUPERVISION

APPLICANT: To meet the requirements for independent licensure, a minimum of two years of supervised work experience and clinical supervision meeting the Board's rules must be verified. For more information on acquiring supervised work experience and clinical supervision, click [here](#). It is an applicant's responsibility to request that Employers or Supervisors complete the required forms to verify supervised work experience and/or clinical supervision.

- **Verification of MFT Supervised Work Experience** – This form must be completed by an employer or direct supervisor from any employment that you are using to meet the requirements for licensure purposes. For the hours of supervised work experience to be considered, you must have been receiving clinical supervision that meets the requirements in Board rule for the entire period. There should be ONE form (per employer) for the entire period of your supervised work experience. **NOTE:** *A Clinical Supervisor who was hired outside the Agency to provide supervision cannot complete this form unless they were pre-approved by the Board for Supervised Private Practice.*
- **Verification of Clinical Supervision** – This form must be completed by the Clinical Supervisor(s) who provided individual and/or group clinical supervision during the period of supervised work experience being submitted for licensure purposes. **NOTE:** *The Board cannot accept hours of clinical supervision from more than six Clinical Supervisors.*

CLINICAL SUPERVISOR EXEMPTION REQUESTS

Please review the [applicable rules](#) for the requirements for acceptable hours of clinical supervision for marriage and family therapy licensure.

If the Clinical Supervisor who will provide or who provided the clinical supervision does not meet the requirements in A.A.C. R4-6-604 (B)(1-4), you may be able to request an exemption pursuant to A.A.C. R4-6-212.01.

Review the Clinical Supervisor Exemption Request form on the Board's website. The form can be submitted at any point during the supervision, but it is **HIGHLY** recommended to submit the form **PRIOR** to beginning supervision to prevent losing supervised work experience and clinical supervision hours if the Clinical Supervisor Exemption request is not approved.

Have you previously submitted a Clinical Supervisor Exemption Request? YES NO

If YES and it was approved, please include a copy of the letter approving the request.

PART VI. WORK EXPERIENCE AND CLINICAL SUPERVISION (cont’d)

THERE ARE TWO OPTIONS FOR EMPLOYER(S) and/or SUPERVISOR(S) TO SUBMIT FORMS:

Option 1 – ONLINE SUBMISSION: *appropriate if the applicant has already submitted their application or will be submitting their application within 3 months. The Board will not hold forms for more than 3 months.*

Employer(s) and/or Supervisor(s) can complete the form(s) online by:

- a. Going to the Board’s website, <https://www.azbbhe.us>
- b. Clicking on Applying for Licensure and choosing the appropriate discipline
- c. Clicking on Submit Online in the supervision forms and attaching any required documents

Option 2 – PRINT PDF: *preferred if the supervisee’s application date is unknown. The supervisee will be responsible for maintaining the signed, sealed envelopes until they submit their application.*

Employer(s) and/or Supervisor(s) can complete the paper form(s) by:

- a. Going to the Board’s website, <https://www.azbbhe.us>
- b. Clicking on Applying for Licensure and choosing the appropriate discipline
- c. Clicking on Print PDF, completing the fillable form and attaching any required documentation
- d. Put the completed form(s) in a sealed envelope
- e. Sign over the seal and give to the supervisee for submission with their application

APPLICANT: Please complete the grid below by listing any Employers or Supervisors who are completing verification forms and the method of submission (emailed or attached in a sealed envelope).

VERIFICATION OF SUPERVISED WORK EXPERIENCE FORMS (ENTER EMPLOYER/SUPERVISOR NAME BELOW)	EMAILED OR ATTACHED	VERIFICATION OF CLINICAL SUPERVISION FORMS (ENTER CLINICAL SUPERVISOR NAME BELOW)	EMAILED OR ATTACHED

PART VII. EXAM INFORMATION

Have you previously passed the examination required for the license you are applying for in Arizona? Yes No

- If yes, you must request an official copy of your score report be forwarded to the Board from AMFTRB.
- If not, you will be provided testing information once authorized to test.

For information on obtaining special examination accommodations under the Americans with Disabilities Act (ADA), please visit www.pteny.com and click on Request for Special Accommodations.

PART VIII. FEDERAL DATA BANK SELF-QUERY

To meet the requirements of A.A.C. R4-6-301(11), the Board will perform a query of the applicant’s data in the [National Practitioner Data Bank](#) (NPDB).

PART IX. PROFESSIONAL CREDENTIALS

Please list current or previous licenses or certifications issued by a state regulatory entity held as follows: any license or certification ever held in the practice of behavioral health; and any professional license or certification NOT in the practice of behavioral health held in the last ten years. Failure to disclose all licenses, certifications or registrations as required above may result in denial of your application or other appropriate action. Do not list licenses issued by the Board.

Title of Credential Held	State	Date Issued	Expiration Date	Credential #	Current Status

For all credentials listed above, attach a verification from the regulatory entity issuing the credential. The verification must include the following information:

- Professional’s name
- Credential title and number (if applicable)
- Credential issue and expiration date
- Credential status
- Whether there are pending complaints
- Past disciplinary actions

Applicants may use an online verification if it contains all required items above. If not, applicant must obtain verification from the regulatory entity issuing the credential. A copy of your wall certificate is NOT sufficient.

PART X. CRIMINAL HISTORY BACKGROUND CHECK

Pursuant to A.R.S. § 32-3280, all applicants for licensure must submit a full set of fingerprints and payment for a criminal history background check through the Arizona Department of Public Safety ("DPS") unless they can provide verification that they hold a current, valid DPS fingerprint clearance card. Please select one of the following:

- I have attached a set of fingerprints on a FD-258 card and a payment of \$40.00 or verification of my online credit card payment of \$40.00.**
- I hold a valid DPS fingerprint clearance card # _____ and have attached a verification from the DPS website https://webapps.azdps.gov/public_inq_acct/acct/ShowClearanceCardStatus.action.**

Your application cannot be accepted without one of the two items above being submitted. If you are submitting a set of fingerprints, they will be sent to DPS for a criminal history background check which can take 2-6 weeks.

PART XI. CERTIFYING STATEMENT

I give my permission for the Arizona Board of Behavioral Health Examiners ("Board") to secure additional information concerning me or my statements in this application from any person or source the Board deems necessary. My signature below authorizes entities in possession of applicable information to release such information to the Board.

I will notify the Board in writing within 10 working days if charged with a misdemeanor that may affect patient safety or a felony pursuant to A.R.S. § 32-3208. Additionally, I will report to the Board any updates to the information provided in this application after submission including, but not limited to: contact information, employment changes, and answers to background information questions.

I certify that by submitting this application for licensure, I have read and understand the Board's rules and statutes and agree to abide by them as an applicant and as a licensee in the event I am approved for licensure.

I, _____ certify under penalty of perjury that all information contained in my application, including all supporting documents, is true and correct to the best of my knowledge and belief, and with full knowledge that any false statements or misrepresentations made in this application may be grounds for refusal, subsequent revocation or suspension of my license(s), or other disciplinary action.

Signature of Applicant

Date

IS MY APPLICATION READY TO SUBMIT?

I HAVE INCLUDED ALL OF THE FOLLOWING DOCUMENTS:

- A copy of my driver's license or state-issued ID (*for current legal name verification*)
- Documentation of legal authorized presence to reside and seek employment in the US (*from pg 2 – a driver's license issued by a state that verifies lawful presence in the US provides acceptable proof*)
- A complete set of fingerprints on a standard FD-258 card with a **\$40.00** payment or proof of online payment, OR a copy of my current DPS fingerprint clearance card (front and back) and verification from the [DPS website](#). NO PAYMENT is needed with a current DPS fingerprint clearance card.
- An official transcript **in a sealed envelope** (if not already on file). If requesting electronic transcripts, please have the institution email them to applications@azbbhe.us.
- Verification of professional credentials
- Verification(s) of MFT supervised work experience emailed by the supervisor/employer or **in a sealed envelope** with job description included
- Verification(s) of clinical supervision hours emailed by the clinical supervisor(s) or **in a sealed envelope**
- Clinical Supervisor Exemption Request (if applicable)
- Verification of supervisor's credentials (if applicable)
- Employment history for previous SEVEN years including an explanation of any gaps in employment of greater than one month
- FEES:** Applicable fees may be paid by credit card on the Board's website by clicking on "[Make a Payment](#)", or through money order or cashier's check (***NO PERSONAL OR BUSINESS CHECKS accepted***) made out to "Arizona Board of Behavioral Health Examiners" or "AZBBHE" by mail, including:
 - ✓ **\$250.00** non-refundable application fee
 - ✓ **\$ 40.00** payment for processing fingerprints **if** mailing a FD-258 card

Fees may be combined into one payment.

SUBMIT TO:

Arizona Board of Behavioral Health Examiners

1740 West Adams St., Suite 3600

Phoenix, Arizona 85007

Office Hours: Monday – Friday 8:00 am to 5:00 pm, excluding state holidays

FOLLOWING SUBMISSION:

- Confirm receipt of the application on the Board's website by:
 - Clicking on "Verifications," then "[Check for pending applications](#)"
 - Search by your last name. Your application will display as "Pending" if received
- Staff will email you updates on the progress of your application including when your application is administratively and substantively complete, if additional information is needed, and next steps in the process
- Staff will email you regarding any Committee or Board meetings at which your application will be reviewed
- If applicable, staff will provide information on taking an exam required for licensure
- You must notify the Board if any information provided in the application changes including, but not limited to:
 - Contact information
 - Employment changes
 - Answers to background information questions.
- You must notify the Board in writing within 10 working days if charged with a misdemeanor that may affect patient safety or a felony pursuant to A.R.S. § 32-3208

Pursuant to A.R.S. §§ 41-1030, 41-1093.05, the following information must accompany all license applications.

41-1030. Invalidation of rules not made according to this chapter; prohibited agency action; prohibited acts by state employees; enforcement; notice

- A. A rule is invalid unless it is made and approved in substantial compliance with sections 41-1021 through 41-1029 and articles 4, 4.1 and 5 of this chapter, unless otherwise provided by law.
- B. An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition.
- C. An agency shall not:
 - 1. Make a rule under a specific grant of rulemaking authority that exceeds the subject matter areas listed in the specific statute authorizing the rule.
 - 2. Make a rule under a general grant of rulemaking authority to supplement a more specific grant of rulemaking authority.
- D. This section may be enforced in a private civil action and relief may be awarded against the state. The court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the state for a violation of this section.
- E. A state employee may not intentionally or knowingly violate this section. A violation of this section is cause for disciplinary action or dismissal pursuant to the Agency's adopted personnel policy.
- F. This section does not abrogate the immunity provided by section 12-820.01 or 12-820.02.
- G. An agency shall prominently print the provisions of subsections B, D, E and F of this section on all license applications, except license applications processed by the corporation commission.
- H. The licensing application may be in either print or electronic format.

41-1093.05. License Applicants; notice

Pursuant to section 41-1093.01, Arizona Revised Statutes, an agency shall limit all occupational regulations to regulations that are demonstrated to be necessary to specifically fulfill a public health, safety or welfare concern. Pursuant to sections 41-1093.02 and 41-1093.03, Arizona Revised Statutes, you have the right to petition this agency to repeal or modify the occupational regulation or bring an action in a court of general jurisdiction to challenge the occupational regulation and to ensure compliance with section 41-1093.01, Arizona Revised Statutes.