



THE STATE  
of

**ALASKA** *Department of Commerce, Community, and Economic Development  
Division of Corporations, Business and Professional Licensing*

**Board of Marital and Family Therapy**

PO Box 110806, Juneau, AK 99811

Phone: (907) 465-2550

Email: [BoardOfMaritalAndFamilyTherapy@Alaska.Gov](mailto:BoardOfMaritalAndFamilyTherapy@Alaska.Gov)

Website: [ProfessionalLicense.Alaska.Gov/BoardOfMaritalFamilyTherapy](http://ProfessionalLicense.Alaska.Gov/BoardOfMaritalFamilyTherapy)

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## Marital and Family Therapist License Application Instructions

A person may apply for licensure to practice marital and family therapy in the State of Alaska under the provisions of AS 08.63. Applicants may qualify for licensure by credentials (see Part I) or by examination (see Part II & III). Part IV describes the procedures for obtaining a temporary license while waiting to take the examination.

### PART I: LICENSURE BY CREDENTIALS

The Board will issue a license to practice marital and family therapy to an applicant who holds a current license to practice marital and family therapy in another jurisdiction that has requirements for licensure substantially equal to or greater than those of this state (AS 08.63.140(1)).

***The following must be received by the division before your application for Marital and Family Therapist License by Credentials can be reviewed:***

#### 1. APPLICATION

A completed application, signed and notarized (#08-4203, pages 1-6).

#### 2. FEES

Fees made payable to "State of Alaska."

Nonrefundable Application Fee: \$ 350.00

License Fee: \$1,250.00

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Total Fees Due: \$1,600.00

#### 3. AUTHORIZATION FOR RELEASE OF RECORDS

A completed Authorization for Release of Records form (#08-4203a).

#### 4. VERIFICATION OF LICENSURE

A completed Verification of Licensure form (#08-4203b) from each U.S. state in which the applicant holds or has held a license to practice as a Marital and Family Therapist. Make additional copies of the form, if necessary.

#### 5. STATUTES AND REGULATIONS

A copy of the current statutes and regulations pertaining to licensure or certification for the practice of marital and family therapy from the state where you are currently licensed.

### PART II: LICENSURE BY EXAMINATION

Once approved by the board to take the National Marital and Family Therapy Exam, the applicant will be notified by the division. All arrangements for the exam are made through the Association of Marital and Family Therapy Regulatory Boards. For more information, please visit [AMFTRB.org](http://AMFTRB.org)

***The following must be received by the division before your application for Marital and Family Therapist License by Examination can be reviewed:***

#### 1. APPLICATION

A completed application, signed and notarized (#08-4203, pages 1-6).

## 2. FEES

Fees made payable to "State of Alaska."

Nonrefundable Application Fee:	\$ 350.00
License Fee:	\$1,250.00
Total Fees Due:	\$1,600.00

## 3. AUTHORIZATION FOR RELEASE OF RECORDS

A completed Authorization for Release of Records form (#08-4203a).

## 4. OFFICIAL TRANSCRIPTS

Official transcripts of a master's or doctorate degree in marital and family therapy or allied mental health field from a regionally accredited educational institution with acceptable course of study sent directly to this division, **and**

- a. To assist the board in its review of your education, a completed Education Course Work Check Sheet (#08-4203d)  
**OR**
- b. If your course of study did not include all of the courses or clinical practice as required, you may substitute post-degree courses or practice as approved by the board to satisfy these requirements. Submit the completed Substitution of Post-Degree Course Work Check Sheet (#08-4203e).

## 5. VERIFICATION OF APPROVED CLINICAL CONTACT HOURS

Verification of having practiced marital and family therapy, including 1,500 hours of direct clinical contact with couples and families and having been supervised in clinical contact for at least 200 hours, including 100 hours of individual supervision and 100 hours of group supervision. The supervisor must be board approved. Submit the completed Verification of Approved Clinical Contact Hours form (#08-4203c).

## 6. VERIFICATION OF TRAINING

Verification that the applicant has received at least six contact hours of training related to domestic violence. Documentation of having received this can be provided by submitting a notarized copy of the transcript, certificate, or letter from the instructor. See 12 AAC 19.320(b)(1)-(7).

## PART III: LICENSED MARITAL AND FAMILY THERAPY ASSOCIATE – LICENSURE BY EXAMINATION

Licensed Marital and Family Therapy Associates qualify to take the National Marital and Family Therapy Exam without completion of (5) and (6) above (12 AAC 19.110(f)). However, before being licensed as a Marital and Family Therapist, completion of all requirements above must be met.

## PART IV: TEMPORARY LICENSE

The board will issue a temporary license to practice marital and family therapy to persons who have satisfied the requirements for examination in Part II above and have been approved by the board to sit for the examination. The temporary license allows an applicant to practice while awaiting the next examination. If the licensee fails the marital and family therapy examination, the board will not renew the person's temporary license.

In addition to Part II above, the applicant must submit a Temporary License Fee of \$300.00.

## MFT Information

Once a person obtains licensure to practice marital and family therapy, they will need to become familiar with the requirements for licensure renewal and continuing education which are found under 12 AAC 19.300-.340.

In accordance with AS 08.63.900(5), the definition for the practice of marital and family therapy means the diagnosis and treatment of mental and emotional disorders that are referenced in the standard diagnostic nomenclature for marital and family therapy, whether cognitive, affective, or behavioral, within the context of human relationships, particularly marital and family systems; marital and family therapy involves:

- A. the professional application of assessments and treatments for psychotherapeutic services to individuals, couples, and families for the purpose of treating the diagnosed emotional and mental disorders;
- B. an applied understanding of the dynamics of marital and family interactions, along with the application of psychotherapeutic and counseling techniques for the purpose of resolving intrapersonal and interpersonal conflict and changing perceptions, attitudes, and behaviors in the area of human relationships and family life.

### AS 47.17.020

In accordance with AS 08.63.050(6), the Board of Marital and Family Therapy is required to ensure that all licensees are aware of the requirements under AS 47.17.020 – Persons required to report. It is an applicant's responsibility to obtain a copy of AS 47.17.020 and review.

## General Information

### APPLICATION PROCESSING:

The average time to process a paper application varies by program but can take several weeks from the date it is received in this office complete with all correct forms, supporting documents and appropriate fees paid. When the application is complete and correct, and all supporting documents have been received and all fees have been paid, the license will be issued. Start the process far enough in advance to allow for processing time. Applications are reviewed in order of receipt in our office, and walk-in customers should not expect immediate review.

### LICENSE TERM:

There is no "inactive" status. If you choose not to renew your license, it will lapse. Licenses are issued for a two-year period and expire on December 31 of even-numbered years, regardless of the date of issuance, except licenses issued within 90 days of the expiration date are issued to the next biennial expiration date. One renewal notice will be mailed at least 30 days before license expiration to the last known address of record.

### PROFESSIONAL FITNESS QUESTIONS:

A "yes" response in the application does not mean your application will be denied. If you have responded "yes" to any professional fitness questions in the application, be sure to submit a signed and dated explanation, and the charging document and judgement.

### DENIAL OF APPLICATION:

Please be aware that the denial of an application of licensure may be reported to any person, professional licensing board, federal, state, or local governmental agency, or other entity making a relevant inquiry or as may be required by law.

### RANDOM AUDIT:

If your program requires continuing education, the Division will audit a percentage of the license renewals. If your license is randomly selected for audit, a letter will be sent with instructions to submit documentation as proof you satisfied the continuing competency requirements as stated on this renewal form. Licensees are randomly selected by computer and may be randomly selected as often as the computer program chooses. You must save your documents for at least four years so you can respond to audits.

### ADDRESS OR NAME CHANGE:

In accordance with 12 AAC 02.900, it is the applicant's/licensee's responsibility to notify the Division, in writing, of changes of address or name. Name and address change notification forms are available on the Division's website. The address of record with the division will be used to send renewals and all other official notifications and correspondence. The name appearing on the license must be your current legal name.

### CERTIFIED TRUE COPIES:

If any of the required documents will be issued under a former name, indicate on the application and submit marriage license and/or court documents that are notarized as a "certified true copy of the original document". To obtain a certified true copy, you must present the notary with the original document along with the photocopy. You must write, "I certify this is a true copy of the original document" and sign your name. The notary will compare the original document with the copy and then notarize your signature.

**SOCIAL SECURITY NUMBERS:**

AS 08.01.060 and 08.01.100 require that a U.S. Social Security Number be on file with the division before a professional license is issued or renewed for an individual. If you do not have a U.S. Social Security Number, please complete the Request for Exemption from Social Security Number Requirement form (#08-4372) located at *ProfessionalLicense.Alaska.Gov* or contact the division for a copy of the form. This form is required with every application if you do not have a U.S. Social Security Number.

**PUBLIC INFORMATION:**

Please be aware that all information on the application form will be available to the public, unless required to be kept confidential by state or federal law. Information about current licensees, including mailing addresses, is available on the division's website at *ProfessionalLicense.Alaska.Gov* under License Search.

**ABANDONED APPLICATIONS:**

Under 12 AAC 02.910, an application is considered abandoned when 12 months have elapsed since correspondence was last received from or on behalf of the applicant. An abandoned application is denied without prejudice. At the time of abandonment, the division will send notification to the last known address of the applicant, who has 30 days to submit a written request for a refund of biennial license and other fees paid. The application fee will not be refunded. If no request for refund is received within that timeframe, no refund will be issued, and all fees will be forfeited.

**BUSINESS LICENSES:**

The status of a professional license will directly impact the status of an associated business license. Renewal applications for business licenses are mailed separately. For more information about business licenses, (907) 465-2550 or *BusinessLicense.Alaska.Gov*

**STALE DOCUMENTS:**

Application forms, authorizations and verifications older than 12 months from the date the document was received by the division will be considered stale; the document must be resubmitted as appropriate before the application will be considered by the division or a licensing board. Application documents include the application documents and verifications of licensure from other licensing jurisdictions. (12 AAC 02.915)

**PAYMENT OF CHILD SUPPORT:**

If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907) 269-6900 to resolve payment issues.

**STATUTES AND REGULATIONS:**

The complete set of statutes and regulations for this program are available by written request or online at the division's website: *ProfessionalLicense.Alaska.Gov*

If you would like to receive notice of all proposed regulation changes for your program, please send a request in writing with your name, preferred contact method (mail or email), and the specific program you want to be updated on to the address below.

Regulations Specialist  
Department of Commerce, Community, and Economic Development  
Division of Corporations, Business and Professional Licensing  
EMAIL: [RegulationsAndPublicComment@Alaska.Gov](mailto:RegulationsAndPublicComment@Alaska.Gov)



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## Marital and Family Therapist License Application

### PART I Application Type

- ☐ Exam
- ☐ Credentials - If applying for licensure by credentials, upon which state license is the application based?
- State: \_\_\_\_\_ License Number: \_\_\_\_\_

### PART II Payment of Fees

Required Fees:	<input type="checkbox"/> Nonrefundable Application Fee	\$ 350.00
	<input type="checkbox"/> License Fee	\$1,250.00
Temporary License:	<input type="checkbox"/> In addition to the above, I would like to request a Temporary License.	\$ 300.00

### PART III Personal Information

Full Legal Name:			
<b>Provide all other names used (maiden, nicknames, aliases).</b> If any documentation will be received in a prior name, you must provide a certified true copy of the documentation showing proof of legal name change(s).			
<input type="checkbox"/> Not Applicable			
<input type="checkbox"/> Other Names Used: _____			
Mailing Address:	P.O. Box or Street	City	State Zip
Contact Phone:		Date of Birth:	
<b>EMAIL AGREEMENT:</b> By choosing to receive correspondence on any matter affecting my license or other business with the Alaska Division of Corporations, Business and Professional Licensing, I agree to maintain an accurate email address through the MY LICENSE web page. I understand that failure to check my email account or to keep the email address in good standing may result in an inability to receive crucial information, potentially resulting in my inability to obtain or maintain licensure.			
Email Address:		Select One:	<input type="checkbox"/> Send my Correspondence Electronically <input type="checkbox"/> Send my Correspondence by Mail
<b>Note: If both boxes are selected above, you will receive correspondence electronically.</b>			
<b>SOCIAL SECURITY NUMBER:</b> AS 08.01.060 requires you to provide your United States Social Security Number. It is considered confidential information and will not be publicly disclosed; it may be used to verify inter-state licensure.			

**PART IV College Education – Master’s**

<b>Name of College or University:</b>			
<b>Location:</b> (City, State)			
<b>Date Attended From:</b>		<b>Date Attended To:</b>	
<b>Degree Awarded:</b>		<b>Date Awarded:</b>	

**PART V College Education – Doctorate**

<b>Name of College or University:</b>			
<b>Location:</b> (City, State)			
<b>Date Attended From:</b>		<b>Date Attended To:</b>	
<b>Degree Awarded:</b>		<b>Date Awarded:</b>	

**PART VI Professional License(s)**

List ALL the states in which you are and have been licensed to practice Marital and Family Therapy. Please indicate whether certified or licensed. For more than three states, please add the remaining states on a separate sheet along with this application.

State or Jurisdiction	Licensed By (Exam, Credential, Other)	License Number	Issue Date	Expiration Date	State Board Exam Administered?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

**PART VII Examinations**

List any state(s) in which you **passed/failed** a marital and family therapy exam. For more than three licenses please add them to a separate sheet along with this application. For more than three states, please add the remaining states in a separate sheet along with this application.

State	Exam Date	Exam Administered By	Result
			<input type="checkbox"/> Pass <input type="checkbox"/> Fail
			<input type="checkbox"/> Pass <input type="checkbox"/> Fail
			<input type="checkbox"/> Pass <input type="checkbox"/> Fail

**PART VIII Practice History**

In chronological order, from most recent, list all relevant or related professional positions held.  
Provide names of employers, direct supervisors, addresses, ZIP code, telephone numbers, positions held, duties and responsibilities.

<b>Employer Name:</b>		<b>Phone Number:</b>	
<b>Full Address:</b>	P.O. Box or Street	City	State Zip
<b>Employment Start Date:</b>		<b>Employment End Date:</b>	
<b>Position Held:</b>		<b>Supervisor Name:</b>	
<b>Duties and Responsibilities:</b>			

<b>Employer Name:</b>		<b>Phone Number:</b>	
<b>Full Address:</b>	P.O. Box or Street	City	State Zip
<b>Employment Start Date:</b>		<b>Employment End Date:</b>	
<b>Position Held:</b>		<b>Supervisor Name:</b>	
<b>Duties and Responsibilities:</b>			

<b>Employer Name:</b>		<b>Phone Number:</b>	
<b>Full Address:</b>	P.O. Box or Street	City	State Zip
<b>Employment Start Date:</b>		<b>Employment End Date:</b>	
<b>Position Held:</b>		<b>Supervisor Name:</b>	
<b>Duties and Responsibilities:</b>			

<b>Employer Name:</b>		<b>Phone Number:</b>	
<b>Full Address:</b>	P.O. Box or Street	City	State Zip
<b>Employment Start Date:</b>		<b>Employment End Date:</b>	
<b>Position Held:</b>		<b>Supervisor Name:</b>	
<b>Duties and Responsibilities:</b>			

**PART IX Professional Associations**

List all professional memberships or associations.

<b>Association Name:</b>			
<b>Full Address:</b>	P.O. Box or Street	City	State Zip
<b>From Date:</b>		<b>To Date:</b>	
<b>Special Projects or Committees:</b>		<b>Office Held: (If Any)</b>	

<b>Association Name:</b>			
<b>Full Address:</b>	P.O. Box or Street	City	State Zip
<b>From Date:</b>		<b>To Date:</b>	
<b>Special Projects or Committees:</b>		<b>Office Held: (If Any)</b>	

<b>Association Name:</b>			
<b>Full Address:</b>	P.O. Box or Street	City	State Zip
<b>From Date:</b>		<b>To Date:</b>	
<b>Special Projects or Committees:</b>		<b>Office Held: (If Any)</b>	

<b>Association Name:</b>			
<b>Full Address:</b>	P.O. Box or Street	City	State Zip
<b>From Date:</b>		<b>To Date:</b>	
<b>Special Projects or Committees:</b>		<b>Office Held: (If Any)</b>	



## PART X Professional Fitness Questions

The following questions must be answered. "Yes" answers may not automatically result in license denial.

**For each "yes" response to any question, you must provide an explanation and documentation.** Use the letter of explanation form (#08-4752) appended to this application; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. A separate letter of explanation form must be provided for each "yes" answer documented below. Documentation includes copies of court orders, charging documents, board, or license actions, etc.

**If you answer "yes" to questions 6 or 7,** in addition to your personal statement, you must also submit a statement from your health care provider indicating your ability to safely practice marital and family therapy. Applications submitted without the appropriate attachments will be considered incomplete and will not be processed. When in doubt about your response, disclose and provide the required explanation and documents.

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

### When in doubt, disclose and explain.

1. Have you ever had a professional license denied, revoked, suspended, or otherwise restricted, conditioned or limited or have you surrendered a professional license, been fined, placed on probation, reprimanded, disciplined, or entered into a settlement with a licensing authority in connection with a professional license you have held in any jurisdiction including Alaska and including that of any military authorities or is any such action pending? ☐ Yes ☐ No
2. Have you ever been disciplined by any state board for any violation of the Marital and Family Therapy Practice Act or unethical conduct in delivery of professional services to clients? ☐ Yes ☐ No
3. Have you ever been the subject of an investigation by any state board or other licensing agency concerning a violation or alleged violation of any state regulation, statute, or law, or any violation or alleged violation of the Marital and Family Therapy Practice Act, or unprofessional or unethical conduct? ☐ Yes ☐ No
4. Have you ever had any malpractice settlements or judgments paid on your behalf? ☐ Yes ☐ No
5. Have you ever been convicted of a crime or are you currently charged with committing a crime? For purposes of this question, "crime" includes a misdemeanor, felony, or a military offense, including but not limited to, driving under the influence (DUI) or driving while intoxicated (DWI), driving without a license, reckless driving, or driving with a suspended or revoked license. "Convicted" includes having been found guilty by verdict of a judge or jury, having entered a plea of guilty, nolo contendere or no contest, or having been given probation, a suspended imposition of sentence, or a fine? ☐ Yes ☐ No
6. Within the past five years, have you been or are you addicted to, excessively used, or misused alcohol, narcotics, barbiturates, or habit-forming drugs? ☐ Yes ☐ No
7. Within the five years immediately preceding the date of application for licensure, have you experienced or been treated for, bipolar disorder, schizophrenia, paranoia, depression (except for situational or reactive depression), psychotic disorder, or other mental or physical or emotional condition or disability? ☐ Yes ☐ No

"Yes" Answers

**If you answered "yes" to questions 6 or 7,** in addition to your personal statement, you must submit a statement from your health care provider indicating your ability to safely practice marital and family therapy. Applications submitted without the appropriate attachments will be considered incomplete and will not be processed.



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## Notary Signature Page

### PART XI Notarized Signature

I hereby certify that I am the person herein named and subscribing to this application and that I have read the complete application, and I know the full content thereof. I declare that all of the information contained herein, and evidence or other documents submitted herewith are true and correct.

I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto, or falsification or misrepresentation of documents to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice in the state of Alaska.

I further understand that it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

A person who makes a false statement on this application may be subject to civil and criminal penalties, including prosecution for perjury (AS 11.56.200 & AS 11.56.230).

<div>Notary Stamp</div>	<b>Applicant Printed Name:</b>			
	<b>Applicant Signature:</b>			
	<b>Notary Public for State of:</b>		<b>Subscribed and Sworn to Before me on this Day:</b>	
	<b>Notary Signature:</b>		<b>My Commission Expires:</b>	



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## Authorization for Release of Records

I hereby authorize the Alaska Division of Corporations, Business, and Professional Licensing and its investigators to examine my employment and educational records, and records pertaining to litigation, judgments, suits and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Corporations, Business, and Professional Licensing and its investigators.

I authorize the division to discuss my records with persons or organizations that are considered appropriate by the division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the division.

This release also applies to any documents or records which contain information pertaining to psychiatric, psychological, drug, or alcohol evaluation, counseling, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment, including all information previously identified, collected, or stored under the authority of any state or federal law, including 42 CFR Part 2.

I request that upon presentation of this release, or a Certified True Copy thereof, that you provide copies of those records to the division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization is given expressly in connection with the application (initial, renewal, reactivation) for issuance of a license as a marital and family therapist.

I hereby release you, your organization, the Alaska Department of Commerce, Community, and Economic Development, Division of Corporations, Business, and Professional Licensing and its investigators, and all others directly and/or indirectly involved in this matter from any liability or damage which may result from furnishing the information requested.

This authorization expires one (1) year from the date of my signature below.

<b>Name:</b>	First	Middle	Last
<b>Full Address:</b>	P.O. Box or Street	City	State Zip
<b>Phone:</b>		<b>Date of Birth:</b>	
<b>Email:</b>			
<b>Signature:</b>		<b>Date:</b>	



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## Verification of Licensure



**Applicant:**

Please complete the identifying information below and forward a copy of this form to all states, territories, or jurisdictions where you currently are or have ever been licensed. Duplicate this form as needed.

<b>Applicant Name:</b>		<b>Date of Birth:</b>	
<b>Mailing Address:</b>	P.O. Box or Street	City	State Zip
<b>Applicant Signature:</b>		<b>Date Signed:</b>	



**Licensing Agency  
or State Board:**

Please complete this bottom part for the applicant identified above and return the form directly to the Alaska Board of Marital and Family Therapy at the letterhead address.

<b>Licensee Name:</b> (As Shown in Your Records)		<b>State or Jurisdiction:</b>	
<b>License Number:</b>		<b>License Status:</b>	
<b>Issued By:</b>	<input type="checkbox"/> Exam <input type="checkbox"/> Credentials <input type="checkbox"/> Other (Please Specify): _____		
<b>Original Issue Date:</b>		<b>Expiration Date:</b>	

- Has this applicant ever been the subject of an investigation by a licensing or disciplinary authority in your state or jurisdiction, or is any such investigation pending? ☐ Yes ☐ No
- Have formal disciplinary proceedings been initiated against this applicant or the applicant's license by a licensing or disciplinary authority in your state or jurisdiction, or is any such action pending? ☐ Yes ☐ No
- Has this applicant's license ever been suspended, revoked, disciplined, restricted, warned, placed on probation, or in any other manner limited by a licensing or disciplinary authority in your state? ☐ Yes ☐ No
- To your knowledge, is there any derogatory information regarding this applicant? ☐ Yes ☐ No

"Yes" Answers

If you answered "yes" to any question above, please attach a detailed explanation or documentation signed and dated by the person whose signature appears below.

Board Seal	<b>Signature:</b>		<b>Date Signed:</b>	
	<b>Printed Name:</b>		<b>Title:</b>	
	<b>Email:</b>		<b>Phone:</b>	



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## Verification of Approved Clinical Contact Hours

→ **Applicant:**

Please complete the identifying information below. It is the applicant's responsibility to request all necessary verifications and pay all applicable fees. The 200 hours of individual and group supervision must be provided by a person who is an Alaska Board of Marital and Family Therapy Approved Supervisor in accordance with AS 08.63.120.

<b>Applicant Name:</b>		<b>MFT Associate License Number:</b>	
<b>Address:</b>			

**MFT Supervisor Information:**

<b>MFT Supervisor Name:</b>			
<b>Supervision Start Date:</b>		<b>Supervision End Date:</b>	
<b>Applicant Signature:</b>		<b>Date Signed:</b>	

→ **MFT Supervisor:**

The above-applicant is applying for licensure in the State of Alaska as a marital and family therapist. Please provide the information requested below, and return the form directly to the Board of Marital and Family Therapy at the letterhead address. The information below must be completed by the supervisor; it may not be completed by the applicant.

<b>MFT Supervisor Name:</b>		<b>License Number:</b>	
<b>License Type:</b>		<b>State of Issuance:</b>	
<b>Professional Clinic or Institution Name:</b>			
<b>Supervision Start Date:</b>		<b>Supervision End Date:</b>	
<b>Total hours of direct clinical contact with couples and families:</b>			
<b>Total hours of individual supervision provided by you to this applicant during this period:</b>			
<b>Total hours of group supervision provided by you to this applicant during this period:</b>			

## Recommendation

The State of Alaska believes a license to practice marital and family therapy carries important responsibilities. Please comment, as supervisor, on the applicant's qualifications, abilities, character, etc., which involve use of marital and family therapy as defined in AS 08.63.900(5)(A)(B):

Comments: .....

### To your knowledge:

1. is the applicant of good moral character? ☐ Yes ☐ No

2. has the applicant within the past five years, ever been addicted to or excessively used alcohol, narcotics, barbiturates, or habit-forming drugs? ☐ Yes ☐ No

3. has the applicant had any malpractice judgments brought against him/her? ☐ Yes ☐ No

4. has the applicant violated the ethical standards for providers of marital and family therapy services? ☐ Yes ☐ No

5. has the applicant misrepresented his or her professional qualifications? ☐ Yes ☐ No

6. has the applicant been practicing marital and family therapy services without a license? ☐ Yes ☐ No

7. has the applicant ever been convicted of a felony? ☐ Yes ☐ No

8. at any time during your supervision of this applicant, were restrictions placed on the applicant?  
*If yes, please explain on a separate sheet.* ☐ Yes ☐ No

9. Please evaluate the applicant's technical knowledge and practical experience in the practice of marital and family therapy:

☐ Excellent ☐ Very Good ☐ Fair ☐ Needs Improvement

10. Would you recommend the applicant for licensure as a marital and family therapist? ☐ Yes ☐ No

Please explain: .....

11. Any further comments the board might consider in reviewing this applicant? ☐ Yes ☐ No

Please explain: .....

## Notarized Signature

I hereby certify that the information is true and complete to the best of my knowledge.

<div>Notary Stamp</div>	<b>Supervisor Printed Name:</b>			
	<b>Supervisor Signature:</b>			
	<b>Notary Public for State of:</b>		<b>Subscribed and Sworn to Before me on this Day:</b>	
	<b>Notary Signature:</b>		<b>My Commission Expires:</b>	



THE STATE  
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**Board of Marital and Family Therapy**

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## Education Course Work Check Sheet

<b>Applicant Name:</b>			
<b>Name of College or University Attended:</b>			
<b>Type of Degree:</b>		<b>Date Awarded:</b>	

### COURSE OF STUDY

Indicate below where and how you obtained the following graduate educational experience. Do not list a course under more than one category. If the course content is not self-evident in the title, attach a separate description.

(a) MARITAL AND FAMILY THERAPY THEORY (Three courses or nine semester or 12 quarter hours)

Courses that meet this requirement are informative of systems theory and other theoretical approaches to marital and family therapy. Courses taught in this area must enable students to think systemically about human issues by focusing on the systems paradigm to conceptualize and distinguish the critical epistemological issues in marital and family therapy. This area must provide a substantive understanding of the major models of system change and the principles and techniques evolving from each model. This comprehensive survey of the major models of system change will include, but are not limited to; structural, strategic, intergenerational, contextual, behavioral, experiential, and systemic. This section of the qualifications must also address the applied aspects of marital and family therapy practice, including the range of techniques associated with each orientation; indications and contraindications for utilizing specific techniques; development of a rationale for intervention; and the role of the therapist.

This area must also focus on two major interdependent components; diagnosis/assessment and treatment processes within the context of marital and family systems. Treatment processes must be offered for specific problems, including, but not limited to loss and bereavement, intense stress, substance abuse, suicide, incest, violence, sexual dysfunctions, divorce, and remarriage.

Any course work in this category which exceeds the required nine semester, or twelve quarter, hours may be applied toward meeting the requirements for family studies.

Institution	Course ID	Full Course Title	Term	Credit Hours	
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter



(b) MARITAL AND FAMILY STUDIES (Three courses or nine semester or 12 quarter hours)

Courses that meet this requirement are informative of the broad dimensions of marriage and/or family and include such courses as marriage and family relations, family sociology, marriage, family and work relationships, or other such related topics in which marriage and the nature of the family and its functions are clearly evident in the course content.

Institution	Course ID	Full Course Title	Term	Credit Hours	
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter

(c) HUMAN DEVELOPMENT (Three courses or nine semester or 12 quarter hours)

Courses that meet this requirement focus on the complex developmental relationships among individuals in the family. Individual-orientation and family/couple life cycle content must stress the interface between the interpersonal and the intrapersonal.

Institution	Course ID	Full Course Title	Term	Credit Hours	
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter

(d) PROFESSIONAL STUDIES OR PROFESSIONAL ETHICS AND LAW (One course or three semester or four quarter hours)

Areas of study must include professional socialization and the role of professional organizations; licensure and certification; legal responsibilities, and liabilities of clinical practice and research; family law (state and federal); confidentiality issues; the marital and family therapy Code of Ethics, and interprofessional cooperation. The content of course work should be specific to the practice and profession of marital and family therapy.

Institution	Course ID	Full Course Title	Term	Credit Hours	
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter

(e) RESEARCH (One course or three semester or four quarter hours)

Emphasis in this area is on understanding research methodology and data analysis, developing computer research skills, and learning to evaluate critically professional research reports relevant to marital and family therapy.

Institution	Course ID	Full Course Title	Term	Credit Hours	
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter

(f) SUPERVISED CLINICAL PRACTICE (One year)

Direct clinical work with couples and families must have been a part of a graduate degree or completed through a supervised clinical practicum in marital and family therapy obtained subsequent to the granting of a degree in an equivalent course of study. This one-year requirement includes nine semester or twelve quarter hours or approximately 15 hours per week for one year. Direct client contact is face-to-face (therapist and client) therapeutic intervention. The balance of time was to be spent in supervision, record keeping, and participation in other clinical activities of the agency or practice.

Institution	Course ID	Full Course Title	Term	Credit Hours	
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter

**Supervisor Signature**

Supervisor Printed Name:

Supervisor Signature:

Date Signed:



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## Substitution of Post-Degree Course(s) Work Check Sheet

**Exam Applicants Only**

The board will, in its discretion, accept post-degree courses or practice to satisfy the course of study requirements in AS 08.63.100(a)(3) (B)(i-vi). See 12 AAC 19.120

### MARITAL AND FAMILY THERAPY THEORY

Courses that meet this requirement are informative of systems theory and other theoretical approaches to marital and family therapy. Courses taught in this area must enable students to think systemically about human issues by focusing on the systems paradigm to conceptualize and distinguish the critical epistemological issues in marital and family therapy. This area must provide a substantive understanding of the major models of system change and the principles and techniques evolving from each model. This comprehensive survey of the major models of system change will include, but are not limited to; structural, strategic, intergenerational, contextual, behavioral, experiential, and systemic. This section of the qualifications must also address the applied aspects of marital and family therapy practice, including the range or techniques associated with each orientation; indications and contraindications for utilizing specific techniques; development of a rationale for intervention; and the role of the therapist.

This area must also focus on two major interdependent components; diagnosis/assessment and treatment processes within the context of marital and family systems. Treatment processes must be offered for specific problems, including, but not limited to loss and bereavement, intense stress, substance abuse, suicide, incest, violence, sexual dysfunctions, divorce, and remarriage.

Any course work in this category which exceeds the required nine semester, or twelve quarter, hours may be applied toward meeting the requirements for family studies.

Institution	Course ID	Full Course Title	Term/Practice Dates	Credit Hours	
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter

### MARITAL AND FAMILY STUDIES

Courses that meet this requirement are informative of the broad dimensions of marriage and/or family and includes such courses as marriage and family relations, family sociology, marriage, family and work relationships, or other such related topics in which marriage and the nature of the family and its functions are clearly evident in the course content.

Institution	Course ID	Full Course Title	Term/Practice Dates	Credit Hours	
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter

## HUMAN DEVELOPMENT

Courses that meet this requirement focus on the complex developmental relationships among individuals in the family. Individual-orientation and family/couple life cycle content must stress the interface between the interpersonal and the intrapersonal.

Institution	Course ID	Full Course Title	Term/Practice Dates	Credit Hours	
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter

## PROFESSIONAL STUDIES OR PROFESSIONAL ETHICS AND LAW

Areas of study must include professional socialization and the role of professional organizations; licensure and certification; legal responsibilities, and liabilities of clinical practice and research; family law (state and federal); confidentiality issues; the marital and family therapy Code of Ethics, and interprofessional cooperation. The content of course work should be specific to the practice and profession of marital and family therapy.

Institution	Course ID	Full Course Title	Term/Practice Dates	Credit Hours	
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter

## RESEARCH

Emphasis in this area is on understanding research methodology and data analysis, developing computer research skills, and learning to evaluate critically professional research reports relevant to marital and family therapy.

Institution	Course ID	Full Course Title	Term/Practice Dates	Credit Hours	
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter

## SUPERVISED CLINICAL PRACTICE

Direct clinical work with couples and families must have been a part of a graduate degree or completed through a supervised clinical practicum in marital and family therapy obtained subsequent to the granting of a degree in an equivalent course of study. This one-year requirement includes nine semester or twelve quarter hours or approximately 15 hours per week for one year. Direct client contact is face-to-face (therapist and client) therapeutic intervention. The balance of time was to be spent in supervision, record keeping, and participation in other clinical activities of the agency or practice.

Institution	Course ID	Full Course Title	Term/Practice Dates	Credit Hours	
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter
					<input type="checkbox"/> Semester <input type="checkbox"/> Quarter

<b>Supervisor Signature</b>			
<b>Supervisor Printed Name:</b>			
<b>Supervisor Signature:</b>		<b>Date Signed:</b>	



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## Letter of Explanation for a Professional Fitness “Yes” Answer

Use this form only to explain and document any professional fitness “Yes” answers. A “Yes” answer is not necessarily disqualifying but concealing one may be.

Each “Yes” answer requires a separate explanation and associated documentation. Submit all relevant documentation with this form, even if you have previously provided it.

- **Explanations** include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. If the space provided is insufficient, make additional copies as needed.
- **Documentation** includes copies of court orders, charging documents, board or license actions, decisions against your professional certification, satisfaction of consent agreements (fines paid, community service completed, off probation, etc.), and fitness to practice letters (statement from your provider that you are safe to practice if you check “Yes” to any of the questions regarding mental or physical health, or drug or alcohol abuse or addiction).
- **Disciplinary actions** may include but not be limited to: suspension, surrender, revocation, probation, academic probation, reprimand, censure, restricted license, limited license, conditioned license, or letters of counseling, concern, advice, warning, caution, admonishment, or reprimand.

If you have multiple “Yes” answers or multiple incidents for any professional fitness question, you must use a separate copy of this form and provide a full explanation and documentation for each incident.

The contents of licensing files are public records. If you believe that the additional information you are attaching to explain a “Yes” answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted according to state law.



Write the professional fitness question number you are answering “Yes” to in the box.

Location of Incident:	Date of Incident:
Explanation of Incident:	
When in doubt, disclose and explain. Make copies as necessary.	

**Did you attach all applicable documents associated with this incident?**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Court orders  | <input type="checkbox"/> Consent agreements  | <input type="checkbox"/> Disciplinary actions                             | <input type="checkbox"/> Charging documents |
| <input type="checkbox"/> Court records   | <input type="checkbox"/> Fitness to practice | <input type="checkbox"/> All other documentation related to this incident |   |
| <input type="checkbox"/> I have additional incidents for this “Yes” answer, or “Yes” answers to other Professional Fitness questions and have attached a separate copy of this form for each incident. |  |   |   |

Full Name:	PL Code:
Signature:	Date:

**You must submit one form for each “Yes” answer. Make copies of this form as necessary.**



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Phone: (907) 465-2550

## Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee: \_\_\_\_\_

Profession Type (e.g., Acupuncture): \_\_\_\_\_

License Number (if applicable): \_\_\_\_\_

I wish to make payment by credit card for the following (check all that apply):

**AMOUNT**

☐ Application Fee: \_\_\_\_\_

☐ License or Renewal Fee: \_\_\_\_\_

☐ Other (fine, exam, etc.): \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

**TOTAL:** \_\_\_\_\_

Name (as shown on credit card): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email (optional): \_\_\_\_\_

Signature of Credit Card Holder: \_\_\_\_\_

08-4438

Rev 12/06/2022

Credit Card Payment Form (all major cards accepted)

### CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed!

1. Credit Card Number: \_\_\_\_\_

2. Expiration Date: \_\_\_\_\_

3. Security Code: \_\_\_\_\_

All 3 fields **MUST** be completed!

This section will be destroyed after the payment is processed.