



INSTRUCTIONS FOR COMPLETION OF

LICENSED ASSOCIATE COUNSELOR OF MENTAL HEALTH (LAMFT) APPLICATION

1. **LAMFT Application** – Submit a completed application, which must be signed and notarized, along with the prorated processing fee. Make your check or money order payable to the “State of Delaware”.
2. **Written Plan for Marriage and Family Experience and Supervision** - Your approved clinical supervisor(s) must complete this form and sign it. The form must clearly indicate the dates and number of hours the applicant plans to complete the marriage and family counseling experience and supervision requirements. The supervisor(s) must be a Delaware licensed marriage and family therapist, an American Association for Marriage and Family Therapy (AAMFT) “approved supervisor,” or AAMFT “approved supervisor” candidate.

Only if one of the above is not available, a licensed clinical social worker, licensed psychologist, licensed professional counselor of mental health, or licensed physician specializing in psychiatry with training in supervision may act as a supervisor. In these instances, the proposed supervisor must complete an Approved Supervisor Form and be pre-approved by the Board.

3. **Verification of Licensure Form** – If you hold or have ever held any license in another state, you will need to contact them and request that they send the Delaware Board a verification of your licensure in good standing.
4. **COAMFTE Course Comparison Form** – Complete this form if your degree is from a program of studies that is not COAMFTE accredited.
5. **Official Transcript** – Submit an official transcript of your completed Marriage and Family Therapy degree. The transcript must be sent directly to the Board from your college or university. If the degree is from a COAMFTE accredited program of studies, no other documentation is required. However, if the program of studies is not COAMFTE accredited you will need to complete and submit the COAMFTE Course Comparison Form.



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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

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DELAWARE BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS
APPLICATION FOR LICENSED ASSOCIATE MARRIAGE AND FAMILY THERAPIST (LAMFT) LICENSE

1. **Full Name:**

Last	First	Middle Initial

2. **Social Security Number:** _____

3. **Mailing Address:**

Street	
Apt or Suite #	
City	
State	
Zip Code	

4. **Contact Information:**

Work Phone #	Home Phone #	Fax #	Email Address

5. **Graduate Education:**

Degree	Date Awarded	Name of Institution Granting Degree

6. **Licensure:** Are you licensed, or have you ever been licensed in any other state(s)? Yes No

If yes, please provide the following information. You will also need to request a letter of good standing from each State Board be sent directly to the Delaware Board.

State	Date Issued	License Number

Pursuant to Section 7 of the Privacy Act of 1974, you are hereby given notice that the disclosure of your social security number on this application is required by 29 Del. C §8735(m). It may be used to enforce child support obligations pursuant to 13 Del. C. §2216 and for other lawful purposes.

WRITTEN PLAN FOR MARRIAGE AND FAMILY EXPERIENCE AND SUPERVISION

7. Planned Marriage and Family Therapy Experience: List your planned post-Master's marriage and family therapy counseling experiences. If needed, use this same format on additional sheets.

a. Dates of planned employment: From _____ to _____ Total Number of Hours _____

Employer _____

Address _____

Supervisor's Name _____

Title/Professional Status _____

Telephone _____

Your Position/Title: _____

Job Responsibilities and Activities (use additional page if needed): _____

8. Planned Professional Direct Supervision: List your planned post-Master's marriage and family therapy supervised counseling experience. If needed, use this same format on additional sheets. A minimum of 1600 hours of professional direct supervision. *If your supervisor is not one of the approved supervisors listed below, he/she must complete an "Approved Supervisor Form" and be pre-approved by the Board.*

a. Dates of planned supervision: From _____ to _____

b. Number of Hours of Planned Couples and Family (Minimum of 500 hrs.) _____

c. Number of Hours of Planned Individual Therapy (Minimum of 500 hrs.) _____

d. Number of Hours of Planned Direct Supervision (Minimum of 100 hrs) _____

1. Number of Planned Individual Direct Supervision (Minimum of 50 hrs.) _____

2. Number of Planned Group Direct Supervision _____

MFT Supervisor's Name _____

Title/Professional Status _____

Telephone _____

(If different than listed above)

I certify that I am a (check all that apply):

- Delaware licensed marriage and family therapist
- American Association for Marriage and Family Therapy (AAMFT) "approved supervisor"
- AAMFT "approved supervisor" candidate.

Signature of Clinical Supervisor

Date

9. Have you ever been convicted of or entered a plea of guilty or nolo contendere (no contest) to any felony, misdemeanor, or any other criminal offense in any jurisdiction? Yes No

If yes, submit a certified copy of your criminal history record.

10. Have there ever been, or are there now any pending professional disciplinary actions against you? **If yes, attach an explanation in full detail by giving all particulars of such action(s).** Yes No

11. Have you ever had a professional license suspended or revoked? **If yes, attach an explanation in full detail by giving all particulars of such action(s).** Yes No

12. Are you presently in violation of any Rule and Regulation set forth by the Delaware Board of Mental Health and Chemical Dependency Professionals? **If yes, attach an explanation in full detail by giving all particulars of such action(s).** Yes No

13. Are you in violation of any grounds for disciplinary actions, as set forth in 24 Del. C., Subchapter I, Section 3009? **If yes, attach an explanation in full detail by giving all particulars of such action(s).** Yes No

14. Have you ever been denied licensure in any other jurisdiction? **If yes, attach an explanation in full detail by giving all particulars of such action(s).** Yes No

To assure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- Completed, signed and notarized application form
- Fee payment
- All required supporting documentation.

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is complete, please allow 4-8 weeks to receive your license.

Delaware Board of Mental Health and Chemical Dependency Professionals

AFFIDAVIT

The undersigned applicant for Licensed Associate Counselor of Mental Health, being sworn, deposes and affirms that he/she meets the following Qualifications for Licensure as stated in Title 24, *Delaware Code*, Chapter 30:

The applicant is not the recipient of any administrative penalties regarding his/her actions as a licensed, registered or certified mental health provider, and has not entered into any "consent agreements" containing conditions placed upon his/her professional conduct, including voluntary surrender of license.

The applicant does not have any impairment related to drugs, alcohol, or a finding of mental incompetence by a physician that would limit the applicant's ability to safely act as a licensed associate counselor of mental health.

The applicant does not have a criminal conviction nor pending criminal charge relating to an offense, the circumstances of which substantially relate to actions as a licensed associate counselor of mental health.

The applicant has not been penalized for any willful violation of any code of ethics or professional mental health standard.

The applicant further states that he/she has not violated any rule or regulation set forth by the Delaware Board of Mental Health and Chemical Dependency Professionals.

Signature of Applicant

State of _____

City of _____ County of _____

Sworn before me this _____ day of _____, 20____.

My commission expires on _____.

(Notary Signature)

Notary Seal

COAMFTE COURSE COMPARISON FORM

1. MARRIAGE AND FAMILY STUDIES (3 courses minimum – 9 semester hours or 12 quarter or 135 didactic contact hours required): Courses in this area should be a fundamental introduction to a wide variety of family structures and a diverse range of presenting issues (i.e. gender, cultural, substance abuse). Topic areas may include: systems theory, family development, family subsystems, blended families, gender issues in families, cultural issues in families, etc.

Educational Institution	Course #	Course Title	To/From Dates	Credit Hrs.	Contact Hrs.

2. MARRIAGE AND FAMILY THERAPY (3 courses minimum – 9 semester hours or 12 quarter or 135 didactic contact hours required): Courses in this area are intended to provide a substantive understanding of the major theories of marriage and family change and the applied practices evolving from each theoretical orientation. Major theoretical approaches might include: strategic, structural, object relations family therapy, behavioral family therapy, communications family therapy, and intergenerational family therapy, sex therapy, and related therapeutic approaches.

Educational Institution	Course #	Course Title	To/From Dates	Credit Hrs.	Contact Hrs.

3. HUMAN DEVELOPMENT (3 courses minimum – 9 semester hours or 12 quarter or 135 didactic contact hours required): Courses in this area should provide knowledge of individual personality development and its normal and abnormal manifestations. The student should have relevant course work in human development across the life span, which includes special issues that affect an individual's development (i.e. culture, gender, and human sexuality). Topic area may include: human development, child/adolescent development, personality theory, human sexuality, etc.

Educational Institution	Course #	Course Title	To/From Dates	Credit Hrs.	Contact Hrs.

4. PSYCHOPATHOLOGY/DSM (1 course minimum – 3 semester hours or 4 quarter or 45 didactic contact hours required): Courses in this area should cover psychopathology, diagnosis through use of DSM, or applications of DSM marriage and family therapy.

Educational Institution	Course #	Course Title	To/From Dates	Credit Hrs.	Contact Hrs.

5. PROFESSIONAL STUDIES (1 course minimum – 3 semester hours or 4 quarter or 45 didactic contact hours required): Courses in this area are intended to contribute to the professional development of the therapist. Areas of study include the therapist's legal responsibilities, professional ethics as a marriage and family therapist, professional socialization, and the role of the professional organization, licensure or certification legislation, independent practice, and inter-professional cooperation.

Educational Institution	Course #	Course Title	To/From Dates	Credit Hrs.	Contact Hrs.

6. RESEARCH (1 course minimum – 3 semester hours or 4 quarter or 45 didactic contact hours required): Courses in this area should assist students in understanding and performing research. Topic areas may include: research methodology, quantitative methods and statistics.

Educational Institution	Course #	Course Title	To/From Dates	Credit Hrs.	Contact Hrs.



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VERIFICATION OF LICENSURE FORM

Section I – To be completed by applicant and sent to those states where applicant is currently licensed or was previously licensed. You may duplicate this form.

Name	
License Type	
License #	
Phone #	

I hereby authorize _____ to release information regarding my licensure,
Name of state licensing Board/Authority

certification, or registration to the Delaware Board of Mental Health and Chemical Dependency Professionals.

Signature of Applicant

Date

Section II - To be completed by State Licensure Board/Authority and returned to the address above:

Date of Original Registration/Licensure: _____

Registration/License No: _____ Expiration Date: _____

Has the licensee ever been subject to any disciplinary action, or had his/her license suspended or revoked? ***If yes, enclose a certified copy of the board's final order.*** Yes No

Are there any current or pending disciplinary proceedings or unresolved complaints against the applicant? Yes No

I certify the statements contained herein are true and correct.

Name of Official: _____ Title: _____

Name of Licensure Authority: _____

Address: _____ Phone: _____

_____ Zip Code: _____

AFFIX BOARD SEAL

Signature and title of official for state licensing authority

Date