

Form II



**TEXAS STATE BOARD OF EXAMINERS OF
MARRIAGE AND FAMILY THERAPISTS
VERIFICATION OF LICENSURE IN OTHER JURISDICTION**

DIRECTIONS TO APPLICANT: Complete Part I and forward to the state where you hold a license to practice Marriage and Family Therapy.

PART I-TO BE COMPLETED BY THE APPLICANT

Name of Applicant	State from which Verification Requested	License No.	Date Issued

I was granted a license as described above and request that verification of that license be submitted to the Texas State Board of Examiners of Marriage and Family Therapists. You are hereby authorized to release any information in your files, favorable or otherwise, directly to this state's Marriage and Family Therapists Board.

Your early attention is appreciated.

_____ Signature _____ Date

PART II-TO BE COMPLETED BY THE STATE BOARD VERIFYING LICENSURE (Please complete this form and return it to the address indicated on the reverse side of this form. Attach copies of any verification of supervision or supervised experience toward LMFT licensure.

Name of Licensee	Licensure Level	License No.	Date Issued
Hours of supervision and direct supervised clinical experience required for licensure held: Total hours of supervision: _____ Number of hours of individual supervision: _____ Total hours of practice: _____ Number of hours of direct clinical services: _____ Number of hours of direct clinical services to couples and families: _____ Other requirements: _____			
Please Verify Supervision Requirements Met in Your Jurisdiction Supervision dates: From _____ to _____ Number of months credited _____ Employer name: _____ Employer address: _____ Clinical Supervisor: _____ phone number: _____ Total hours of supervision: _____ Number of hours of individual supervision: _____ Total hours of practice: _____ Number of hours of direct clinical services: _____ Number of hours of direct clinical services to couples and families: _____			
Please Verify Supervision Requirements Met in Your Jurisdiction Supervision dates: From _____ to _____ Number of months credited _____ Employer name: _____ Employer address: _____ Clinical Supervisor: _____ phone number: _____ Total hours of supervision: _____ Number of hours of individual supervision: _____ Total hours of practice: _____ Number of hours of direct clinical services: _____ Number of hours of direct clinical services to couples and families: _____			
Exam Taken _____ AMFTRB _____ Other _____	Date Exam Passed	Exam Score	
License Current? _____ Yes _____ No	Expiration Date _____	Complaints and/or Disciplinary Action _____ Yes* _____ No	

***Explain Complaints or Disciplinary Actions:**

Board Seal of State
Board verifying licensure

Signature	Date	Telephone No.
Name (please type or print)	Title	

Mail To:
Texas State Board of Examiners of Marriage and Family Therapists
Mail Code 1982
P.O. Box 149347
Austin, TX 78714-9347
Phone #: 1-512-834-6628 Fax #: 1-512-834-6677



PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us/> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)
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