South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psycho-Educational Specialists
110 Centerview Dr. • Columbia • SC • 29210
P.O. Box 11329 • Columbia • SC 29211-1329
Phone: 803-896-4658 • Contact.Counselor@llr.sc.gov • Fax: 803-896-4719
llr.sc.gov/cou

LMFT ASSOCIATE TO A LICENSED MARRIAGE AND FAMILY THERAPIST APPLICATION

Once you have completed the requirements of clinical supervision, submit this application, fee and required documentation listed below. A link to the documentation is listed below or the forms are attached for your convenience.

Include with your application:

- Check or money order in the amount of $150 made payable to LLR-Board of Professional Counselors Application fee is non-refundable. A returned check fee of up to $30, or an amount specified by law, **may** be assessed on all returned funds.
- Completed Associate Supervision Log from all supervisors. https://llr.sc.gov/cou/PDFs/Associate_Supervision_Log.pdf
- Completed MFT Confirmation of Clinical Supervision of Post Master's Client Contact Form. https://llr.sc.gov/cou/PDFS/MFT_Confirmation_of_Clinical_Supervision.pdf

APPLICANT INFORMATION

Associate License Number: _____

Last Name:_____ First:_____ Middle:_____ Suffix:_____

Home Address: _____ City:_____ State: ____ Zip: _____

Mailing Address: _____ City:_____ State: ____ Zip: _____
(If different than above)

Phone: _____ Email Address: _____

PERSONAL HISTORY INFORMATION

Answer all the questions below; you are required to include a detailed written statement of explanation with your application for any "Yes" answers. However, if you answer "Yes" to question #3, you will also need to describe any pending charges in addition to providing a criminal background check from the state in which the offense took place (i.e., SLED, etc.).**You do not need to re-disclose anything you previously disclosed on your initial application.**

1. Since you were initially licensed as an Associate, have you had any application for any professional license refused or denied by any licensing authority? Yes ☐ No ☐

Name: _____

2. Since you were initially licensed as an Associate, have your privileges been restricted or terminated by any association and/or licensed facility? Yes ☐ No ☐

3. Since you were initially licensed as an Associate, have you been convicted of or pled guilty or nolo contendere to a felony, or to a crime involving drugs or moral turpitude? Yes ☐ No ☐

   If yes, attach a detailed written statement, certified copy of the court disposition, an official statewide background check from the state in which the conviction occurred and from the South Carolina Law Enforcement Division https://catch.sled.sc.gov/). If applicable, have a statement from your probation or parole officer sent directly to the Board.

4. Since you were initially licensed as an Associate, have you practiced the profession under the influence of alcohol and/or drugs, or do you use alcohol and/or drugs to such a degree that you are unfit to competently and safely practice the profession? Yes ☐ No ☐

5. Since you were initially licensed as an Associate, have you sustained a physical or mental impairment or disability which renders your ability to practice dangerous to the public? Yes ☐ No ☐

STATEMENT OF APPLICANT

Should I furnish any false information on this application or on any supporting document or material, I understand that such an act may constitute cause for denial of my application or revocation of my license. By signing below, I certify that I have read and understand the Board's statutes, regulations, and the Code of Ethics specific to the professional license I am seeking.

_____ _____

Applicant Signature Date

PRIVACY DISCLOSURE

South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

Other personal information collected by the Department for the licensing boards it administers is limited to such personal information as is necessary to fulfill a legitimate public purpose. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on the application may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act, and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical.

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ASSOCIATE SUPERVISION LOG

Associate: _____ License Number: _____

Supervisor/QLMHP: _____ Supervisor License No.: _____

Supervisor Candidate: _____ Sup Candidate License No.: _____

Date From/To	Individual/Triadic Supervision Hours (min of 60 Hours)	Group Supervision Hours (max 60 hours)	Supervisor/QLMHP or Supervisor Candidate Signature and/or Initials
	hrs min	hrs min	
	hrs min	hrs min	
	hrs min	hrs min	
	hrs min	hrs min	
	hrs min	hrs min	
	hrs min	hrs min	
	hrs min	hrs min	
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LMFT CONFIRMATION OF CLINICAL SUPERVISION OF POST-MASTER'S CLIENT CONTACT

Applicant/Associate Name: _____
(As shown on license)

Associate License Number: _____

Licensed Supervisor/Mental Health Practitioner or Supervisor Candidate Verification Information
(To be completed by supervisor/mental health practitioner)

Check appropriate category: ☐ Supervisor ☐ Supervisor Candidate ☐ Mental Health Practitioner

License Type: _____ License No.: _____

Supervisor/Supervisor Candidate/Mental Health Practitioner Name: _____
(As shown on license)

Mailing Address: _____

City: _____ State: _____ Zip: _____

Daytime Telephone No.: _____ Email: _____

Supervisor /Mental Health Practitioner Name: _____
(If supervision is to be completed by a supervisor candidate, indicate the candidate's supervisor)

License No.: _____

☐ I verify that the applicant was under my supervision, at which time I critiqued the applicant's marriage and family therapy counseling and therapy-related skills based on one or more of the following forms of observation of the supervisee's marriage and family therapy practice: (Check all that apply)

☐ Direct/Live Observation ☐ Live Supervision ☐ Audio Recordings

☐ Written Clinical Materials ☐ Video Recordings ☐ Co-Therapy

APPLICANT'S EMPLOYMENT

Name, address, telephone and type of work experience (minimum of two years' experience)	Total Years	From (MM/YY)	To (MM/YY)

1. **Confirmation of Supervised Clinical Experience of Direct Counseling Client Contact**
(Must reflect a minimum of 1,380 hours of supervised clinical experience.)

Confirmation of 1,380 hours of direct client contact in marriage and family therapy of individuals, couples or groups under the supervision of a licensed marriage and family therapy supervisor, supervisor candidate, or other qualified licensed mental health practitioner, that included experience assessing and treating clients with the more serious problems as categorized in standard diagnostic nomenclature.	Total Hours	From (MM/YY)	To (MM/YY)

2. **Confirmation of 120 Hours of Post-Master's Immediate Supervision**
Confirmation of hours of supervision by a licensed marriage and family supervisor or supervisor candidate (attach the supervision log)

	Total Hours	From (MM/YY)	To (MM/YY)
A. Individual (a minimum of 60 hours required to be individual supervision)			
B. Group			

RECOMMENDATION

☐ I recommend / ☐ I do not recommend this applicant for licensure as a South Carolina marriage and family therapist. **Note:** If you do not recommend this applicant/Associate, the board requests that you send a separate letter directly to the board office stating your reasons.

Additional comments:

ATTESTATION

I attest that all information provided herein concerning supervision and work experience is accurate to the best of my knowledge and is in keeping with the Professional Counselors, Marriage and Family Therapists, Addiction Counselors, and Psycho-Educational Specialist Practice Act. I understand that supervision for licensed associates and the duration for associate licensure are for a period of not less than two years.

Signature of Supervisor/Mental Health Prac: _____ Date: _____

Signature of Supervisor Candidate: (If applicable) _____ Date: _____