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

REQUIREMENTS AND INSTRUCTIONS FOR LICENSURE AS A MARRIAGE AND FAMILY THERAPY ASSOCIATE

Marriage and Family Therapy Associate applicants must meet education and examination requirements. Associates can only practice under supervision, pursuant to an approved clinical supervision plan.

EDUCATION

COAMFTE OR CACREP ACCREDITED SPECIALTY PROGRAM

To meet education requirements for licensure, an applicant can either show evidence of graduation from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) or from a marriage, couple and family counseling specialty program accredited by the Council for Accreditation of Counseling & Related Educational Programs (CACREP) at the time of graduation;

OR

NON-COAMFTE OR CACREP ACCREDITED SPECIALTY PROGRAM

Submit evidence of successful completion of a master's degree, specialist's degree or doctoral degree with a minimum of sixty (60) graduate semester hours in marriage and family therapy from a program accredited by a national educational accrediting body such as COAMFTE or one that requires or follows substantially similar educational standards, or from a marriage, couple and family counseling specialty program accredited by CACREP; or a post-degree program accredited by COAMFTE or one that requires or follows substantially similar educational standards, or from a marriage, couple and family counseling specialty program accredited by CACREP; and from a college or university accredited by the Commission on the Colleges of the Southern Association of Colleges and Schools, one of its transferring regional associations, the Association of Theological Schools in the United States and Canada, or a regionally accredited institution of higher learning subsequent to receiving the graduate degree.

Non-COAMFTE OR CACREP Accredited Specialty Program Required Graduate-Level Coursework Documentation

Complete and submit the MFT Coursework Requirements Verification and MFT Clinical Contact Hour/Clinical Supervision Review Forms along with official transcripts from all graduate institutions. Instructions for completion are found on the forms. The coursework description must be copied from the catalogue for the year in which the courses were taken or taken from the institution's website. The Clinical Contact Hours/Clinical Supervision descriptions are required as well. A syllabus will also be accepted.

EXAMINATION

All licensure candidates must take and pass the National Marriage and Family Therapy Examination administered by Professional Testing Corporation (PTC). Once your educational experience and application have been approved, you will be sent instructions on how to apply for the exam (if you have not already taken and passed the exam.)

ASSOCIATE SUPERVISION

SUPERVISION

In order to obtain the Marriage and Family Therapy license, documentation of completion of a minimum of one thousand five hundred (1500) hours of post-master's clinical experience and post master's clinical supervision in marriage and family therapy performed over a period of not fewer than two (2) years must be submitted to the Board. Of the one thousand five hundred (1500) hours, there must be a minimum of one thousand three hundred eighty (1,380) hours of documented direct client contact hours, and a minimum of one hundred twenty (120) hours of documented supervision by a licensed Marriage and Family Therapy Supervisor or other qualified licensed mental health practitioner approved by the Board prior to beginning supervision that included experience assessing and treating clients with the more serious problems as categorized in standard diagnostic nomenclature. In addition to a licensed Marriage and Family Therapy Supervisor, a qualified licensed mental health practitioner (QLMHP) includes a person licensed as a Professional Counselor Supervisor, an Addiction Counselor Supervisor, a Psychologist or a Medical Doctor. The LMFT-S or QLMHP must be approved by the Board and shown to have knowledge and expertise necessary to provide marriage and family therapy supervision, including diagnosis and treatment of more serious problems categorized in standard diagnostic nomenclature.

A minimum of sixty (60) hours of the supervision hours must be individual/triadic, and the remaining sixty (60) hours may be individual/triadic or group.

These supervised experience hours are obtained as an Associate, pursuant to a Plan for Clinical Supervision. The Plan for Clinical Supervision of Post-Master's Clinical Experience in Marriage and Family Therapy form may be submitted along with the Associate license application, or submitted once the applicant has obtained employment; however, it must be effective once the applicant has passed the exam and the Associate license has been issued. A Marriage and Family Therapy Associate cannot provide marriage and family therapy services until the supervision plan is submitted to the Board and approved, and the Associate license is issued.

ASSOCIATE EXTENSION

An LMFT-Associate license is a two-year license. If Post-Master's clinical experience has not been completed within that two-year period, you will need to apply for an Associate Extension.

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APPLICATION FOR LICENSURE AS A MARRIAGE AND FAMILY THERAPY ASSOCIATE

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.
- Copy of your valid driver's license, state issued ID, passport or military ID
- Copy of your social security card
- Legal documentation for name change (marriage cert., divorce decree, etc.)(if applicable)
- Exam Score Report (if applicable)
- Plan for Clinical Supervision of Post-Master's Clinical Contact Hours/Clinical Supervision Review Form (may be submitted after you obtain employment rather than submitting with this application; however, the Plan must be submitted and approved before you can provide LMFT counseling services.)
- Coursework Description and Verification Form (if applicable)
- LMFTA Clinical Contact Hours/Clinical Supervision Review Form (if applicable)

Have submitted directly to the Board office via email or mailing address above from the issuing agent:

- Official Transcripts
- National Marital and Family Therapy Exam Scores
- Out of State License Verification, if applicable

APPLICANT INFORMATION

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

Have you ever had a legal name change? ☐ Yes ☐ No Prior Name: _____

If yes, please submit legal documentation supporting the change. (Marriage certificate, divorce decree, etc.)

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

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

Phone: _____ Email Address: _____

Date of Birth: _____ Social Security No.: _____

Gender (For statistical purposes only): ☐ Female ☐ Male

EXAM INFORMATION

1. Have you taken and passed the National Marital and Family Therapy Examination? If yes, provide a copy of your score report. ☐ Yes ☐ No

Name: _____

PROFESSIONAL EDUCATION INFORMATION

Contact all graduate institutions and have an official transcript mailed or emailed directly to the Board. Undergraduate transcripts are not needed. You may include with your application unopened, sealed transcripts that were mailed to you from the school.

Did you graduate from a COAMFTE accredited program or from a CACREP accredited marriage, couple and family counseling specialty program? ☐ Yes ☐ No

(If **no**, you will need to complete the Coursework Definition and Verification Form and the Clinical Contact Hours/Clinical Supervision Review Form.)

Institution/Program	Attendance Dates (MM/YR – MM/YR)	Graduation Date	Degree Earned

OUT-OF-STATE LICENSURE

If you are a licensed Marriage and Family Therapy Associate in another state, the Board may consider giving you credit for completed supervised hours. (NOTE: Providing credit for supervised hours completed as a licensed associate in another state is discretionary.)

1. Are you licensed as a Marriage and Family Therapy Associate in another state? ☐ Yes ☐ No
   a. List state(s) where you are actively licensed: _____
   b. Do you have supervised hours you would like to be reviewed by the SC Board? ☐ Yes ☐ No
      If yes, provide the following:
      i. Confirmation of Clinical Supervision Form
      ii. Associate Supervision Log
      iii. Have an official license verification mailed/sent directly to the SC Board.
      iv. Have an official license verification for your supervisor mailed/sent directly to the SC Board. (Supervisor may need to request.)

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.).

1. Have you ever had any application for any professional license refused or denied by any licensing authority? ☐ Yes ☐ No
2. Have your privileges ever been restricted or terminated by any association and/or licensed facility? ☐ Yes ☐ No

Name: _____

3. 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 certified copy of the court records regarding your conviction, the nature of the offense, date of discharge. Also, if applicable, have a statement from your probation or parole officer sent directly to the Board.

4. Currently or within the last five years, 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. Currently or within the last five years, 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.

_____ _____

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

STATE OF SOUTH CAROLINA
DEPARTMENT OF LABOR, LICENSING AND REGULATION

VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES
AFFIDAVIT OF ELIGIBILITY

Pursuant to Section 8-29-10, *et seq.* of the South Carolina Code of Laws (1976, as amended), the Department of Labor, Licensing and Regulation must verify that any person who applies for a South Carolina license is lawfully present in the United States. Complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

The undersigned _____, of _____
(Print clearly First, Middle, and Last name) (Home Address, City, State, and Zip Code)
being first duly sworn deposes and states as follows:

Check only one box:

1. ☐ I am a United States citizen; or
2. ☐ I am a Legal Permanent Resident of the United States eighteen years of age or older; or
3. ☐ I am a Qualified Alien or non-immigrant under the Federal Immigration and Nationality Act, Public Law 82-414, eighteen years of age or older, and lawfully present in the United States.
4. ☐ Other:_____Please submit any documentation that supports this status.

Date of Birth: _____

Alien Number:_____ I-94 Number: _____

(**If you checked number 2, 3, or 4 you must attach a copy of your immigration documents**. See instruction sheet for a list of accepted immigration documents.)

Section B: ATTESTATION.

I understand that in accordance with section 8-29-10 of the South Carolina Code of Laws, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall, in addition to other sanctions imposed by this State or the United States, be guilty of a felony, and upon conviction must be fined and/or imprisoned for not more than 5 years (or both).

I understand that the representations made in this Affidavit shall apply through any license(s) or renewals issued, and that I shall have an affirmative duty to immediately advise the Department of Labor, Licensing and Regulation of any change of my immigration or citizenship status.

I swear and attest the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension, or revocation of a license, certificate, registration or permit.

_____
Signature of Affiant

SWORN to before me this_____day of_____, 20_____

_____
Notary Signature

_____
Print Name

Notary Public for _____

My Commission Expires: _____

Rev: 02-02-2015

INSTRUCTION SHEET FOR COMPLETING AFFIDAVIT OF ELIGIBILITY

CHECK box 1:
If you are a United States Citizen by birth or naturalization

CHECK box 2:
If you are a Legal Permanent Resident and you are not a U.S. Citizen, but are residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant.
PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

CHECK box 3:
If you are a Qualified Alien. You are a Qualified Alien if you are:
An alien who is lawfully admitted for residence under the INA.
An alien who is granted asylum under Section 208 of the INA.
A refugee who is admitted to the United States under Section 207 of the INA.
An alien who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least 1 year.
An alien whose deportation is being withheld under Section 243(h) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under Section 241(b)(3).
An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980.
An alien who is a Cuban/Haitian Entrant as defined by Section 501(e) of the Refugee Education Assistance Act of 1980.
An alien who has been battered or subjected to extreme cruelty, or whose child or parent has been battered or subject to extreme cruelty.
PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

ACCEPTED IMMIGRATION DOCUMENTS:
Unexpired Reentry Permit (I-327)
Permanent Resident Card or Alien Registration Receipt Card With Photograph (I-551)
Unexpired Refugee Travel Document (I-571)
Unexpired Employment Authorization Card Which Contains a Photograph (I-766)
Machine Readable Immigrant Visa (with Temporary I-551 Language)
Temporary I-551 Stamp (on passport or I-94)
I-94 (Arrival/Departure Record) in Unexpired Foreign Passport
I-20 (Certificate of Eligibility for Nonimmigrant, F-1, Student Status)
DS2019 (Certificate of Eligibility for Exchange Visitor, J-1, Status)

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MFT PLAN FOR CLINICAL SUPERVISION OF POST-MASTER'S CLINICAL EXPERIENCE IN MARRIAGE AND FAMILY THERAPY

- This form must be signed by the licensed marriage and family therapy supervisor and supervisor candidate (if applicable) or licensed mental health practitioner and by the applicant/MFT associate.

Please refer to www.llr.sc.gov/cou/ for a current list of licensed marriage and family therapy supervisors.

Applicant/Associate Name:_____ License No: _____ (If applicable)

LICENSED SUPERVISOR / SUPERVISOR CANDIDATE INFORMATION (To be completed by supervisor)
If supervision will be provided by a qualified licensed mental health practitioner rather than an MFT-S or MFT-S Candidate, complete the below Qualified Licensed Mental Health Practitioner section.

MFT-Supervisor Name: _____ MFT-Supervisor License No.: _____

Contact Number: _____ Email: _____

Mailing Address: _____

MFT-Supervisor Candidate Name: _____ MFT-S Candidate License No.: _____ (If applicable)

Contact Number: _____ Email: _____

Mailing Address: _____

QUALIFIED LICENSED MENTAL HEALTH PRACTITIONER
A qualified licensed mental health practitioner (QLMHP) means a person licensed as a Professional Counselor Supervisor, an Addiction Counselor Supervisor, a Psychologist or a Medical Doctor. The QLMHP must be pre-approved by the Board and shown to have knowledge and expertise necessary to provide marriage and family therapy supervision, including diagnosis and treatment of more serious problems categorized in standard diagnostic nomenclature.

Mental Health Practitioner Name: _____ License Type/No.: _____

Contact Number: _____ Email: _____

Mailing Address: _____

LOCATION OF SUPERVISED PRACTICE

Facility Name: _____ Facility Phone: _____

Address: _____

Type of Work Experience: _____

Start Date: _____ End Date: _____ Position Title: _____
Planned over two years

The following requirements regarding supervision must be met:

The supervised clinical experience requires completion of a minimum of one thousand five hundred (1500) hours of post-master's clinical experience and post master's clinical supervision in the practice of marriage and family therapy performed over a period of not fewer than two (2) years. Of the one thousand five hundred (1500) hours documented, there must be a minimum of one thousand three hundred eighty (1,380) hours of direct client contact and a minimum of one hundred twenty (120) hours of supervision by a licensed marriage and family therapy supervisor or other qualified licensed mental health practitioner approved by the Board that included experience assessing and treating clients with the more serious problems as categorized in standard diagnostic nomenclature. A minimum of sixty (60) hours of the supervision hours must be individual/triadic, and the remaining sixty (60) hours may be individual/triadic or group. At the conclusion of the supervised clinical experience, you must submit the Board form documenting that this supervision has been obtained.

Supervision is defined as:
(1) "Supervision" means direct contact between a supervisor and an associate or other person requiring supervision under this chapter. Supervision may be conducted either in person or via a HIPAA compliant technological medium. During this time, the person supervised apprises the supervisor of the diagnosis and treatment of each client seen during the supervisory process. The supervisor provides the supervised person with oversight and guidance in diagnosing, treating, and dealing with clients, and the supervisor evaluates the supervised person's performance. The focus of a supervision session is on raw data from clinical work which is made directly available to the supervisor through such means as written clinical materials, direct (live) observation, co therapy, audio and video recordings, and live supervision. Supervision is a process clearly distinguishable from personal psychotherapy and is contrasted in order to serve professional goals. The major focus in supervision of supervisors is on the development of supervisory abilities as opposed to an exclusive focus on clinical skills.

(2) "Group supervision" means a regularly scheduled meeting of not more than six (6) supervisees, and an approved supervisor, for a minimum of two (2) hours.

(3) "Individual/triadic supervision" means a meeting of one (1) or two (2) supervisees with a supervisor for a period of at least a one (1) hour session.

APPLICANT/ASSOCIATE CERTIFICATION

I have read and understand the supervision requirements, and understand that as an Associate I can only provide therapy services while being supervised. I also understand that I must provide the completed supervision forms at the conclusion of the period of supervision. If I obtain a new supervisor, I understand that I must provide both a Confirmation of Supervision Form and a new Plan for Clinical Supervision Form to the Board for approval before continuing to practice and in order to obtain clinical contact and supervision hours.

Applicant/Associate Signature: _____ Date: _____

SUPERVISOR/QLMHP CERTIFICATION

I have read and understand the supervision requirements, and agree to provide supervision in accord with Board statutes and regulations to the above MFT applicant.

Signature of Supervisor/QLMHP: _____ Date: _____
(Original signature required)

SUPERVISOR CANDIDATE CERTIFICATION

I have read and understand the supervision requirements, and agree to provide supervision in accord with Board statutes and regulations to the above MFT applicant.

Signature of Supervisor Candidate: (If applicable) _____ Date: _____
(Original signature required)