

STATE OF MAINE  
COUNSELING PROFESSIONALS LICENSURE

APPLICATION FOR LMFT LICENSURE



Department of Professional and Financial Regulation

Office of Licensing and Registration

35 State House Station

Augusta, ME 04333-0035

Office Telephone: (207) 624-8626  
TTY/HEARING IMPAIRED (207) 624-8563  
Email: [diane.l.staples@state.me.us](mailto:diane.l.staples@state.me.us)

Office located at: 122 Northern Avenue, Gardiner, Maine

Last Revised: 5/2000



STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
**Board of Counseling Professionals Licensure**

35 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0035

(207) 624-8563 (TTY/HEARING IMPAIRED)

ANGUS S. KING, JR.  
GOVERNOR

ANNE L. HEAD  
DIRECTOR

Dear Applicant:

The application material you have requested from the Board of Counseling Professionals Licensure is enclosed. It contains all of the information you will need to complete your application. Please read the forms, the laws and the rules carefully. Follow the directions in the rules for licensure eligibility requirements appropriate to the category of license for which you are applying. Do not rely solely on the applicant information sheet enclosed. This document is intended to be just a quick checklist and is furnished for your convenience. Be sure to read the laws and rules.

If you have questions about the application package you are about to send to us, please feel free to call our office. However, once you have submitted your application, we ask that you refrain from calling the office to inquire about the status of your application. If the application package you submit to us is complete, it will be prepared and presented to the board for official action. If there are deficiencies about your application, it will be returned to you together with a notice that your application is incomplete for the reasons noted. Any application received by the board must be complete before the Board will review it. **If all components of the application are not complete 10 days prior to the Board meeting the application will not be reviewed at that Board meeting.** Due to the volume of applications being reviewed by the board at any given time, we cannot guarantee a particular review date, but the board will endeavor to expedite the review of your application.

Results of the board's action will not be provided by phone. Therefore, we ask that you refrain from calling our office after the meeting to receive telephone results of board actions. You will be notified, in writing, within two weeks of the board meeting, of the board's decision regarding your application. Calling our office will cause a delay in notifications being prepared for mailing. We appreciate your thoughtful attention to this request.

It is not within the scope of the staff of this office who work with the Board of Counseling Professionals Licensure to answer questions, or address concerns, underlying decisions made, or actions taken, by the board; these must be submitted in writing to the Board at this address. A written response will be provided.

We wish you well with your application for Maine licensure, and look forward to receiving your material soon.

Sincerely,

Board of Counseling Professionals Licensure



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OFFICE PHONE: (207)624-8626

FAX: (207)624-8637

(207)624-8653 (TTY/HEARING IMPAIRED)  
OFFICES LOCATED AT: 122 NORTHERN AVENUE,  
GARDINER, MAINE



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**LICENSURE (SEE CHAPTER 6 OF RULES FOR APPLICATION PROCEDURE)**  
**(SEE CHAPTER 2, SECTION 3 OF RULES FOR REQUIREMENTS)**  
**Licensed Marriage & Family Therapist**

**A COMPLETE APPLICATION FOR LICENSURE SHALL INCLUDE THE FOLLOWING:**

- Completed and Signed Application Form. ([Attachment 1](#))
- Application Fee of \$40.00 (Non-Refundable).
- License Fee: Permanent License Fee \$200.00
- Completed Criminal History Form (enclose separate check for \$8.00 made payable to treasurer, State of Maine) ([Attachment 2](#))
- Official Transcript - forwarded directly to the Board by the academic institution holding the transcript (If the transcript does not indicate the number of on-site internship clock hours, a letter from a school official documenting the number of clock hours in the internship will be required- [Attachment 6](#)) (Applicant should also submit a course brochure/catalog which describes courses. A course syllabus should be submitted, if the brochure/catalog does not adequately describe course content).
- Completed Supervisor's Affidavit forms. ([Attachment 5](#)).
- Reference Forms-3 forms to be completed by professionals in the counseling field.([Attachment 4](#))
- Official proof of a passing score on an examination as prescribed in the Rules - forwarded to the Board directly by the organization holding the test scores or a request for examination ([Attachment 8](#))
- A copy of your Disclosure Statement. ([Attachment 11](#))
- Education Worksheet for appropriate license applied for. ([Attachment 10](#))

Page 1



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**A COMPLETE APPLICATION FOR LICENSURE COMITY SHALL INCLUDE THE FOLLOWING:**  
(SEE CHAPTER 5 OF THE BOARDS RULES)

- Completed and Signed Application Form. ([Attachment 1](#))
- Application Fee of \$40.00 (Non-Refundable).
- License Fee: Permanent License Fee \$200.00
- Completed Criminal History Form (enclose separate check for \$8.00 made payable to treasurer, State of Maine) ([Attachment 2](#))
- Official Transcript - forwarded directly to the Board by the academic institution holding the transcript (If the transcript does not indicate the number of on-site internship clock hours, a letter from a school official documenting the number of clock hours in the internship will be required- [Attachment 6](#))
- A copy of the relevant licensing law and Board rules of the licensing or certifying state of jurisdiction
- A copy of the current license
- Verification of licensure in another state ([Attachment 7](#))
- A copy of your disclosure statement ([Attachment 11](#))



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**APPLICATION FOR LMFT LICENSURE**

\*\*\*\*\*

**A LICENSE FEE & AN APPLICATION FEE ARE REQUIRED FOR EACH LICENSE APPLIED FOR**  
 (Make Checks Payable to the Maine State Treasurer)

**CHECK APPROPRIATE CATEGORY:**

- Standard Licensure**
- Licensure By Comity**

**PERSONAL INFORMATION:**

Name \_\_\_\_\_ SSN # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_  
 Daytime Telephone (     ) \_\_\_\_\_ Date of Birth \_\_\_\_\_

**WORK INFORMATION:**

Workplace \_\_\_\_\_  
 Street/P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Zip Code \_\_\_\_\_ Work Telephone (     ) \_\_\_\_\_

Attachment 1-Page 1



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**EDUCATION: (Official transcripts must be submitted directly from Institution)**

Institution Name & Address \_\_\_\_\_

Degree Granted & Date Conferred \_\_\_\_\_

Institution Name & Address \_\_\_\_\_

Degree Granted & Date Conferred \_\_\_\_\_

Institution Name & Address \_\_\_\_\_

Degree Granted & Date Conferred \_\_\_\_\_

**COUNSELING EXPERIENCE:**

1. Workplace Name \_\_\_\_\_

Address \_\_\_\_\_

Dates Employed \_\_\_\_\_

2. Workplace Name \_\_\_\_\_

Address \_\_\_\_\_

Dates Employed \_\_\_\_\_

3. Workplace Name \_\_\_\_\_

Address \_\_\_\_\_

Dates Employed \_\_\_\_\_

**SUPERVISORS:**

Name \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

**CREDENTIALING HISTORY: (If you answer YES on any of #2 - #5, please attach an explanation of each on a separate sheet)**

1. Have you ever held a professional license/certification/registration in this or any other state/country? [ ] YES [ ] NO

If yes, what profession? \_\_\_\_\_

Where? \_\_\_\_\_ Expiration Date \_\_\_\_\_

2. Has your license/certification/registration or professional membership ever been disciplined? [ ] YES [ ] NO

3. Have you ever been convicted of a crime other than a minor traffic violation? [ ] YES [ ] NO

If yes, please describe in detail the date(s), crime(s) and submit a copy of the court judgment(s) as well as a letter from you explaining the circumstances surrounding your conviction.

4. Do you have pending against you any complaints from a regulatory board or professional organization? [ ] YES [ ] NO

5. Have you ever been or are you currently a defendant in a civil proceeding related to your professional activities? [ ] YES [ ] NO

6. Have you ever taken a Counseling Examination? [ ] YES [ ] NO

If yes: Where? \_\_\_\_\_ Which Exam? \_\_\_\_\_ Date Taken? \_\_\_\_\_

**COMITY: (See Chapter 5 of the Board Rules)**

License Issue Date \_\_\_\_\_ State/Country \_\_\_\_\_

Issuing Authority \_\_\_\_\_

Have you taken a qualifying examination in any other state? [ ] YES [ ] NO

If yes: Where? \_\_\_\_\_ Which Exam? \_\_\_\_\_ Date Taken? \_\_\_\_\_

I HAVE READ AND COMPLETED THIS APPLICATION AND I ATTEST THAT ALL INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I ALSO AGREE TO FOLLOW THE CODE OF ETHICS AS APPROVED BY THE BOARD.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_



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TO: PROSPECTIVE APPLICANT  
FROM: OFFICE OF LICENSING & REGISTRATION  
RE: CRIMINAL RECORDS CHECK

---

### CRIMINAL HISTORY RECORDS CHECK PROCEDURE

Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration **requires** a criminal history records check as part of the application process for all applicants.

Please complete the applicant information section and return it to the Board of Occupational Therapy with your completed application and supporting documentation as may be necessary.

You must provide a separate check in the amount of \$8.00, made payable to Maine State Treasurer, as payment for your criminal history record check in addition to the licensing fees presently required. The Department of Public Safety will not accept Visa or MasterCard as payment for the Criminal History Record Check. Please note that the criminal history record will be returned to the licensing board, not the applicant.

Public Law Chapter 401, sec. W-1, amends Title 25 §1541, sub-§6 to allow the State Bureau of Identification to charge a fee to government organizations for services provided. Therefore, as of October 1, 1999 all criminal background checks of individuals are subject to a fee as determined by the Commissioner of Public Safety.

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**(Clerk Name and Phone Number) Diane L. Staples  
(207) 624-8626**



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**CRIMINAL HISTORY RECORD CHECK FEE: \$8.00**

Make checks payable to: Treasurer, State of Maine  
**Submit this Application with License Application**

**APPLICANT INFORMATION**

Name: _____		
Last	First	Middle
Address: _____		
Social Security/Federal I.D. #: _____	Date of Birth: _____	
Any other names used: _____		

Please return the criminal history record information or a notice of no record to the following:

**REQUESTING AGENCY INFORMATION**

**(Office Use Only)**

Date: _____	Contact Person: <b>DIANE L. STAPLES</b>
Agency Name & Address:	<b>Office of Licensing and Registration Board of Counseling Professionals Licensure 35 State House Station Augusta, Maine 04333-0035</b>

[Attachment 2](#)



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**ACCOMMODATION REQUEST FORM**

*The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission.*

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**PHONE:** (     ) \_\_\_\_\_ **SOCIAL SECURITY #** \_\_\_\_\_

ACCOMMODATIONS REQUESTED FOR THE \_\_\_\_\_ EXAMINATION

(CHECK ALL THAT APPLY)

- ACCESSIBLE TESTING SITE
- SEPARATE TESTING AREA
- BRAILLE
- LARGE PRINT
- TAPE
- READER AS ACCOMMODATION FOR VISUAL IMPAIRMENT
- SCRIBE/AMANUENSIS AS ACCOMMODATION FOR VISUAL OR MOTOR IMPAIRMENT
- READER AS ACCOMMODATION FOR LEARNING DISABILITY
- SCRIBE/ANANUESIS AS ACCOMMODATION FOR LEARNING DISABILITY
- SIGN LANGUAGE INTERPRETER
- EXTENDED TIME
- TIME-AND-A-HALF
- DOUBLE TIME
- MORE THAN DOUBLE TIME(SPECIFY): \_\_\_\_\_
- USE OF COMPUTER OR OTHER ADAPTIVE EQUIPMENT (SPECIFY): \_\_\_\_\_
- OTHER \_\_\_\_\_

**COMMENTS:** \_\_\_\_\_

\_\_\_\_\_  
**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Attachment 3-Page 1**

**SOME ACCOMMODATION REQUESTS MAY REQUIRE ADDITIONAL DOCUMENTATION  
(see page 2)**



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## DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

IF YOU HAVE EXISTING DOCUMENTATION OF HAVING THE SAME OR SIMILAR ACCOMMODATION PROVIDED TO YOU IN ANOTHER TEST SITUATION, YOU MAY SUBMIT SUCH DOCUMENTATION INSTEAD OF HAVING THIS PORTION OF THE FORM COMPLETED.

I have known \_\_\_\_\_ since \_\_\_\_\_ in my capacity as a  
(test applicant) (date)

\_\_\_\_\_  
(professional title)

The applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, he/she should be accommodated by providing the following: (check all that apply)

- TAPED TEST
- LARGE PRINT TEST
- READER
- SCRIBE/AMANUENSIS
- EXTENDED TIME:
- TIME-AND-A-HALF
- DOUBLE TIME
- MORE THAN DOUBLE TIME (PLEASE JUSTIFY)
- SEPARATE TESTING AREA
- USE OF COMPUTER OR OTHER ADAPTIVE EQUIPMENT (PLEASE SPECIFY):

\_\_\_\_\_  
OTHER (PLEASE SPECIFY): \_\_\_\_\_

\_\_\_\_\_  
SIGNED: \_\_\_\_\_ TITLE: \_\_\_\_\_

DATE: \_\_\_\_\_ LICENSE # (if applicable): \_\_\_\_\_



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**AUTHORIZATION OF CREDIT CARD PAYMENT**

**Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.**

<b>Name:</b> (applicant fees being paid for)		
<b>Mailing Address:</b> (applicant fees being paid for)		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>County:</b>		<b>Telephone #:</b> (____) _____ - _____
<b>Name of cardholder:</b> (if other than applicant)		
<b>Mailing Address:</b> (if other than applicant)		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>

**I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:**

**Visa**     **MasterCard** \_\_\_\_\_ **Card number**

**Expiration date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **in the amount of: \$** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_



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**REFERENCE FORM**

**EACH APPLICANT MUST HAVE ONE FORM COMPLETED BY THREE DIFFERENT COUNSELING PROFESSIONALS.  
PLEASE PRINT OR TYPE**

Name of applicant \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone#(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name of Counseling Professional \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone #(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Professional title \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

It is required that each applicant shall demonstrate trustworthiness, ethical integrity and competence to engage in the practice of counseling in such a manner as to safeguard the interests of the public.

Do you believe that the above said applicant demonstrates trustworthiness, ethical integrity and competence? Yes \_\_\_\_\_ No \_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_  
Signature of Counseling Professional

\_\_\_\_\_  
Date

Attachment 4



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PLEASE PRINT OR TYPE**

Name of applicant \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone #(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name of Counseling Professional \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone #(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Professional title \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

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COMMENTS: \_\_\_\_\_

\_\_\_\_\_  
Signature of Counseling Professional

\_\_\_\_\_  
Date

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**REFERENCE FORM**

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PLEASE PRINT OR TYPE**

Name of applicant \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone #(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name of Counseling Professional \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone #(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Professional title \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

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Do you believe that the above said applicant demonstrates trustworthiness, ethical integrity and competence? Yes \_\_\_\_\_ No \_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_  
Signature of Counseling Professional

\_\_\_\_\_  
Date

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**SUPERVISOR'S AFFIDAVIT**

**TO BE COMPLETED BY A SUPERVISOR IN ACCORDANCE WITH CHAPTER 2 OF THE RULES**

(Please print or type) New Applicant \_\_\_\_\_ or conditionally licensed \_\_\_\_\_  
Name of Applicant \_\_\_\_\_ SS# \_\_\_\_\_  
Name of Approved Supervisor \_\_\_\_\_  
Supervisor's License Title and Number \_\_\_\_\_  
State of Licensure \_\_\_\_\_ Original Date \_\_\_\_\_ Expiration Date \_\_\_\_\_ Years in Practice \_\_\_\_\_  
Facility or Agency \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip Code \_\_\_\_\_ County \_\_\_\_\_ Telephone # \_\_\_\_\_

**IN WHICH SPECIALTY AREA:** (Please check)

Clinical Professional Counselor \_\_\_\_\_ Professional Counselor \_\_\_\_\_  
Marriage and Family Therapist \_\_\_\_\_ Pastoral Counselor \_\_\_\_\_

**SUPERVISION (List number of hours)**

Individual \_\_\_\_\_ Group Supervision \_\_\_\_\_ Total number of supervision hours \_\_\_\_\_

**SUPERVISED EXPERIENCE (List number of hours)\***

Hours of direct counseling with individuals \_\_\_\_\_ couples \_\_\_\_\_ families \_\_\_\_\_ groups \_\_\_\_\_  
Total hours of direct counseling \_\_\_\_\_  
Supervised experience in counseling other than the direct provision of counseling \_\_\_\_\_  
Total number of hours of supervised experience \_\_\_\_\_

**On the supervisor's stationary, signed and dated, please comment on the following:**

1. Please describe the applicant's functions in terms of prevention, diagnosis and treatment of mental illness/disorders and psychosocial treatment:
2. Please state briefly the licensee's personal character, ethical conduct, and competence:
3. Please comment on the licensee's ability to function as a counselor (i.e. strengths and weaknesses):

I HEREBY ATTEST THAT THE ABOVE-NAMED APPLICANT IS/WAS UNDER MY SUPERVISION FROM THE PERIOD OF \_\_\_\_\_ TO \_\_\_\_\_. I ATTEST THAT ALL INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Supervisor's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

If out-of state supervisor, please submit proof of license. Any clarification necessary for completion of this form must be provided by the applicant.\*Pastoral counselor supervisors will be required to follow requirements in Chapter 2, Section 4, C of the Rules.

Attachment 5



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DEGREE/INTERNSHIP VERIFICATION FORM  
DATE \_\_\_\_\_

TO: Board of Counseling Professionals Licensure  
Division of Licensing & Enforcement  
35 State House Station  
Augusta, ME 04333

Student Name: \_\_\_\_\_ SS# \_\_\_\_\_

Institution: \_\_\_\_\_

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

**Degree Verification**

Date of Graduation: \_\_\_\_\_ Program: \_\_\_\_\_

Degree Awarded: \_\_\_\_\_ Accreditation: \_\_\_\_\_

Concentration in which degree was awarded: \_\_\_\_\_

**Internship Verification**

Dates of Internship: \_\_\_\_\_ Clock Hours: \_\_\_\_\_

Signature of Person Verifying Degree/Internship: \_\_\_\_\_

Please Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Department: \_\_\_\_\_ Date: \_\_\_\_\_

**Attachment 6**



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OFFICE PHONE: (207)624-8626

FAX: (207)624-8637

(207)624-8653 (TTY/HEARING IMPAIRED)  
OFFICES LOCATED AT: 122 NORTHERN AVENUE,  
GARDINER, MAINE



ANGUS S. KING, JR.  
GOVERNOR

STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
**Board of Counseling Professionals Licensure**  
35 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0035  
(207) 624-8563 (TTY/HEARING IMPAIRED)

ANNE L. HEAD  
DIRECTOR

**VERIFICATION OF LICENSURE IN OTHER STATE**

**DIRECTIONS TO APPLICANT:**

Complete front portion of form and forward one to each state where you hold or have held a license to practice counseling, family therapy or pastoral counseling.

To: \_\_\_\_\_ I am applying for a license in the State of \_\_\_\_\_  
State Board

Maine to practice as a \_\_\_\_\_. I was granted license # \_\_\_\_\_

license type \_\_\_\_\_ on \_\_\_\_\_ by the State of \_\_\_\_\_.

The Maine Board of Counseling Professionals Licensure requests that I submit verification that my license in the State of \_\_\_\_\_ is in good standing.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Maine Board of Counseling Professionals Licensure. Your early attention is appreciated.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Note: Because some States charge a fee to complete this form, you should check \_\_\_\_\_ with each State before mailing.

(Page 2 to be completed by State)

**Attachment 7-Page 1**



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GARDINER, MAINE

DIRECTIONS TO STATE BOARD: Please complete and return form to the following address:  
MAINE BOARD OF COUNSELING PROFESSIONALS LICENSURE  
#35 STATE HOUSE STATION  
AUGUSTA, MAINE 04333

Name of Licensee: \_\_\_\_\_ License Type: \_\_\_\_\_

License #: \_\_\_\_\_ Date Issued: \_\_\_\_\_

License Current: Yes \_\_\_\_\_ No \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name of Exam Taken: \_\_\_\_\_ Date Exam Passed: \_\_\_\_\_

If no exam was taken, how was license obtained?

1. Grandfathered: \_\_\_\_\_ 2. Endorsement/Comity: \_\_\_\_\_ State: \_\_\_\_\_

What were the requirements for education and supervision at the time the license was issued?

---

---

Are there any pending complaints against this licensee?

Yes \_\_\_\_\_ No \_\_\_\_\_

Have there been any other actions taken against this licensee?

Yes \_\_\_\_\_ No \_\_\_\_\_

Explanation of above if answer is yes: \_\_\_\_\_

---

---

State Board Seal

Signature and Title: \_\_\_\_\_

Date: \_\_\_\_\_



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DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
**Board of Counseling Professionals Licensure**  
35 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0035  
(207) 624-8563 (TTY/HEARING IMPAIRED)

ANNE L. HEAD  
DIRECTOR

## EXAMINATION

APPLICANTS WHO APPLY FOR EXAMINATION MUST SUBMIT ALL MATERIALS REQUIRED FOR LICENSURE BEFORE APPROVAL TO SIT FOR AN EXAMINATION WILL BE GRANTED. APPLICATION FOR EXAMINATION MUST BE SUBMITTED AT LEAST 90 DAYS PRIOR TO EXAM.

APPLICATION FEES MAY BE PAID BY CHECK. CHECKS ARE TO BE MADE PAYABLE TO THE "MAINE STATE TREASURER".

THE BOARD DOES NOT TAKE AN ADVISORY ROLE IN AN APPLICANT'S COURSE SELECTION. TO DETERMINE IF YOU HAVE MET THE MINIMUM REQUIRED CORE COURSES AND/OR IF YOU QUALIFY FOR LICENSURE, PLEASE CAREFULLY READ THE BOARD'S LAW AND RULES.

BOARD MEETINGS ARE USUALLY HELD THE FOURTH MONDAY OF EACH MONTH. IN ORDER TO BE REVIEWED, APPLICATIONS MUST BE RECEIVED AT LEAST 2 WEEKS PRIOR TO THE BOARD MEETING.

YOU WILL BE INFORMED OF THE RESULTS OF THE APPLICATION IN WRITING APPROXIMATELY TWO WEEKS AFTER THE BOARD MEETING. RESULTS OF THE APPLICATION REVIEW WILL NOT BE GIVEN OVER THE TELEPHONE.



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AUGUSTA, MAINE  
04333-0035  
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ANNE L. HEAD  
DIRECTOR

**REQUEST FOR EXAMINATION**

**APPLICANTS WHO APPLY FOR EXAMINATION MUST SUBMIT ALL MATERIALS REQUIRED FOR LICENSURE BEFORE APPROVAL TO SIT FOR AN EXAMINATION WILL BE GRANTED.**

Please check the appropriate examination, fill in the information requested below and **return this form** will all other required application materials to the Maine Board of Counseling Professionals Licensure, 35 State House Station, Augusta, ME 04333.

Applicant for licensure as Professional Counselor, Clinical Professional Counselor, or Pastoral Counselor.

**(NCE)**\_\_\_\_\_ App. deadline: 10/12/1999 Exam Date: 01/22/2000  
App. deadline: 01/10/2000 Exam Date: 04/15/2000  
App. deadline: 07/10/2000 Exam date: 10/21/2000  
App. deadline: 10/10/2000 Exam date: 01/2001

Applicant for licensure as Marriage and Family Therapist.

**(PES)**\_\_\_\_\_ App. Deadline: 02/07/2000 Exam Date: 05/12/2000  
App. Deadline: 08/14/2000 Exam Date: 11/17/2000

If you require special accommodations, please fill out the **Accommodation Request Form** and return it with your application materials.

.....  
(Please Print)

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

TELPEHONE #: work \_\_\_\_\_ home \_\_\_\_\_ DATE: \_\_\_\_\_

**Attachment 8**



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DIRECTOR

**PREPARATION GUIDE FOR THE NATIONAL COUNSELOR EXAMINATION FOR  
LICENSURE AND CERTIFICATION (NCE)**

*The Official Guide for the NCE*

- Describes the NCE
- Answers commonly asked questions about the NCE
- Suggests test-taking strategies
- Helps you assess your strengths & weaknesses regarding the subject matter covered by the exam
- Assists you in setting study priorities
- Lists over 40 potential resources for study and review
- Provides 134 practice examination questions
- Includes 38 former examination questions with justified responses

Developed and distributed by the National Board for Certified Counselors (NBCC), this guide will help you understand and prepare for the National Counselor Examination for Licensure and Certification (NCE). In an effort to reduce anxiety regarding the examination, we have tried to anticipate your questions about the nature of the examination and the testing procedures.

**Price: \$24.95 (Price includes postage and handling)**

To order your preparation guide for the NCE, please detach the bottom portion of this form and mail it with your check, money order, or credit card information to:

**NBCC/NCE Preparation Guide  
3-D Terrace Way  
Greensboro, NC 27403**

-----  
Please send me \_\_\_\_\_ copy(s) of the PREPARATION GUIDE for the NATIONAL COUNSELOR EXAMINATION for LICENSURE and CERTIFICATION.

I am enclosing a check or money order payable to NBCC in the amount of \_\_\_\_\_, or please charge my: [  ] VISA [  ] MASTER CARD [  ] AMERICAN EXPRESS

Cardholder Name: \_\_\_\_\_ Account #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Amount Charged: \_\_\_\_\_

Send preparation guide to: Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

**Attachment 9**



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ANNE L. HEAD  
DIRECTOR

**Educational Requirements Worksheet for  
Licensed Marriage and Family Therapist**

**INSTRUCTIONS:** Place the relevant course(s) from your transcripts into the appropriate category on the worksheet. A single course may be listed only once and may **NOT** be used to fulfill more than one content area. **NOTE:** You must attach a college catalog, description or syllabus to substantiate the specific material included in each course listed on the worksheet. Also, include a letter from the University where you took your internship verifying the total number of on-site hours completed.

Content Area	Course No.	Course Title	Credit Hours	
			Qrt.	Sem.
1. Marital and Family Studies (minimum of 9 semester hours)				
2. Marital and Family Therapy (minimum of 9 semester hours)				
3. Human Development (minimum of 9 semester hours)				
4. Human Sexuality (minimum of 3 semester hours)				
5. Professional Studies (minimum of 3 semester hours)				
6. Clinical Practicum				

**NOTE: The following page contains the definitions of the above content areas  
PLEASE BE SURE TO INCLUDE THIS COMPLETED WORKSHEET WITH YOUR APPLICATION**

Attachment 10-Page 1



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GARDINER, MAINE

**Educational Requirements for Licensed Marriage and Family Therapist**

## **Chapter 2, Section 3A1**

**Marital and Family Studies:** Each applicant shall have completed at least nine (9) graduate semester hours or its equivalent. Coursework includes theories of family development, general systems theory, theories of family functioning, the family life cycle, sociology of the family, families under stress, contemporary family forms, family sub-systems, family of origin and external societal influences, family pathology such as addiction, child abuse and sexual abuse, and other related topics.

**Marital and Family Therapy:** Each applicant shall have completed at least nine (9) graduate semester hours or its equivalent. Coursework includes the study of major marital and family therapy treatment approaches and techniques to provide a substantive understanding of systems change. The coursework may include strategic, structural, integrative experiential, systems, neo-analytic, communications and behavioral treatment modalities.

**Human Development:** Each applicant shall have completed at least nine (9) graduate semester hours or its equivalent. Coursework includes the study of human development across the life cycle, personality theory, cognitive development, (diagnosis of) psychopathology.

**Human Sexuality:** Each applicant shall have completed at least three (3) graduate semester hours or its equivalent. Coursework includes the study of human sexuality over the life cycle, sex roles, sexual function and dysfunction.

**Professional Studies:** Each applicant shall have completed at least three (3) graduate semester hours or its equivalent. Coursework includes the following: study of professional ethics, family law, family violence, legal responsibilities and interprofessional co-operation, research and assessment.

**Clinical Practicum:** The one year clinical practicum: A minimum of 300 hours of direct client contact dealing with a range of marital and family therapy cases under supervision. Supervision includes, but is not limited to, direct observation by supervisor using either a one-way mirror, video, audio tapes or co-therapy.



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ANNE L. HEAD  
DIRECTOR

## SUGGESTED FORMAT FOR DISCLOSURE STATEMENT

### Disclosure Statement

- A. Name, M.S.**  
Such-and-such Counseling Service  
555 Main Street  
City, Maine (207) 666-7777
- B. Degree:** Highest degree and related field of study  
**Licensure:** LMFT, original: 5/93 expiration: 5/99
- C. Areas of competence** - I am trained for work with individuals, couples, and ....(continued concisely, but with a much detail as necessary to give clients an idea of the range of your skills).
- D. Course of treatment** - At the first interview ....(Include a description of your usual process of intake, assessment, goal setting, and treatment planning -- designed to give prospective client an idea of what to expect).
- E. Confidentiality** - A statement indicating the limits and scope of confidentiality. The following exceptions **must** be included:
  1. Threat of serious harm to self or others.
  2. Reasonable suspicion of child abuse, or abuse of elder or any incapacitated person.
  3. Court order.
  4. Voluntary release signed by client or guardian.
  5. In defense against legal action or formal complaint which client makes before a court or regulatory board.
  6. During supervisory consultations.
- F. Supervision** – A statement indicating supervision arrangement of counselor, when applicable.
- G. Fee schedule, hours of business, policy regarding third party payments** - explained with whatever words provide information with clarity.
- H. Accountability** - A statement to the effect that “the practice of counseling is regulated by the Department of Professional and Finance Regulation, and complaints may be registered by contacting:
 

Board of Counseling Professionals Licensure  
35 State House Station  
Augusta, ME 04333  
(207) 624-8626

 Additional accountability procedures that may pertain to professional organizations.



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