TEXAS BEHAVIORAL HEALTH EXECUTIVE COUNCIL
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 is requested	License Number	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 below. Attach copies of any verification of supervision or supervised experience toward LMFT licensure.)

Name of Licensee	Licensure Level	License #	Date of issuance	Expiration Date
Exam Taken _____ **AMFTRB** ____ **Other** (specify)_____			**Date Exam Passed**	**Exam Score**

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 attach copies of supervised clinical experience documentation.

License Current? Expiration Date	Complaints and/or Disciplinary Action
____ Yes ____ No _____	_____ Yes* _____ No

***Please attach copies of any disciplinary orders. Explain Complaints or Disciplinary Actions:**

_____

Board Seal of State Board verifying License

_____ _____

Signature Date

Name (printed)	Title	Phone number

Mail to: TX BHEC TSBEMFT, 333 Guadalupe Ste 3-900, Austin, TX 78701