

FORM II

**NORTH DAKOTA MARRIAGE AND FAMILY THERAPY
LICENSURE BOARD**

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

Printed Name

Title

Telephone Number

Signature

Date

Mail Completed Form To:
North Dakota State Board of Marriage and Family Therapists
c/o Mallary Schaefer
20 1st St SW
Suite 250
Minot, ND 58701