NORTH CAROLINA MARRIAGE AND FAMILY THERAPY LICENSURE BOARD
201 Shannon Oaks Circle, Cary, NC 27511
Phone: (919) 654-6914 Fax: (919) 336-5156 Email: ncmftlb@nc.rr.com Web: www.nclmft.org

NORTH CAROLINA APPLICATION FOR LICENSED MARRIAGE AND FAMILY THERAPIST (LMFTA or LMFT)

Prior to completing this form, print and review the application instructions provided.

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Demographic Information:
1. Name (Last, First, Middle)
2. Other Names
3. Will documents be submitted in another name(s)? □ Yes □ No If yes, list name(s):
4. Date of Birth (mm/dd/yyyy)
5. Home/Private Mailing Address (Street and/or Box)
6. City, State, Zip
7. Business/Public Mailing Address (Street and/or Box)
8. City, State, Zip
9. Home/Private Phone (include area code) Business/Phone (include area code)
10. E-Mail – Non-Published E-Mail – Published
11. Do you consent to receiving information about your application or license from the Board via email? □ Yes □ No
12. Are you Active Duty Military or the Spouse of an Active Duty Member of the Military? □ Yes □ No

Personal Data Information: **Name (Last, First, Middle)**
13. Have you been convicted of a felony or entered a plea of guilty or nolo contendere to any felony charge under the laws of the United States or of any state of the United States, including a military court martial? □ Yes □ No
14. Have you been convicted of or entered a plea of guilty or nolo contendere to any misdemeanor involving moral turpitude, misrepresentation, or fraud in dealing with the public, or conduct otherwise relevant to fitness to practice marriage and family therapy, or a misdemeanor charge reflecting the inability to practice marriage and family therapy with due regard to the health and safety of clients. □ Yes □ No
15. Have you engaged in fraud or deceit in securing or attempting to secure a license or have you willfully concealed from the Board material information in connection with an application for a license? □ Yes □ No
16. Have you practiced any fraud, deceit, or misrepresentation upon the public, the Board, or any individual in connection with the practice of marriage and family therapy, the offer of professional marriage and family therapy services, the filing of Medicare, Medicaid, or other claims to any third-party payor, or in any manner otherwise relevant to fitness for the practice of marriage and family therapy? □ Yes □ No
17. Have you made fraudulent, misleading, or intentionally or materially false statements pertaining to education, licensure, license renewal, supervision, continuing education, any disciplinary actions or sanctions pending or occurring in any other jurisdiction, professional credentials, or qualifications or fitness for the practice of marriage and family therapy to the public, any individual, the Board, or any other organization? □ Yes □ No
18. Have you had a license or certification denied, suspended or revoked, or have you been disciplined by or are you currently under investigation by a licensing or certification board in any other jurisdiction? □ Yes □ No
19. Have you aided or abetted the unlawful practice of marriage and family therapy by any person not licensed by the Board? □ Yes □ No
20. Have you demonstrated or been advised of an inability to practice marriage and family therapy with reasonable skill and safety by reason of illness, inebriation, misuse of drugs, narcotics, alcohol, chemicals, or any other substance affecting mental or physical functioning, or as a result of any mental or physical condition. □ Yes □ No
21. Have you practiced marriage and family therapy outside the boundaries of demonstrated competence or the limitations of education, training, or supervised experience? □ Yes □ No
22. Have you been guilty of immoral, dishonorable, unprofessional, or unethical conduct as defined in this subsection or in the current code of ethics of the American Association for Marriage and Family Therapy? □ Yes □ No
23. Have you ever been involved in, reprimanded for or disciplined by an employer or educational institution for misconduct including acts of dishonesty, fraud or deceit; lying or misrepresentation of credentials; academic misconduct including acts such as cheating or plagiarism; theft; or sexual harassment? □ Yes □ No

Examination: Name (Last, First, Middle)

24.

Have you passed the National MFT Examination? □ **Yes** □ **No**
If yes, answer the following:

a) Date of Examination (mm/dd/yyyy) _____
b) Exam Score _____
c) How many times have you taken the National MFT Exam? _____
d) Which state approved you to take the National MFT Exam?
□ **North Carolina** □ **Other (list name of state)** _____

If you have not passed the National MFT Exam, answer the following:
e) Have you registered with and scheduled an examination date with the examination service?
□ **Yes** □ **No** *(If 'no', do not submit this application for licensure as it will not be reviewed.)*
f) Date you are scheduled to take the examination _____

Note: If you do not take or pass a scheduled exam, then a licensure application submitted BEFORE you pass the examination will be automatically denied which means a new application, related application documents and application fee will be required as the submitted application will not be retained.

Other License, Certification or Registration

List all states (including North Carolina) where credentials are or were held.

25.

State	Type	Number	Issue Date	Expiration Date

Endorsers

26.

Name	Mailing Address	Phone *(include area code)*

Education

27.

Graduate Institution	Attended From (m/yy) (a)	Attended To (m/yy) (b)	Degree Confer Date (m/yy) (c)	Degree Type (d)	Degree Name (e)	Specialization or Concentration (f)

Educational Qualifications:

Name (Last, First, Middle)

28.Theoretical Foundation of Marriage and Family Therapy

(2 courses minimum) 6 semester credits or 9 quarter credits.

Course Title	Number	Semester Credits	Quarter Credits

29. Practice of Marriage and Family Therapy

(2 courses minimum) 6 semester credits or 9 quarter credits.

Course Title	Number	Semester Credits	Quarter Credits

30. Assessment and Diagnosis

(1 course minimum) 3 semester credits or 5 quarter credits.

Course Title	Number	Semester Credits	Quarter Credits

31. Human Development and Family Relations

(1 course minimum) 3 semester credits or 5 quarter credits.

Course Title	Number	Semester Credits	Quarter Credits

32. Professional Identity and Ethics

(1 course minimum) 3 semester credits or 5 quarter credits.

Course Title	Number	Semester Credits	Quarter Credits

Name (Last, First, Middle)			
33. Research in Marriage and Family Therapy (1 course minimum) 3 semester credits or 5 quarter credits.			
Course Title	Number	Semester Credits	Quarter Credits
34.Supervised Clinical Practicum (3 practicums minimum) 9 semester credits or 14 quarter credits.			
Course Title	Number	Semester Credits	Quarter Credits
36. Electives (Minimum of 12 semester credits or 18 quarter credits)			
Course Title	Number	Semester Credits	Quarter Credits

Experience: **Name (Last, First, Middle)** **37.**					
Start Date (mm/yyyy)	**End Date (mm/yyyy)**	**Company/ Organization, Mailing Address & Phone**	**Position/Title**	**Duties (general description/ summary**	***Supervisor's Name***

Affidavit: **Name (Last, First, Middle)**
38.

APPLICANT

a. I affirm that the information I am submitting is true and correct to the best of my knowledge and belief.
b. I authorize the North Carolina Marriage and Family Therapy Licensure Board to communicate with any person or entity in connection with this or any subsequent application filed with the Board.
c. I authorize the release of any files or records needed to process this application.
d. I understand that a criminal background check, at my expense, can be requested by the Board.
e. I will hold the Board, its members, officers and agents, free from any damage or complaint by reason of any action they, or any of them, may take in connection with this request.
f. I have read the AAMFT Code of Ethics and I will adhere to the ethical standards of conduct in Marriage and Family Therapy as adopted by the North Carolina Marriage and Family Therapy Licensure Board, i.e. AAMFT Code of Ethics.
g. I have reviewed the NC Statutes and Rules which may be accessed at www.nclmft.org.
h. I have reviewed the instructions describing the application process.
i. I am of good moral character and have not engaged in any practice or conduct that would be a ground for denial, revocation, or suspension of a license under G.S. 90-270.60.
j. I am the person who executed this application.
k. I have not suppressed information that might affect this application.
l. I declare and affirm that the statements made in this application are true, complete and correct.
m. I understand that giving the Board false information of any kind may result in the voiding of this application and denial of licensure.
n. I understand that this application cannot be processed unless it has been notarized and then mailed or delivered directly to the Board's office.
o. I understand that the fee submitted with this application is not refundable.
p. I understand that incomplete applications will not be processed and may be returned.
q. I have read and understood this affidavit.

Name: (please print) _____

Signature_____ Date_____

NOTARY

The undersigned, _____(name of document signer), personally appeared before me and proved to me through satisfactory evidence of identification, one of the following acceptable forms of identification: State-issued driver's license, Military identification or State-issued identification card, to be the person whose name is signed on the preceding or attached document, and acknowledged to me that it was signed voluntarily for its stated purpose.

_____

Notary Public: Notary Commission Expires On

Sworn to me this_____day of_____, _____

State of _____ (Seal)

39. APPLICANT: ATTACH PHOTO HERE

Do Not Staple. Use Tape or Glue Only.

Original photograph (not a computer printed one), measuring approximately 2" x 2" and taken within one year of the filing of this application. Photograph must be of passport quality of your head and shoulders only.

40. APPLICANT SOCIAL SECURITY NUMBER
You are required by state and federal law to provide a social security number with your application.

_____

This page intentionally left blank.

See instruction numbers:

41. (Examination Reporting)
42. (Transcript Submission for required document attachments)
43. Verification of Licensure in Other States (if applicable)

Endorser 1: **Name – Applicant (Last, First, Middle)**
44.

To Endorser (*Please print*):_____

Instructions to the Endorser: The above-named individual is preparing to make application for licensure to the NC Marriage and Family Therapy Licensure Board and has listed you as a reference/endorser. Please complete and return this form to the applicant in a sealed envelope with your signature over the seal. Forms submitted without the endorser's signature over the seal will not be accepted. Faxed copies are not accepted.

1. How long have you known the applicant?

2. What is your professional relationship with the applicant?

3. What is your knowledge of the applicant's professional qualifications?
   □ Limited □ Moderate □ Thorough

4. To the best of your knowledge, do you find the applicant adheres to legal and ethical standards? □ Yes □ No

5. Are you aware of any issues that would impair the individual's ability to practice?
   □ Yes □ No
   If yes, please explain. Attach separate page (*do not write on the reverse of this page*).

6. Please note any areas of concern, comments or recommendations to the Board. Attach separate page if necessary (*do not write on the reverse of this page*).

_____
(Endorser's signature) (Date)

_____
(Address)

_____
(Email) (Phone)

RETURN FORM TO: the applicant in a sealed envelope with your signature over the seal.

Endorser 2: **Name – Applicant (Last, First, Middle)**
44.

To Endorser (*Please print*):_____

Instructions to the Endorser: The above-named individual is preparing to make application for licensure to the NC Marriage and Family Therapy Licensure Board and has listed you as a reference/endorser. Please complete and return this form to the applicant in a sealed envelope with your signature over the seal. Forms submitted without the endorser's signature over the seal will not be accepted. Faxed copies are not accepted.

1. How long have you known the applicant?

2. What is your professional relationship with the applicant?

3. What is your knowledge of the applicant's professional qualifications?
   □ Limited □ Moderate □ Thorough

4. To the best of your knowledge, do you find the applicant adheres to legal and ethical standards? □ Yes □ No

7. Are you aware of any issues that would impair the individual's ability to practice?
   □ Yes □ No
   If yes, please explain. Attach separate page (*do not write on the reverse of this page*).

5. Please note any areas of concern, comments or recommendations to the Board. Attach separate page if necessary (*do not write on the reverse of this page*).

_____
(Endorser's signature) (Date)

_____
(Address)

_____
(Email) (Phone)

RETURN FORM TO: the applicant in a sealed envelope with your signature over the seal.

Endorser 3: **Name – Applicant (Last, First, Middle)**
44.

To Endorser (*Please print*):_____

Instructions to the Endorser: The above-named individual has made application to the NC Marriage and Family Therapy Licensure Board and has listed you as a reference/endorser. Please complete and return this form to the applicant in a sealed envelope with your signature over the seal. Forms submitted without the endorser's signature over the seal will not be accepted. Faxed copies are not accepted.

1. How long have you known the applicant?

2. What is your professional relationship with the applicant?

3. What is your knowledge of the applicant's professional qualifications?
   □ Limited □ Moderate □ Thorough

4. To the best of your knowledge, do you find the applicant adheres to legal and ethical standards? □ Yes □ No

8. Are you aware of any issues that would impair the individual's ability to practice?
   □ Yes □ No
   If yes, please explain. Attach separate page (*do not write on the reverse of this page).*

5. Please note any areas of concern, comments or recommendations to the Board. Attach separate page if necessary (*do not write on the reverse of this page).*

_____
(Endorser's signature) (Date)

_____
(Address)

_____
(Email) (Phone)

RETURN FORM TO: the applicant in a sealed envelope with your signature over the seal.

Clinical and Supervision Reports Summary

45. Name – Applicant (Last, First, Middle)

Office Use Only	*Report From*	*Report To*	*Individual Clinical Hours*	*Group Clinical Hours*	*Relational Clinical Hours*	*Assess-ment Hours*	*Psycho-Education Hours*	*Total Clinical Hours*	*Individual Supervision Hours*	*Group Supervision Hours*	*Total Supervision Hours*
			Pre-Degree	**Pre-Degree**	**Pre-Degree**	**Pre-Degree**	**Pre-Degree**	**Pre-Degree**	**Pre-Degree**	**Pre-Degree**	**Pre-Degree**
		Total Pre-Degree									
Office Use Only	*Report From*	*Report To*	*Individual Clinical Hours*	*Group Clinical Hours*	*Relational Clinical Hours*	*Assess-ment Hours*	*Psycho-Education Hours*	*Total Clinical Hours*	*Individual Supervision Hours*	*Group Supervision Hours*	*Total Supervision Hours*
			Post-Degree	**Post-Degree**	**Post-Degree**	**Post-Degree**	**Post-Degree**	**Post-Degree**	**Post-Degree**	**Post-Degree**	**Post-Degree**
		Total Post-Degree									

For Office Use Only, do not write in this section:

Clinical Hours – Up to 500 pre-degree may be accepted. Maximum Assessment and Psycho-Education Accepted = 250 each. Minimum of 500 relational required for licensure as LMFT. Supervision – A minimum of 25 supervision hours post-degree required.

Individual & Group Clinical Accepted	*Relational Clinical Accepted*	*Assessment Accepted*	*Psycho-Education Hours Accepted*	*Total Clinical Accepted*	*Individual Supervision Accepted*	*Group Supervision Accepted*	*Total Supervision Accepted*
Individual and/or Group Pending	*Relational Pending*	*Total Clinical Hours Pending*	*Total Supervision Pending*				

Clinical and Supervision Report: Pre-Degree

46. (Last, First, Middle)

To: Supervisor's Name *(Please print)*_____

Instructions to the Supervisor: The above-named individual is preparing to make application to the NC Marriage and Family Therapy Licensure Board and has listed you as a supervisor. Please complete and return this form to the applicant in a sealed envelope with your signature over the seal. In addition, send a copy of the completed form to the supervisee. Forms submitted without the supervisor's signature over the seal will not be accepted. Faxed or emailed copies are not accepted by the Board.

Check One:

☐ **AAMFT Approved Supervisor:** Certification Date_____ Expiration Date _____
(Attach a copy of your approved supervisor certificate or a letter from AAMFT which includes the date you were certified as an AAMFT Approved Supervisor and the expiration date of the certification.)

☐ **AAMFT Supervisor Candidate:** under the supervision of _____
(Attach a copy of your supervisor candidate verification form.) (Approved Supervisor's name)

☐ **Other Supervisor Credentials:** _____

Period of Supervision From:_____ To:_____
(mm/dd/yyyy) (mm/dd/yyyy)

46. CLINICAL HOURS:

Individual	*Group*	*Relational*	*Assessments*	*Psycho-education*	*Total Clinical Hours*

46. SUPERVISION HOURS:

Individual	*Group*	*Total Supervision Hours*

The Board reserves the right to require tracking logs for verification of hours submitted.

☐ My signature attests to the accuracy of (1) my supervisory status; and (2) supervision was provided in accordance with section .0502 (b & c) of the NC Administrative Code defined as: Approved ongoing supervision shall focus on the raw data from the supervisee's continuing clinical practice, which shall be available to the supervisor through a combination of direct observation, co-therapy, written clinical notes, and audio and video recordings. None of the following shall be deemed to constitute acceptable approved ongoing supervision: peer supervision, i.e., supervision by a person of equivalent, rather than superior qualifications, status and experience; supervision by current or former family members or any other persons where the nature of the personal relationship prevents or makes difficult the establishment of a professional relationship; administrative supervision - for example, clinical practice performed under administrative rather than clinical supervision by an institutional director or executive; a primarily didactic process wherein techniques or procedures are taught in a classroom, workshop or seminar; consultation, staff development, or orientation to a field or program, or role-playing of family interrelationships as a substitute for current clinical practice in an appropriate clinical situation.

Supervisor's Address: _____

Supervisor's E-Mail:_____ Phone_____

Supervisor's signature: _____ Date _____

RETURN FORM TO: the applicant in a sealed envelope with your signature over the seal.

Clinical and Supervision Report: Post-Degree

47. (Last, First, Middle)

To: Supervisor's Name *(Please print)*_____

Instructions to the Supervisor: The above-named individual is preparing to make application to the NC Marriage and Family Therapy Licensure Board and has listed you as a supervisor. Please complete and return this form to the applicant in a sealed envelope with your signature over the seal. In addition, send a copy of the completed form to the supervisee. Forms submitted without the supervisor's signature over the seal will not be accepted. Faxed or emailed copies are not accepted by the Board.

Check One:

☐ **AAMFT Approved Supervisor:** Certification Date_____Expiration Date _____
(Attach a copy of your approved supervisor certificate or a letter from AAMFT which includes the date you were certified as an AAMFT Approved Supervisor and the expiration date of the certification.)

☐ **AAMFT Supervisor Candidate:** under the supervision of _____
(Attach a copy of your supervisor candidate verification form.) (Approved Supervisor's name)

☐ **Other Supervisor Credentials:** _____

Period of Supervision From:_____To:_____

(mm/dd/yyyy) (mm/dd/yyyy)

47. CLINICAL HOURS:

Individual	*Group*	*Relational*	*Assessments*	*Psycho-education*	*Total Clinical Hours*

47. SUPERVISION HOURS:

Individual	*Group*	*Total Supervision Hours*

The Board reserves the right to require tracking logs for verification of hours submitted.

☐ My signature attests to the accuracy of (1) my supervisory status; and (2) supervision was provided in accordance with section .0502 (b & c) of the NC Administrative Code defined as: Approved ongoing supervision shall focus on the raw data from the supervisee's continuing clinical practice, which shall be available to the supervisor through a combination of direct observation, co-therapy, written clinical notes, and audio and video recordings. None of the following shall be deemed to constitute acceptable approved ongoing supervision: peer supervision, i.e., supervision by a person of equivalent, rather than superior qualifications, status and experience; supervision by current or former family members or any other persons where the nature of the personal relationship prevents or makes difficult the establishment of a professional relationship; administrative supervision - for example, clinical practice performed under administrative rather than clinical supervision by an institutional director or executive; a primarily didactic process wherein techniques or procedures are taught in a classroom, workshop or seminar; consultation, staff development, or orientation to a field or program, or role-playing of family interrelationships as a substitute for current clinical practice in an appropriate clinical situation.

Supervisor's Address: _____

Supervisor's E-Mail:_____Phone_____

Supervisor's signature: _____Date _____

RETURN FORM TO: the applicant in a sealed envelope with your signature over the seal.

Supervision Agreement: LMFTA APPLICANTS ONLY

48. (Last, First, Middle)

To: Supervisor's Name *(Please print)*_____

Instructions to the Supervisor: The above-named individual is preparing to make application to the NC Marriage and Family Therapy Licensure Board for Licensed Marriage and Family Therapy (LMFTA) practice in the State of North Carolina and has listed you as their potential approved supervisor. Please complete and return this form to the applicant in a sealed envelope with your signature over the seal. In addition, send a copy of the completed form to the supervisee. Forms submitted without the supervisor's signature over the seal will not be accepted. Faxed or emailed copies are not accepted by the Board.

Check One:

☐ **AAMFT Approved Supervisor:** Certification Date _____Expiration Date_____
(Attach a copy of your approved supervisor certificate or a letter from AAMFT which includes the date you were certified as an AAMFT Approved Supervisor and the expiration date of the certification.)

☐ **AAMFT Supervisor Candidate:** under the supervision of _____
(Attach a copy of your supervisor candidate verification form.) (Approved Supervisor's name)

(The Board reserves the right to require a fully credentialed supervisor, not a candidate in instances in which an applicant has limited pre-degree clinical experience or is being considered for licensure with a related mental health degree.)

Note: Supervisors for NC LMFTAs, in addition to the above qualifications, must be a licensed mental health practitioner in the State of North Carolina.

By signing the **NC Marriage and Family Therapy Licensure Board Supervision Agreement**, you have agreed to:

- Provide ongoing clinical supervision in a professional setting.
- Discuss and review live sessions, case notes, charts, records and available audio or visual tapes for all clients in accordance with treatment plans.
- Monitor the appropriateness of clients served based on the supervisee's therapeutic skill, directing the supervisee to refer clients who fall beyond their level of competence.
- Review North Carolina licensing law, administrative rules and the Code of Ethics with the supervisee.
- Establish and maintain a record-keeping system to track each supervisee's client contact and supervision hours and agree to provide this supporting documentation upon request by the Board.
- Submit quarterly supervision reports on Board approved forms within one month of end of the reporting period and provide a copy to the supervisee.
- Notify the Board of any changes to your (supervisor) contact information, licensing status or any change in your status as an AAMFT Approved Supervisor.
- **Notify the Board immediately of any interruption or proposed termination of the supervision plan *(i.e. termination of supervision contract or supervisee fails to obtain a minimum of one hour of supervision per month).***
- **Notify the Board if you have concerns about a supervisee being licensed.**

☐ **My signature attests to the accuracy of (1) my supervisory status; and (2) I have agreed to provide supervision for the above person working toward licensure in accordance with section .0502 (b & c) of the NC Administrative Code and Supervision Guidelines incorporated with this agreement as Supervision Agreement - Addendum 1 (two pages)**

Supervisor's Address: _____

Supervisor's E-Mail:_____Phone_____

Supervisor's signature: _____Date _____

RETURN FORM TO: the applicant in a sealed envelope with your signature over the seal.

Supervision Agreement: LMFTA APPLICANTS ONLY Addendum 1

NC ADMINISTRATIVE CODE 21 NCAC 31 .0502 (b & c)

(b) On-going supervision shall focus on the raw data (quantitative information about the client) from the supervisee's continuing clinical practice, which shall be available to the supervisor through a combination of direct observation, co-therapy, written clinical notes, and audio and video recordings.

(c) None of the following constitutes ongoing supervision:

(1) Peer supervision, i.e., supervision by a person of equivalent, rather than superior, qualifications, status and experience;

(2) Supervision by current or former family members of your immediate or extended family, or any other persons where the nature of the personal relationship prevents or makes difficult the establishment of a professional relationship;

(3) Administrative supervision - clinical practice performed under administrative rather than Clinical supervision by an institutional director or executive;

(4) A primarily didactic process wherein techniques or procedures are taught in a classroom, workshop or seminar; or

(5) Consultation, staff development or orientation to a field or program or role-playing of family interrelationships as a substitute for clinical practice in a clinical situation.

CLINICAL EXPERIENCE SITE

The clinical experience work site may include community-based agencies, institutions, hospitals, schools, and private practice. Work experience may be either paid or unpaid.

GENERAL INFORMATION

- Supervisor is not required to be on-site or come from within the same agency. LMFTAs may secure appropriate supervision by contracting with a supervisor.
- Approved supervisors in North Carolina must be AAMFT Approved Supervisors or AAMFT Approved Supervisory Candidates.
- The purpose of the supervision agreement is to enhance the applicant's professional development while meeting licensing requirements, keeping in mind the responsibilities to clients and the profession.
- Supervisors are expected to know and abide by *this* Board's Code of Ethics (AAMFT Code of Ethics)..
- A supervisor may not be a spouse, relative by blood or marriage, a person of close personal relationship, or former therapist.
- NC has a two-tier licensure system: LMFT and LMFTA. Once approved by the NC MFT Licensure Board as an LMFTA the licensee then begins their accumulation of hours toward full, unrestricted licensure (LMFT).
- In the State of NC, accumulating hours toward LMFT, once no longer in the qualifying degree program can only be obtained **post-licensure, not post-graduate.** In other words, until approved as an LMFTA, practice is not authorized and thus hours toward full licensure cannot be accumulated. There are limited exemptions to the requirement for licensure in NC that allows the practice of MFT (a licensed hospital or government entity such as the military or licensure in another exempt discipline). Information about exempt settings, refer to NC Statute 90-270.48A.
- Experience completed in other jurisdictions (states other than NC) must be completed legally in accordance with the laws of the jurisdiction. The NC LMFTA is issued for practice in NC.
- Supervisors are accountable for the supervisee's practice.
- Supervisors should gain thorough knowledge of the supervisee's practice activities including: practice setting, record keeping, financial management, ethics of clinical practice, a back-up plan for coverage.
- Supervisors should verify a supervisee is authorized to legally practice in the State of North Carolina prior to beginning supervision.

CLINICAL HOURS

- A minimum of 1500 client contact hours is required to achieve licensure as an LMFT. The LMFTA allows for acquisition of the total experience hours required for LMFT. Up to 500 hours earned while a student, under an AAMFT Approved Supervisor may be counted toward licensure requirements. Of the required 1500 clinical hours for LMFT, a minimum of 500 hours must be relational hours.

- **Clinical Contact Hours** are defined as face-to-face (therapist and client) therapy with individuals, couples, families, or groups from a systemic perspective and includes relational hours. Distance counseling, where the supervisee provides therapy directly to a client (video, i.e. Skype, secure, encrypted connection) may be counted in the same way as face-to-face hours. Telephone counseling is NOT face-to-face and therefore cannot be counted toward clinical contact hours for LMFTAs.

- Direct client contact must relate to client treatment plans, be goal directed; and assist client(s) to effect change in relationships, cognition, affect, and/or behavior. Assessments (intake and otherwise) may be counted up to 250 hours of direct client contact. Assessment is a clinical encounter that involves gathering of current and historical data from a client that is then used to determine what type of therapeutic service is most appropriate. If the individual who conducted the assessment does not provide the therapeutic service, it is considered an assessment hour only. Client psycho-education may be counted up to 250 hours direct client contact. Psycho-education refers to a treatment approach that provides education for individuals and families in assistance with emotional, mental, social and relational disturbances.

- The following are **not direct client contact** and may not be counted: observing therapy without actively participating in follow-up therapy at some point during or immediately following the session; record keeping; administrative activities; supervision; and client contact while not receiving supervision.

- **Relational hours** are defined as hours spent providing therapy with more than one client in the room who are all part of the same treatment plan. Relational hours may also include face-to-face communication with members of the larger system who are also working in direct collaboration with the same client(s). This contact may only be counted if it is authorized by the client(s) or required by law for the purpose of developing and carrying out a treatment plan.

SUPERVISION HOURS

Graduates of marriage and family therapy programs who have completed 200 hours of approved ongoing supervision of their clinical hours within their degree shall complete a minimum of an additional 25 hours of approved ongoing supervision post-degree (LMFTA licensure) concurrently with the completion of the remaining hours of post-degree clinical experience.

- Individual Supervision is defined as no more than 2 supervisees per session.
- Group Supervision is defined as 2- 6 individuals in a supervisory session.
- Supervision Hour is defined as minimum of 50 clock minutes.
- Frequency of Supervision: There must be a minimum of one hour of supervision per month.
- Supervision must involve discussions of live sessions, case notes, charts, records, and available audio or video tapes. The review should evaluate the appropriateness of the services to clients and the supervisee's therapeutic skill. Supervision must occur in a professional setting, one on one with the supervisee, or privately with a small group of other supervisees.
- Supervision encourages responsible provision of services, promotes the welfare and best interests of clients, fosters refinement of skills, and promotes personal and professional development.
- Supervision should include: setting goals, responsibilities, practical arrangements, licensing requirements -- laws, rules, personal time management, strategies of clinical decision-making, prioritizing responsibilities, professional relationships, coordinating with other professionals and staff, ethical, and cultural consideration.
- Evaluation of practice should include: diagnosis, assessment and identification of presenting problems, application of ethics, research methods, knowledge of human behavior and/or social environment, termination of clinical relationships, methods for maintaining clinical/professional boundaries, treatment planning, and therapeutic interventions or treatment approaches.