

SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES
**SOUTH DAKOTA BOARD OF EXAMINERS FOR COUNSELORS &
MARRIAGE AND FAMILY THERAPISTS**

PO BOX 340, 1351 N. Harrison Ave., Pierre, SD 57501
Tel: 605.224.1721 Email: sdbce@midwestsolutionsd.com
Website: dss.sd.gov/licensingboards/counselors/counselors.aspx

APPLICATION FOR PLAN OF SUPERVISION—MARRIAGE AND FAMILY THERAPIST

No supervision hours can accrue until a Plan of Supervision is approved for the applicant.

Please submit:

- 1) Completed application;
- 2) **Attachment 1** completed and submitted directly to the Board by your Proposed Supervisor;
- 3) Proof of graduation (i.e. transcripts) from a COAMFTE or CACREP approved program or a 48-hour master's degree in counseling from an accredited Institution submitted directly to the Board;
- 4) Verification of other licenses;
- 5) Quality color photograph of applicant;
- 6) Verification of any name change (i.e. marriage/divorce); and
- 7) Non-refundable \$100 application fee.

*The application fee for a Plan of Supervision is non-refundable. If the applicant uses more than one approved supervisor to meet the supervision requirements for full licensure, no fee will be charged for additional supervisors. If adding a 2nd (or 3rd) Supervisor, complete Page 1 and **Attachment 1**.*

APPLICANT INFORMATION

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

E-mail: _____ Phone: _____

Name of Business: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

PROPOSED SUPERVISOR NAME

Name: _____ SD License Number: _____ Issue Date of License: _____

License type: LPC-MH LMFT

Attachment 1 Completed: **Yes** **No** *Attachment 1 must be completed and submitted directly to the Board by the Proposed Supervisor.*

EDUCATION

Name of Post Graduate Institution: _____

City/State: _____

Date of Graduation: _____ Degree: _____

Was your program of study COAMFTE or CACREP approved? Yes No*

**If No, complete Attachment 2 and document the content areas of your education.*

Please request your school send an official copy of your transcripts directly to the South Dakota Board of Examiners for Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD 57501 or electronically to sdbce@midwestsolutionssd.com. Transcripts must be received directly from the school to be valid. Date requested: _____

NATIONAL EXAMINATION

A passing score on the MFT National Examination is required prior to applying for licensure for Licensed Marriage & Family Therapist (LMFT).

When completed, request your official MFT national exam score be sent to the South Dakota Board of Examiners for Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD 57501 or released to the Board through the AMFTRB online results portal.

MILITARY STATUS

YES NO Are you a member or the spouse of a member of the armed forces of the United States?

If Yes, were you or your spouse the subject of a military transfer to South Dakota? Yes No

If Yes, did you leave employment to accompany your spouse to South Dakota? Yes No

LEGAL QUESTIONS (If you answer yes to any question below, please provide a separate written explanation.)

YES NO Have you ever been convicted, pled no contest/nolo contendere, pled guilty or been granted a deferred judgment or suspended imposition of sentence or had prosecution deferred with respect to a felony?

YES NO Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgement or suspended imposition of sentence, or had prosecution deferred with respect to a misdemeanor other than a class 2 traffic offense?

YES NO Have you been disciplined with a reprimand, censure, suspension, temporary suspension, probation, revocation, or refusal to renew a professional license in any state?

YES NO Are you \$1,000 or more behind in child support payments?

YES NO Have you previously made application for licensure to this Board?

OTHER LICENSES

Do you currently hold a valid license to practice counseling in another state? YES NO
If yes, which state(s)? _____

If yes, please request the issuing state send a Letter of Verification to the South Dakota Board of Examiners for Counselors & Marriage and Family Therapists at PO Box 340, Pierre, SD 57501 or electronically to sdbce@midwestsolutionssd.com. Date requested: _____

STATISTICAL INFORMATION

These questions are asked for statistical purposes. Your answers are optional.

What is your gender? Female Male

What is your race? Please check all that apply.

- Asian
- American Indian or Alaska Native
- Black or African American
- Native Hawaiian or Pacific Islander
- Hispanic or Latino
- White or Caucasian
- Other
- Decline to Provide

APPLICATION FEE Please include a personal check, cashier’s check, certified check or money order made payable to the State of South Dakota for the applicable amount.

\$100 non-refundable application fee

To be signed in the presence of a Notary Public

BY MY SIGNATURE BELOW, I VERIFY, UNDER PENALTY OF PERJURY, THAT I AM THE APPLICANT COMPLETING THIS APPLICATION AND THAT ALL INFORMATION SUBMITTED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER UNDERSTAND THAT FALSE OR INCORRECT INFORMATION, OMISSIONS, INACCURACIES OR FAILURES TO MAKE FULL DISCLOSURE MAY RESULT IN THE CANCELLATION OR DENIAL OF A PLAN OF SUPERVISION OR LICENSE ISSUED PURSUANT TO THIS APPLICATION AND MAY BE SUBJECT TO CIVIL AND CRIMINAL PROCEEDINGS. I AGREE ALL INFORMATION IN THIS APPLICATION CAN BE VERIFIED AND INVESTIGATED. I HAVE READ, AND AM FAMILIAR WITH THE SOUTH DAKOTA CODIFIED LAWS AND ADMINISTRATIVE RULES REGULATING PROFESSIONAL COUNSELING AND HEREBY AGREE TO ABIDE BY SUCH LAWS AND REGULATIONS.

Applicant Signature

Date

State of _____)
) SS
County of _____)

On this ___ day of _____, 20___, the above applicant, _____, personally appeared, known to me or satisfactorily proven to be the same person whose name s subscribed to the written instrument, and acknowledged that he/she executed the same for the purposes therein contained. In witness where of, I have here unto set my hand and official seal.

(SEAL)

Notary Signature: _____

Notary Name: _____

My Commission Expires: _____

Attach Photo Here

For identification purposes, the applicant shall furnish one color headshot taken not more than six months before the date of application.

Mail completed application and fee to:

SD Board of Examiners for Counselors & Marriage and Family Therapists
PO Box 340
Pierre, SD 57501

For Office Use Only:

Application Fee Check number _____ Amount _____ Date _____

**ATTACHMENT 2 – COURSEWORK REQUIREMENTS
MARRIAGE AND FAMILY THERAPIST**

In the blanks provided, please write which course number(s) meet(s) these requirements from your transcript. If a course title is not clearly indicative of the content areas as outlined below, include the college catalog description or course syllabus and highlight the areas of the literature that best demonstrate coverage of the content area.

Content Area	Course Number(s)	Course Title(s)	College/ University
MARRIAGE AND FAMILY STUDIES (9 SEM CREDITS MINIMUM) Introductory systems theory, family development, family systems (marital, sibling, individual subsystems), special family issues, gender and cultural issues, all with major focus from a systems theory orientation;			
MARRIAGE AND FAMILY THERAPY (9 SEM CREDITS MINIMUM) Advanced systems theory and interventions, major systemic marriage and family treatment approaches, (structural, strategic, neoanalytic (object relations), behavioral marriage and family therapy, communications, sex therapy, etc.			
HUMAN DEVELOPMENT (9 SEM CREDITS MINIMUM) At least one course in psychopathology-abnormal behavior is required and at least one course in assessment is required. The third course may be selected from human development (normal and abnormal), personality theory, or human sexuality;			
PROFESSIONAL STUDIES (3 SEM CREDITS MINIMUM) Professional ethics as a therapist including legal and ethical responsibilities and liabilities, family law, etc.			
RESEARCH (3 SEM CREDITS MINIMUM) Research course in marriage and family studies and therapy including research design, methodology, statistics;			
PRACTICUM (SUPERVISED CLINICAL PRACTICE) 1 year minimum during graduate work			