

INSTRUCTIONS

Licensed Associate Marriage and Family Therapist

The requirements of licensure and practice for Illinois Associate Licensed Marriage and Family Therapist (ALMFT) licensure are provided by the ACT (225 ILCS 55/) and the RULES in Administrative Code (68 IAC Part 1283).

The ACT and RULES are available online at: www.idfpr.illinois.gov/profs/MarrFamTherapy.asp

STEP 1.

Use the chart below to complete PART I (Page 1), Box A., Items 1-4 of the application.

1. Profession Name	2. Profession Code	3. Licensure Method (From STEP 1)	4.Fee
Associate Licensed Marriage and Family Therapist (ALMFT)	208	NON-EXAMINATION*	\$100

* The Licensure Method Non-Examination means that an individual is not required to complete a licensure examination for this level of license. An individual becomes eligible to sit for the Association of Marital and Family Therapy Regulatory Board's (AMFTRB) Examination in Marital and Family Therapy when the ALMFT license is issued.

STEP 2.

Complete the rest of the 4-page application, noting the following:

PART IV: Record of Licensure Information (Page 3)

Applicants who have never held a marriage and family therapy or related license may mark N/A for “not available” or “not applicable” in of the application.

PART V: Record of Examination (Page 3)

All attempts (pass or fail) of the Association of Marital and Family Therapy Regulatory Board's (AMFTRB) Examination in Marital and Family Therapy must be listed. Applicants should also list other state licensing or jurisprudence exams if different than the AMFTRB examination. Candidates who have never taken a licensure examination may mark N/A for “not available” or “not applicable” in of the application.

PART VII: Examination Coding Information

This portion of the application is not used for LMFT or ALMFT applications. Please leave this part of the application blank or mark N/A for "not applicable". A separate examination registration process is followed when an applicant has been approved to take the exam.

STEP 3.

SUPPORTING DOCUMENTS - The following supporting documents may be required with your application. Read the instructions for each form thoughtfully.

\$100 Licensure Application fee - Please make your check or money order payable to IDFPR. DO NOT SEND CASH.

CCA form - This form is required to be completed by all applicants.

ED form(s) - This form is required for all applicants. The applicant completes the "APPLICANT" portion of the form, then arranges for his or her marriage and family therapy program college or university to complete the "SCHOOL OFFICIAL" portion of the form. The school official's original signature and seal is required, do not submit photocopies. Do not submit the form unless it has been completed by the marriage and family therapy program. A separate form is required for each college or university through which marriage and family therapy coursework was completed. Education requirements are detailed in RULES Section 1283.30.

Official Transcript(s) - Official final transcripts are required from each college or university through which marriage and family therapy coursework was completed.

AC-MFT form - This form is completed by the applicant. Applicants completing core area coursework at more than one college or university may submit a separate AC-MFT form for each college or university through which marriage and family therapy coursework was completed.

Syllabi - A photocopy of the official syllabus is required for every course listed on the AC-MFT form(s). Candidates are encouraged to submit syllabi for their entire marriage and family therapy program.

COAMFTE accreditation - An applicant who has completed a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), or a marriage and family therapy program accredited by the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) may submit evidence of his or her program's accreditation instead of the following documents: Official Transcript, AC-MFT form, and Syllabi.

AAMFT Clinical Fellow Membership Certificate - This document is optional. An applicant who is a Clinical Fellow member of the American Association for Marriage and Family Therapy (AAMFT) may submit a photocopy of his or her membership certificate instead of the following documents: Official Transcript, AC-MFT form, Syllabi, PCE-MFT, CSW-MFT, SR-MFT.

CT form - A candidate who is licensed as an ALMFT or LMFT in another state or U.S. Jurisdiction must provide Certification of Licensure from his or her first state of marriage and family therapy licensure and the state in which she or he has most recently been practicing. The applicant must contact the appropriate Board or Agency in the other state(s) to arrange for an original Certification of Licensure to be sent directly to the Department.

Personal History Documents - An applicant marking “YES” in response to any of the personal history questions in PART VI, page 4 of the application will need to provide a signed personal statement of explanation and corresponding documentation.

Proof of name change(s) - If any of the supporting documents listed above list a different name than the name on the application, proof of name change(s) must be submitted. An applicant must document each step of each change. Examples of acceptable documentation include: Signed Marriage Certificates, Marriage Licenses, Divorce Decrees, Court orders showing change(s) of name.

STEP 4

The application, supporting documents, and application fee may be submitted with the application or to:

**Illinois Department of Financial and Professional Regulation
Division of Professional Regulation
P.O. Box 7007
Springfield, Illinois 62791**

An application is valid for 3 years from date it is received by the Department.

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.illinois.gov.

For assistance--Call one of the following numbers and state that you are applying to become licensed as a marriage and family therapist and need help with your application:

**1-800-560-6420
TTY - 1-866-325-4949**

Please allow 6 weeks from mailing your application before making an inquiry concerning its status.

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IMPORTANT NOTICE

Elder and Child Abuse Reporting

"Pursuant to Public Act 91-0244, effective January 1, 2000, if you have reason to believe that an adult 60 years of age or older who resides in a domestic living situation who, because of dysfunction is unable to seek assistance for himself or herself has, within the previous 12 months been subject to abuse, neglect or financial exploitation, the mandated reporter shall, within 24 hours after developing such belief, report this suspicion to the Department on Aging. Reports should be made to **DEPARTMENT ON AGING AT 1-800-252-8966.**"

"Public Act 91-0244 also requires that if you have reasonable cause to believe a child known to you in your professional capacity may be an abused or neglected child you are required to report such possible neglect or abuse to the **DEPARTMENT OF CHILDREN AND FAMILY SERVICES AT 1-800-25abuse.**"

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APPLICATION FOR LICENSURE AND/OR EXAMINATION

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is **VOLUNTARY**. However, failure to comply may result in this form not being processed.

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE and/or EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

- A. Type or print legibly with black ink only.
- B. **FEES ARE NOT REFUNDABLE.**
- C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

A. Check the box indicating the appropriate information regarding your application. Military Military Spouse Not Military Decline to Answer
 Military service member is defined as: "Service member means any person who, at the time of application under this Section, is an active duty member of the United States Armed Forces or any reserve component of the United States Armed Forces, the Coast Guard, or the National Guard of any state, commonwealth, or territory of the United States or the District of Columbia or whose active duty service concluded within the preceding 2 years before application." The following will be considered proof of you or your spouse's active military status: DD214, Letter of Service signed by Unit Commanding Officer, or Proof of Service document from the Servicemember's electronic personnel portal. Proof for Spouses: Military Permanent Change of Station Orders with the spouse identified by name; Official Notification of Change of Assignment with your marriage license, a certified DD1172 verifying marital status, or a letter signed by the commanding officer verifying change of assignment and the name of the military spouse.

B. SEE REFERENCE SHEET, CHART I, OR INSTRUCTIONS PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
	_ _ _		\$

C. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

<input type="checkbox"/> This is the first time I have made application for this profession in Illinois.	<input type="checkbox"/> My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
<input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.	<input type="checkbox"/> I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.
<input type="checkbox"/> Other: _____	

PART II: Applicant Identifying Information--You must notify the Department of Financial and Professional Regulation - Division of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST FIRST MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
		_ _ - _ - _

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY	ZIP CODE	COUNTY
	_ - -	

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY	ZIP CODE	COUNTY
	_ - -	

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)	7. MOTHER'S MAIDEN NAME

8. PLACE OF BIRTH CITY STATE/COUNTRY	9. DATE OF BIRTH	10. AGE
	_ / _ / _	_
	Month Day Year	<input type="checkbox"/> Female <input type="checkbox"/> Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED	12. REQUIRED E-MAIL ADDRESS
Work: (_ _ _) _ - _ (Area Code)	
Home: (_ _ _) _ - _ (Area Code)	
Fax: (_ _ _) _ - _ (Area Code)	
Fax: (_ _ _) _ - _ (Area Code)	

NAME (Last, First, MI):

SS#:

Profession:

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)

1 2 3 4 5 6 7 8 9 10 11 12 Graduated High School? Yes No Received OR G.E.D.? Yes No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION ____ / ____ ____ Month Year
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5. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 5 6 7 8 Graduated? Yes No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE		TYPE OF DEGREE EARNED
		FROM Month/Year	TO Month/Year	

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)				
INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE		Did You Complete Training?
		FROM Month/Year	TO Month/Year	
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure				
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				

(If additional space is needed, attach a separate sheet.)

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS
			(Passed, Failed, Absent)

(If additional space is needed, attach a separate sheet.)

PART VI: Personal History Information <i>(This part must be completed by all applicants)</i>	YES	NO
1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. <i>If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.</i>		
2. Have you been convicted of a felony? <i>In general, a felony conviction by itself does not usually result in denial of licensure.</i>		
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? <i>If yes, attach a copy of the certificate.</i>		
4. Do you now have any disease or condition that presently limits your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition? <i>If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.</i>		
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? <i>If yes, attach a detailed explanation.</i>		
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? <i>If yes, attach a detailed explanation.</i>		

PART VII: Examination Coding Information *(This part is for examination applicants only)*

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes

b) CHART III - Select the examination site you desire and enter Test Center Code:

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c) CHART IV - Find your School of Graduation and enter school code:

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d) Record the number of times you have taken this exam in Illinois or any other state:

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PART VIII: Child Support and Tax Information *(Every applicant is required by law to respond to the following questions)*

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

Are you more than 30 days delinquent in complying with a child support order? Yes No
(NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 ILCS 2105-15(g), "The Department shall deny any license application or renewal authorized under any licensing Act administered by the Department to any person who has failed to file a return, or to pay the tax, penalty, or interest shown in a filed return, or to pay any final assessment of tax, penalty, or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirement of any such tax Act is satisfied."

Are you delinquent in the filing of state taxes? Yes No

PART IX: Certifying Statement

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than \$50.

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

HEALTH CARE WORKERS CHARGED WITH OR CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME	LAST	FIRST	MIDDLE	3. PROFESSIONAL LICENSE NUMBER (if any) _____ - _____
2. ADDRESS STREET, CITY, STATE, ZIP CODE				4. SOCIAL SECURITY NUMBER _____ - _____

Pursuant to 20ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding convictions pertaining to certain offenses. **Please check applicable profession.**

- | | | |
|---|---|--|
| <input type="checkbox"/> Acupuncturists | <input type="checkbox"/> Naprapaths | <input type="checkbox"/> Physician Assistants |
| <input type="checkbox"/> Advanced Practice Registered Nurses | <input type="checkbox"/> Nursing Home Administrators | <input type="checkbox"/> Podiatrists |
| <input type="checkbox"/> Advanced Practice Registered Nurse - Full Practice Authority | <input type="checkbox"/> Occupational Therapists | <input type="checkbox"/> Professional Counselors |
| <input type="checkbox"/> Athletic Trainers | <input type="checkbox"/> Occupational Therapy Assistants | <input type="checkbox"/> Prosthetists |
| <input type="checkbox"/> Audiologists | <input type="checkbox"/> Optometrists | <input type="checkbox"/> Registered Nurses |
| <input type="checkbox"/> Clinical Psychologists | <input type="checkbox"/> Orthotists | <input type="checkbox"/> Registered Surgical Assistants |
| <input type="checkbox"/> Clinical Social Workers | <input type="checkbox"/> Pedorthists | <input type="checkbox"/> Registered Surgical Technologists |
| <input type="checkbox"/> Dental Hygienists | <input type="checkbox"/> Perfusionists | <input type="checkbox"/> Respiratory Care Practitioners |
| <input type="checkbox"/> Dentists | <input type="checkbox"/> Pharmacists | <input type="checkbox"/> Speech Pathologists |
| <input type="checkbox"/> Genetic Counselors | <input type="checkbox"/> Physical Therapists | |
| <input type="checkbox"/> Licensed Clinical Professional Counselors | <input type="checkbox"/> Physical Therapy Assistants | |
| <input type="checkbox"/> Licensed Practical Nurses | <input type="checkbox"/> Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.) | |
| <input type="checkbox"/> Licensed Social Workers | | |
| <input type="checkbox"/> Marriage and Family Therapists | | |
| <input type="checkbox"/> Medication Aide | | |

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

	Yes	No
1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *	<input type="checkbox"/>	<input type="checkbox"/>
2) Are you currently charged with or have you been convicted of a criminal battery against any patient <i>in the course of patient care or treatment</i> , including any offense based on sexual conduct or sexual penetration?	<input type="checkbox"/>	<input type="checkbox"/>
3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *	<input type="checkbox"/>	<input type="checkbox"/>
4) Are you currently charged with or have you been convicted of a forcible felony? *	<input type="checkbox"/>	<input type="checkbox"/>

If YES to any of the above, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant _____ Email _____ Date _____

* DEFINITIONS

730 ILCS 150 et. seq.—Acts that require Sex Offender Registration:

(B) As used in this Article, "sex offense" means:

(1) A violation of any of the following Sections of the Criminal Code of 1961:

- 11-20.1 (child pornography),
- 11-20.3 (aggravated child pornography),
- 11-6 (indecent solicitation of a child),
- 11-9.1 (sexual exploitation of a child),
- 11-9.2 (custodial sexual misconduct),
- 11-9.5 (sexual misconduct with a person with a disability),
- 11-15.1 (soliciting for a juvenile prostitute),
- 11-18.1 (patronizing a juvenile prostitute),
- 11-17.1 (keeping a place of juvenile prostitution),
- 11-19.1 (juvenile pimping),
- 11-19.2 (exploitation of a child),
- 11-25 (grooming),
- 11-26 (traveling to meet a minor),
- 12-13 (criminal sexual assault),
- 12-14 (aggravated criminal sexual assault),
- 12-14.1 (predatory criminal sexual assault of a child),
- 12-15 (criminal sexual abuse),
- 12-16 (aggravated criminal sexual abuse),
- 12-33 (ritualized abuse of a child).

An attempt to commit any of these offenses.

(1.5) A violation of any of the following Sections of the Criminal Code of 1961, when the victim is a person under 18 years of age, the defendant is not a parent of the victim, the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act, and the offense was committed on or after January 1, 1996:

- 10-1 (kidnapping),
- 10-2 (aggravated kidnapping),
- 10-3 (unlawful restraint),
- 10-3.1 (aggravated unlawful restraint).

(1.6) First degree murder under Section 9-1 of the Criminal Code of 1961, when the victim was a person under 18 years of age and the defendant was at least 17 years of age at the time of the commission of the offense, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.7) (Blank).

(1.8) A violation or attempted violation of Section 11-11 (sexual relations within families) of the Criminal Code of 1961, and the offense was committed on or after June 1, 1997.

(1.9) Child abduction under paragraph (10) of subsection (b) of Section 105 of the Criminal Code of 1961 committed by luring or attempting to lure a child under the age of 16 into a motor vehicle, building, house trailer, or dwelling place without the consent of the parent or lawful custodian of the child for other than a lawful purpose and the offense was committed on or after January 1, 1998, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.10) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after July 1, 1999:

- 10-4 (forcible detention, if the victim is under 18 years of age), provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act,
- 11-6.5 (indecent solicitation of an adult),
- 11-15 (soliciting for a prostitute, if the victim is under 18 years of age),
- 11-16 (pandering, if the victim is under 18 years of age),
- 11-18 (patronizing a prostitute, if the victim is under 18 years of age),
- 11-19 (pimping, if the victim is under 18 years of age).

(1.11) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after August 22, 2002:

- 11-9 (public indecency for a third or subsequent conviction).

(1.12) A violation or attempted violation of Section 5.1 of the Wrongs to Children Act (permitting sexual abuse) when the offense was committed on or after August 22, 2002.

(2) A violation of any former law of this State substantially equivalent to any offense listed in subsection (B) of this Section.

(C) A conviction for an offense of federal law, Uniform Code of Military Justice, or the law of another state or a foreign country that is substantially equivalent to any offense listed in subsections (B), (C), (E), and (E5) of this Section shall constitute a conviction for the purpose of this Article.

* DEFINITIONS

A “**forcible felony**”, for the purposes of Section 2105-165 of the Code (section numbers are from the Criminal Code of 1961 [720 ILCS 5]) and 68 Illinois Administrative Code 1130.120 is one or more of the following offenses:

- a) First Degree Murder (Section 9-1);
- b) Intentional Homicide of an Unborn Child (Section 9-1.2);
- c) Second Degree Murder (Section 9-2);
- d) Voluntary Manslaughter of an Unborn Child (Section 9-2.1);
- e) Drug-induced Homicide (Section 9-3.3);
- f) Kidnapping (Section 10-1);
- g) Aggravated Kidnapping (Section 10-2);
- h) Unlawful Restraint (Section 10-3);
- i) Aggravated Unlawful Restraint (Section 10-3.1);
- j) Forcible Detention (Section 10-4);
- k) Involuntary Servitude (Section 10-9(b));
- l) Involuntary Sexual Servitude of a Minor (Section 10-9(c));
- m) Trafficking in Persons (Section 10-9(d));
- n) Criminal Sexual Assault (Section 11-1.20);
- o) Aggravated Criminal Sexual Assault (Section 11-1.30);
- p) Predatory Criminal Sexual Assault of a Child (Section 11-1.40);
- q) Criminal Sexual Abuse (Section 11-1.50);
- r) Aggravated Criminal Sexual Abuse (Section 11-1.60);
- s) Aggravated Battery (Section 12-3.05);
- t) Compelling Organization Membership of Persons (Section 12-6.5);
- u) Compelling Confession or Information by Force or Threat (Section 12-7);
- v) Home Invasion (Section 12-11);
- w) Robbery (Section 18-1);
- x) Armed Robbery (Section 18-2);
- y) Vehicular Hijacking (Section 18-3);
- z) Aggravated Vehicular Hijacking (Section 18-4);
- aa) Aggravated Robbery (Section 18-5);
- bb) Terrorism (Section 29D-14.9);
- cc) Causing a Catastrophe (Section 29D-15.1);
- dd) Possession of a Deadly Substance (Section 29D-15.2);
- ee) Making a Terrorist Threat (Section 29D-20);
- ff) Falsely Making a Terrorist Threat (Section 29D-25);
- gg) Material Support for Terrorism (Section 29D-29.9);
- hh) Hindering Prosecution of Terrorism (Section 29D-35);
- ii) Boarding or Attempting to Board an Aircraft with Weapon (Section 29D-35.1);
- jj) Armed Violence (Section 33A-2); and
- kk) Attempt (Section 8-4) of any of the above specified offenses.

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IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION BY LICENSING AGENCY / BOARD

SUPPORTING DOCUMENT

CT

APPLICANT: Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. You are authorized to photocopy this form as necessary.

1. NAME LAST FIRST MIDDLE 	2. DATE OF BIRTH ___ / ___ / ___ Month Day Year	3. SOCIAL SECURITY NUMBER - - - - . - - - - . - - - -
4. ADDRESS STREET, CITY, STATE, ZIP CODE 	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. <div style="text-align: center;"> _____ Profession Name _____ Profession Code </div>	
6. MAIDEN OR GIVEN SURNAME 	7. APPLICANT TELEPHONE NUMBER (Daytime) Area Code (___ ___ ___) _____ - _____	
8a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)	8b. LICENSE NUMBER (If applicable)	8c. ISSUANCE DATE OF LICENSE (If applicable)

I hereby authorize _____ to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service, the information requested below.

Name of Licensing Agency or Board

Signature _____ Date _____

RETURN COMPLETED FORM TO APPLICANT

LICENSING AGENCY: The Illinois Department of Financial and Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas which are not applicable.

PART I - CERTIFICATION OF EXAMINATION STATUS

A. The applicant has written is scheduled to write the following examination:

_____ Name of Examination _____ Date of Examination

B. The applicant has or will have written the above-named examination _____ number of times.

PART II - CERTIFICATION OF LICENSURE

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE	B. LICENSE NUMBER
C. ISSUANCE DATE OF LICENSE	D. EXPIRATION DATE OF LICENSE

E. LICENSURE METHOD

<input type="checkbox"/> Examination (Administered in Your State) <input type="checkbox"/> National (Name) _____ <input type="checkbox"/> State Constructed _____ <input type="checkbox"/> Other (Name) _____ <input type="checkbox"/> Endorsement of License (State) _____ Acceptance of Examination Results _____ (Administered in Another State) _____	<input type="checkbox"/> Reciprocity with (State) _____ <input type="checkbox"/> Waiver/Grandfather _____ <input type="checkbox"/> Credentials _____ <input type="checkbox"/> Other (Describe) _____
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F. CURRENT LICENSURE STATUS <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed <input type="checkbox"/> Other (Explain) _____ _____ _____	G. IF LICENSED BY EXAMINATION, RECORD SCORES <table style="width: 100%;"> <tr> <td>Type of Examination</td> <td style="text-align: right;">Score</td> </tr> <tr> <td>Written</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>Practical</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>Other (Describe) _____</td> <td style="text-align: right;">_____</td> </tr> </table> Received no Grade Below _____ Examination Period _____ days _____ hours	Type of Examination	Score	Written	_____	Practical	_____	Other (Describe) _____	_____
Type of Examination	Score								
Written	_____								
Practical	_____								
Other (Describe) _____	_____								

PART III - CERTIFICATION OF EXAMINATION SCORES

A1. National or other Profession Specific Examination
(Record all available information)

Date of Examination _____

Scaled Score	_____	Raw Score	_____
Standard Deviation	_____	Corrected Score	_____
National Mean	_____	Percent Score	_____

A 2

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

B. State Constructed Examination

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

PART IV - FORMAL ACTIONS

- A. Is there now or has there ever been any formal action commenced against the applicant? Yes No
- B. Have there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? **(If yes, attach a certified copy of disciplinary action.)** Yes No

PART V - RECIPROCAL REGISTRATION

This state does does not grant the same privilege of reciprocal registration to Illinois registrants.

I certify that the information contained herein is true and correct according to the official records of the State.

SEAL	_____	_____
	Print Name	Signature
	_____	_____
	Title	Date
	_____	_____
_____	Area Code ()	
Agency/Board Street Address	Telephone Number	
_____	_____	
City, State, ZIP Code		

Attention Licensing Agency/Board: RETURN THIS FORM TO THE APPLICANT.

Attention Applicant: FOR INCLUSION WITH APPLICATION PACKET.

NAME (Last, First, MI):

SS#:

Profession:

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF EDUCATION

SUPPORTING DOCUMENT

ED

APPLICANT: Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form.

1. NAME LAST FIRST MIDDLE 	2. DATE OF BIRTH ___/___/___ Month Day Year	3. SOCIAL SECURITY NUMBER ___ - ___ - ____
4. ADDRESS STREET, CITY, STATE, ZIP CODE 	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. <div style="display: flex; justify-content: space-around;"> _____ _____ </div> <div style="display: flex; justify-content: space-around;"> Profession Name Profession Code </div>	
6. MAIDEN OR GIVEN SURNAME 	8. DATE OF GRADUATION / COMPLETION ___/___/___ Month Day Year	
7. NAME OF INSTITUTION ATTENDED 	I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below. <div style="display: flex; justify-content: space-between;"> <div style="width: 45%; text-align: center;"> _____ Date </div> <div style="width: 45%; text-align: center;"> _____ Signature of Applicant </div> </div>	

SCHOOL OFFICIAL: Complete the bottom portion of this page and the reverse side. RETURN THE COMPLETED FORM TO THE APPLICANT.

A. NAME OF INSTITUTION 	B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE
C. DEPARTMENT OF INSTITUTION 	D. SPECIFIC PROGRAM OR CURRICULUM CONCENTRATION OF APPLICANT
E. MAJOR AREA OF STUDY OF THE APPLICANT 	F. APPLICANT WAS (CHECK ONE): <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Co-op
G. CREDIT HOURS EARNED (CHECK ONE AND COMPLETE) <input type="checkbox"/> _____ Semester Hours <input type="checkbox"/> _____ Quarter Hours <input type="checkbox"/> _____ Course Hours	H. DATES OF ATTENDANCE From ___/___/___ To ___/___/___ Month Day Year Month Day Year
I. Total academic years attended ___/___/___ Years Months Days OR Total calendar years attended ___/___/___ Years Months Days	J. TYPE OF DEGREE OR CERTIFICATE AWARDED (e.g., B.A., M.A., M.D., Ph.D.)
K. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET ___/___/___ Month Day Year	L. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED ___/___/___ Month Day Year
M. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE <input type="checkbox"/> Applicant has graduated on ___/___/___ <input type="checkbox"/> Applicant has completed program on ___/___/___ Month Day Year Month Day Year <input type="checkbox"/> Applicant will graduate on ___/___/___ <input type="checkbox"/> Applicant will complete program on ___/___/___ Month Day Year Month Day Year	
N. IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN THE NORMALLY REQUIRED TIME, PLEASE EXPLAIN: 	

O. USE THIS SPACE TO RECORD ANY OTHER INFORMATION THAT YOU FEEL WOULD ASSIST THE DEPARTMENT IN EVALUATING THE APPLICANT'S EDUCATIONAL EXPERIENCES.

NAME (Last, First, MI):

I certify that the information recorded herein is true and correct according to the official records of this institution.

SS#:

Print Name of School Official

Signature of School Official

Title

Date

SCHOOL SEAL OR NOTARY SEAL

NOTE: If the institution does not have a school seal, this form must be notarized.

Subscribed and sworn before me this ____ day of _____, 20____.

Profession:

Date of Expiration

Signature of Notary Public

SCHOOL OFFICIAL: RETURN THIS FORM TO APPLICANT

ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 55/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

ACADEMIC COURSEWORK AND PRACTICUM

SUPPORTING DOCUMENT

ACW-MFT

APPLICANT: Complete a separate form for each institution in which you have completed graduate coursework. You may copy this form as needed.

This form is not necessary if you are either a Clinical Member of the American Association for Marriage and Family Therapy or have a graduate degree from a program approved by the Illinois Department of Financial and Professional Regulation as an Approved Comprehensive Program of Study in Marriage and Family Therapy. (See Instruction Sheet to determine what proof to submit instead.)

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH ____/____/____ Month Day Year	3. SOCIAL SECURITY NUMBER ____-____-____
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. <input type="checkbox"/> Associate Licensed Marriage and Family Therapist (208) <input type="checkbox"/> Licensed Marriage and Family Therapist (166)	
6. MAIDEN OR GIVEN SURNAME	8. DEPARTMENT	
7. NAME OF COLLEGE/INSTITUTION	10. PROGRAM (AREA OF SPECIALIZATION AS IT APPEARS ON TRANSCRIPT.)	
9. ADDRESS OF COLLEGE/INSTITUTION		

A. ACADEMIC COURSEWORK: Indicate which specific courses or equivalent experiences you believe to meet the course areas listed below. Course descriptions and syllabi are required for courses whose titles do not reflect the content area listed below.

AREA	COURSE TITLE	COURSE NO.	YEAR	CREDITS	SEMESTERS OR QUARTERS
Individual Development and Family Studies 1 course: 3 semester hours					
Theoretical Foundations and Clinical Practice ¹ 6 courses: 18 semester hours					
Professional Studies and Ethics 1 course: 3 semester hours					
Research 1 course: 3 semester hours					

¹ The course work in this subsection must balance methods for working individually (one client in a therapy session), and for working conjointly with at least two clients present in therapy sessions who are in significant relationships with each other outside the therapy context, and must include methods for working with groups.

B. PRACTICUM OR INTERNSHIP (300 hours)

This practicum or internship occurred during my 1st qualifying degree after completion of 1st qualifying degree

SITE NAME		SUPERVISOR NAME/DEGREE	
SITE ADDRESS		SUPERVISOR'S BUSINESS/INSTITUTION NAME/ADDRESS	
TOTAL HOURS WORK EXPERIENCE	TOTAL FACE-TO-FACE CONTACT HRS	STARTING DATE	ENDING DATE

NAME (Last, First, MI):

C. MANDATORY TOPICS: Indicate which specific courses or equivalent experiences you believe meet the mandatory topic areas listed below. Please note that the same course may be used to cover more than one mandatory topic area.

MANDATORY TOPICS	LIST AT LEAST ONE COURSE WHERE TOPIC WAS COVERED	COURSE NO.	YEAR
Historical Development, Theoretical and Empirical Foundations, and Contemporary Directions			
Overview of the Major Clinical Theories of Marital and Family Therapy			
Assessment and Evaluation of Individuals, Couples and Families			
Treatment and Intervention Methods for Working with Individuals, Couples, Families, and Groups in Therapy			
Assessment and Treatment of Mental, Emotional, Behavioral and Interpersonal Disorders and Psychopathology			
Contemporary Issues			
Crisis Intervention			

SS#:

Profession: