License Marriage and Family Therapist Check List:

-Initial

____Have completed a master's or doctoral program in marriage and family therapy from a program accredited by the American Association for Marriage and Family Therapy, Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) or completed a master's or doctoral degree in marriage and family therapy from a regionally accredited educational institution; or earned a master's graduate degree in another mental health field (psychiatry, psychology, clinical social work, psychiatric nursing, etc.) from an accredited counseling program from a college or university accredited by an agency recognized by the U.S. Department of Education in counseling and completed a COAMFTE accredited post-graduate degree clinical training program in marriage and family therapy or completed a post-graduate degree clinical training program in marriage and family therapy from a regionally accredited educational institution. An applicant may substitute equivalent post-degree courses to meet the course of study requirements. The coursework must be verified by the official graduate school transcripts, which specify number of quarter or semester hours. Applicants who have obtained the American Association for Marriage and Family Therapy (AAMFT) clinical membership status are considered to have met the educational requirements for licensure. If applying through the AAMFT clinical status, verification must be from the AAMFT directly to the department. Of the graduate credit hours required above, at least forty-five (45) credit hours shall be in the following areas:

____Three (3) courses in the analysis of family systems, with one (1) course in each of the following:

____A supervised clinical practice that includes at least sixty (60) hours of approved supervision and 300 hours of direct client contact with couples, families, and individuals, at least 100 hours of which are relational therapy;

____Normal and abnormal personality development which includes individual development across the life span and the family life cycle; and

____Psychopathology with emphasis on standard diagnostic manuals, as well as family systems models;

____Courses in couples therapy theory and techniques as follows:

____One course in diagnosis and treatment of mental and emotional disorders in family systems

____A comprehensive survey course with substantive overview of the extant major models of family therapy; and

____Two (2) additional courses which focus on one (1) or several marriage and family therapy models, or three (3) separate courses, each of which focuses on one (1) or several marriage and family therapy models;

____Courses in couples therapy theory and techniques as follows:

____A comprehensive survey of extant, major models of couples' therapy;

____An intensive study of at least three (3) different models; or

____Three (3) separate courses, each of which addresses a separate couples' model;

____One (1) course covering gender and ethnicity as they relate to marriage and family theory and practice, or two (2) separate courses with one (1) focusing on gender issues and the other one (1) on ethnicity;

____One (1) course covering sexual issues in marriage and family therapy, including sexual normality, sexual dysfunction, and sexual orientation; and

____One (1) course in ethical, legal, and professional issues in marriage and family therapy.

Supervision: Practicum Experience

____Applicant must complete the supervised counseling work experience required of this section; There must be at least 400 hours of supervised practicum, inclusive of at least 150 face-to-face counseling hours. The practicum may include seventy-five (75) hours of client-centered advocacy; if not, there must be an additional seventy-five (75) hours of face-to-face counseling. Some students will complete more than the minimum supervised hours. The practicum experience shall be completed under the on-site clinical supervision of a person who is a licensed mental health counselor, licensed psychologist, licensed clinical social worker, licensed marriage and family therapist, licensed physician with a specialty in psychiatry or other licensed provider approved by the board.

Supervision: Post Graduate

Applicants must complete the following supervised, clinical or counseling work experience after the award of the master's degree, doctoral degree, or its substantial equivalent as determined by the board, of which shall:

____Be a minimum of two (2) years or the equivalent of fulltime, postgraduate supervised clinical or counseling work experience in professional/mental health counseling; and

____Be completed following the practicum, internship, and all graduate coursework, with the exception of the thesis; and

____Be a minimum of 3,000 total hours, including at least 1,000 client contact clock hours of supervised clinical experience at a setting acceptable to the board; and

____Have direct clinical contact with couples and families and must have been supervised a minimum of 200 hours including 100 individual and 100 group hours; and

____The supervisee must meet with the supervisor for a minimum of four (4) hours per month and provide documentation of supervised hours; and

____Have only supervised clinical contact credited for this requirement; and

____Compute part-time employment on a prorated basis for the supervised work experience; and

____Have the background, training, and experience that is appropriate to the functions performed; and

____The documented hours of client service, or post-graduate experience, must be under the on-site supervision of a licensed marriage and family therapist, licensed psychologist, licensed psychiatrist or licensed social worker within the U.S or other qualified licensed provider approved by the Health Care Professions Licensing Board of the Commonwealth of the Northern Marianas. Licensed and qualified supervisors providing telepsychology clinical supervision must be board approved and licensed in the CNMI.

____At the discretion of the Board, may approve tele-supervision.

____Any licensed Marriage and Family Therapist providing tele-supervision from outside the CNMI must be licensed by the Board and, if providing services for a fee, must have a CNMI business license to conduct business in the CNMI.

-Renewal

____ Renewal Application

____2x2 photo

____$200 renewal fee payable to "**CNMI TREASURER**"

____For initial licensure, MFT are required to take HIV/AIDS 7 CE hours and at every renewal, he/she is required to take Law and Ethics and/or cultural competency for a total of 6 CE hours.

____40 CE hours or 4 CEU during the 24 months prior to the expiration of license

-Schedule of Fees

Application fee	$100
Initial license fee	$200
Renewal fee	$200
Temporary license fee	$100
Delinquent fee (charged every 1st of the month after expiration date)	$25
Replacement/Duplication of license	$75
Replacement/Duplication of wallet size card	$25
Letter of Good Standing/Verification fee	$25

Commonwealth of the Northern Mariana Islands
HEALTH CARE PROFESSIONS LICENSING BOARD
P.O. Box 502078, Bldg., 11925 Pohnpei Court
Capitol Hill, Saipan, MP 96950
Tel No: (670) 664-4809 Fax: (670) 664-4814
Email: info@cnmilicensing.gov.mp
Website: www.cnmilicensing.gov.mp

Attach a recent 2x2 ID photo here taken within 6 months of the application.

APPLICATION FOR LICENSE TO PRACTICE

License Marriage and Family Therapy

☐ Initial	☐ Endorsement	☐ Temporary

HCPLB STAFF USE ONLY

Date Received:

APPLICATION INFORMATION – Please Type or Print

1. Last:	First:	Middle:	**2.** Social Security No:
3. Birthdate: (Mo/Day/Yr.)	**4.** Color of Eyes: Color of Hair:	**5.** Height: Weight:	**6.** Sex:
7. Mailing Address:		**8.** Email Address:	
9. Residence Address:		**10.** Phone No: (W): (H):	
11. NPI # (if available):	**12.** Specialty:	**13.** Citizenship: ____U.S. ____Other Specify:	

14. EDUCATION – (*Provide an original, notarized or certified copy of your degree*)

Name of Schools	Location (City/State or Country)	Degree Earned	Dates (Mo/Yr.) From	To

15. EXAMINATION – (*List examination(s) you have taken and passed*)

Examination	Date	Result (Pass/Fail)

16. EXPERIENCE

Name of Place	Location (City/State or Country)	Dates (Mo/Yr.) From	To

17. LICENSES – (*List of all jurisdiction where you are licensed or applied for a license.*)

Name of Jurisdiction	Date Issued	Expiration Date	License Number	Current Status

18. Name/Address of Intended Employment within the CNMI	**Will you be practicing telehealth from off island?**
	☐ Yes
	☐ No

If you answer "yes" for any of items 18-32 you must attach a detailed explanation on a separate sheet, which includes state or country where action is pending or took place, relevant dates, action taken and reasons for such action. (Include Findings of Fact, Conclusion of Law, Final Order and whether you have been reinstated. If reinstated, date and conditions of license.)

19. Have you ever been charged with, or been found to have committed dishonorable, unprofessional conduct, negligence, incompetence, misconduct, or repeated negligent acts by any licensing board, other agency, or clinic?	Yes ☐	No ☐
20. Has a claim or an action ever been filed against you for your profession which resulted in a settlement, judgment, or arbitration award of $25.000 or more?	Yes ☐	No ☐
21. Has any licensing board, other agency, or disciplinary authority refused to issue you a license, renew your license, suspended, revoked, accepted surrender of your license, placed on probation or conditioned your license, held by you now or previously, or ever fined or otherwise disciplined you?	Yes ☐	No ☐
22. Is there any ongoing or pending investigation against you?	Yes ☐	No ☐
23. Is there any disciplinary action pending against you?	Yes ☐	No ☐
24. Has any clinic or training program restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?	Yes ☐	No ☐
25. Has your ability to practice your profession in a competent and safe manner ever been impaired or limited by any condition, behavior, impairment, or limitation of a physical, mental, or emotional nature?	Yes ☐	No ☐
26. Have you used or are you currently using any chemical substances(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice your profession in a safe and competent manner?	Yes ☐	No ☐
27. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?	Yes ☐	No ☐
28. Have you been treated for or had a recurrence or a diagnosed addictive disorder?	Yes ☐	No ☐
29. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice your profession safely?	Yes ☐	No ☐
30. Do you have any other condition in which in any way impairs or limits your ability to practice your profession safely?	Yes ☐	No ☐
31. Have you ever been found guilty, pleaded guilty, no contest, or nolo contendere to a crime involving moral turpitude or crime related to your profession, or felony in any court?	Yes ☐	No ☐
32. Is criminal action pending against you in any court?	Yes ☐	No ☐
33. Are you required to register as a Sex Offender?	Yes ☐	No ☐
34. Do you plan to engage in telemental health services from outside the CNMI?	Yes ☐	Yes ☐

34. DECLARATION:

I hereby certify that I am the person herein named subscribing to this application. I have read the complete application, and I know the full content hereof. I declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct. I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto or falsification on misrepresentation of credentials to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license to practice a health profession in the Commonwealth of the Northern Mariana Islands. I further certify that I have read and will abide by P.L. 15-105 and the HCPLB Regulations.

_____ _____

Signature of Applicant Date

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*Please complete the application form and attach all original, certified or notarized documents and a non-refundable application fee of $100.00 (money order or cashier's check make payable to "**CNMI Treasurer**"). Do not send cash.*

2022

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (print name), do hereby authorize a disclosure of records concerning myself to the Health Care Professions Licensing Board (HCPLB). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the HCPLB may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the HCPLB relating to substance abuse or dependence and/or mental health.

I further agree that the HCPLB may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, and fellowship) records, including records or any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the HCPLB deems reasonably necessary for the purposes set forth in this release.

Release of Liability:
I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the HCPLB pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the HCPLB, the Commonwealth of the Northern Mariana Islands, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

I have read and fully understand the contents of this "Authorization to Release Information".

_____ _____

Signature of Applicant Date
