

## Application Information

Mental Health Practitioner (LMHP)  
Marriage and Family Therapist (CMFT)  
Professional Counselor (CPC)  
Master Social Worker (CMSW)

Nebraska offers 2 types of mental health practice licenses:

- **Licensed Mental Health Practitioner** does **NOT** include: Diagnosing major mental illness or disorder except in consultation with a licensed independent mental health practitioner, qualified physician or licensed clinical psychologist; the consultant must make the diagnosis.
- **Licensed Independent Mental Health Practitioner** includes diagnosis & treatment of major mental illness/disorders, without supervision or consultation

If you are **seeking an Independent Mental Health Practice License (LIMHP)** you must complete a separate application for that license type. <http://dhhs.ne.gov/licensure/Documents/IndependentMHPLicenseApp.pdf>

**Certificates:** Nebraska offers certificates in social work, professional counseling and marriage and family therapy.

The **term** 'social worker' 'certified professional counselor' and 'certified marriage and family therapist' **is title protected**, which means, if you **WISH TO USE ANY OF THESE TITLES**, you must also obtain the applicable certification(s).

**Each Section of the application includes detailed instructions.**

**You must submit your application with the fee** (see page 1 of the application for fees). **It may be mailed, or hand-delivered to our office.** Our address is listed below, in Contact information.

You can verify receipt and issuance of your application at the following web site: <https://www.nebraska.gov/LISSearch/search.cgi>  
If your file shows '**status: pending**', your application has been received by the Department and is in the review process.

**All applications will be reviewed in date order received.** Once reviewed, you will receive an e-mail or letter within approximately 10 days advising you that your license has been issued or that your application is incomplete. If incomplete, you will be informed of how to complete your application. You have 90 days to complete your application; if not completed within this 90 days, your application will be closed and all documents destroyed. A new application will then be required.

**Records Retention Schedule:** When your license is issued, your application and documents will be kept by the Department for 5 years; then all documents will be destroyed. We encourage you to keep a copy of your application for your records.

**DO NOT USE WHITE OUT ON YOUR APPLICATION.**  
**If you do, it will be returned to you.**

**Submit your application and payment (check or money order) together.**  
**We're unable to accept electronic payments.**



Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

**Licensure Unit**

Division of Public Health /Licensure Unit  
P.O. Box 94986, Lincoln, Nebraska 68509-4986

**APPLICATION FOR A LICENSE  
AS A MENTAL HEALTH PRACTITIONER  
and  
CERTIFICATION as CMFT, CPC, and/or CMSW**

Check below the type of license/certification you are requesting:

**DO NOT USE WHITE OUT ON YOUR APPLICATION.  
If you do, it will be returned to you.**

**License:**

**Fees:**

<input type="checkbox"/> Independent Mental Health Practitioner (LIMHP)  <input type="checkbox"/> Mental Health Practice License (LMHP)	<p><b><u>If applying for ONLY 1 license type:</u></b> \$155 or \$38.75 (if applying March-August Even # Year)</p> <p><b><u>If applying for BOTH LIMHP &amp; LMHP license types:</u></b> \$205 or \$63.75 (if applying March-August Even # Year)</p>
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**Certifications:**

**Fees:**

<input type="checkbox"/>	Marriage and Family Therapist	If requesting CMFT, you must also be applying for or have a MHP or Independent MHP License in Nebraska)	\$50 \$25 (if applying March-August Even # Year)
<input type="checkbox"/>	Professional Counselor	If requesting CPC, you must also be applying for or have a MHP or Independent MHP license in Nebraska)	\$50 \$25 (if applying March-August Even # Year)
<input type="checkbox"/>	Master Social Worker	If requesting CMSW and will be providing mental health services, must also be applying for or have a MHP or Independent MHP license in Nebraska)	\$50 \$25 (if applying March-August Even # Year)
<input type="checkbox"/>	<b>Master Social Work Certification Only (NOT requesting a MHP or Independent MHP License)</b> <b>If you select this certification</b> and do not request or hold a Nebraska mental health practice license, you cannot provide mental health therapy; you may <b>ONLY</b> provide social work activities. A description of Social work activities can be found at: <a href="http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-172/Chapter-094.pdf">http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-172/Chapter-094.pdf</a>		\$125 \$31.25 (if applying March-August Even # Year)

Make fee payable to: Licensure Unit

**NOTE: All credentials expire 9/1 of even years**

**You must complete all sections of this application**

SECTION A: PERSONAL INFORMATION			
1	You must print your <b>Legal Name</b> below		
	First:	Middle:	Last Name:
	List any other names you are or have been known as (AKA), including maiden and your last name on your birth certificate.		
2	Address:	Street/PO/Route:	
	City:	State or Country:	Zip:

3	Date of Birth (Month/Day/Year):	Place of Birth (City/State or COUNTRY):		
4	Phone #: (optional)*	Additional Phone #: (optional)*		
5	E-Mail Address: * phone number and e-mail are optional, but providing this information will speed up our communication with you			
6	Social Security Number:			
	If you are not a U.S. Citizen, list A# or I-94#:	Alien Registration Number ("A#"):	I-94#:	

**Nebraska Rev. Stat. §§38-123 and 38-130 requires you to provide your social security number to DHHS. Although your number is not public information, DHHS may share your social security number for child support enforcement or other administrative purposes and provide it to the Department of Revenue or the Department of Labor.**

➔ **US CITIZENSHIP/LAWFUL PRESENCE** (must be at least 19 years old). **You must submit evidence of:**

**U.S. Citizen, a PHOTOCOPY** of one of the following:

- Birth Certificate (Hospital issued keepsake birth certificates cannot be accepted).
- U.S. Passport (unexpired or expired).
- Certificate of Naturalization.
- Other documents that show U.S. Citizenship.

**A Driver's License is NOT acceptable.**

**NOT a U.S. Citizen, a PHOTOCOPY** of one of the following:

- Green Card, otherwise known as a Permanent Resident Card (Form I-551), both front and back of the card;
- Form I-94 (Arrival-Departure Record) **AND** an unexpired foreign passport with a valid unexpired US visa; or
- Employment Authorization Card **AND**
  - An approved deferred action status (DACA);
  - A pending application for asylum in the United States;
  - A pending or approved application for temporary protected status in the United States; or
  - A pending application for adjustment of status to that of an alien lawfully admitted for permanent Residence in the United States or conditional permanent resident status in the United States.

**NOTE:** Documents (other than those for U.S. Citizenship) are verified by our office through the Department of Homeland Security. This process may take up to 30 days.

SECTION B: EXAMINATION CATEGORY				
1	Examination Type <b>(Check all that apply)</b>			
	<input type="checkbox"/> National Board for Certified Counselor Examination (NBCC)	NCE <input type="checkbox"/>	NCMHCE <input type="checkbox"/>	
	<input type="checkbox"/> Association of Marital and Family Therapy Regulatory Boards (AMFTRB) Examination			
	<input type="checkbox"/> American Association of State Social Work Boards (AASSWB)	Clinical <input type="checkbox"/>	Advanced <input type="checkbox"/>	Level C <input type="checkbox"/>
	<input type="checkbox"/> Other Examination, Name: _____			
2	Date of Examination: _____			

➔ **EXAMINATION: You must submit:**

- An **official** copy of your examination scores sent directly to us from the testing agency or another licensing board. If you tested based on a letter of authorization from the Licensure office, we have this information.

The following identifies the examination required based on the degree you hold:

- a. **Social Work Degree or Equivalent Degree:**  
Must have passed the Clinical Category of the ASWB examination; pass score is 75.
- b. **Marriage and Family Therapy Degree or Equivalent Degree:**  
Must have passed the Association of Marital and Family Therapy Regulatory Boards (AMFTRB) examination.
- c. **Counseling Related Degree:**  
Must have passed the National Board of Certified Counselor's National Counselor Examination (NBCC/NCE) or the National Clinical Mental Health Counselor Examination (NBCC/NCMHCE).

**SECTION C: EDUCATION**

Check this box if you hold an active **Nebraska PLMHP** (provisional mental health practice license) **If yes, you are NOT required to complete the below educational information nor submit a transcript.**

Name of College/University:	
Type of Degree Received:	
Date of Degree:	
Degree Major:	

**Check applicable accreditation**, if you received a master's or doctorate degree from one of the following accredited programs:

<input type="checkbox"/>	Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE)
<input type="checkbox"/>	Council for Accreditation of Counseling and Related Educational Programs (CACREP)
<input type="checkbox"/>	Council on Social work Education (CSWE)
<input type="checkbox"/>	Council on Rehabilitation Education (CORE)
<input type="checkbox"/>	The American Psychological Association (APA) for a doctoral degree program enrolled in by a person who has a master's degree or its equivalent in psychology

**→ EDUCATION: You must submit:**

**Transcript:** An official college or university transcript verifying receipt of a master's or doctoral degree which the degree focus is primarily therapeutic mental health. This transcript may be submitted with your application in a sealed envelope or send directly by your school either by mail or electronically to [cindy.L.kelley@nebraska.gov](mailto:cindy.L.kelley@nebraska.gov).

**Coursework:** If you received a master's/doctoral degree **from a program other than those listed below, you must submit a syllabus for each course listed on the application and it must be from the time you completed that course.**

- Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE)
- Council for Accreditation of Counseling and Related Educational Programs (CACREP)
- Council on Social work Education (CSWE)
- Council on Rehabilitation Education (CORE)
- The American Psychological Association (APA) for a doctoral degree program enrolled in by a person who has a master's degree or its equivalent in psychology

**If you do not know whether your program was accredited, go to the applicable accreditation web site before completing your application.**

**Practicum/Internship:** You must submit the affidavit of practicum/internship (page 7 of the application). **This practicum/internship must have been completed as part of your degree program (not as work experience after your degree was issued).**

**Information Relating to Military Education, Training, or Service:** If you have completed education, training, or service that you believe is substantially similar to the education required for this credential while you were a member of the military, you may submit such evidence with your application for review.

**SECTION D: SUPERVISOR'S PERSONAL INFORMATION**

The supervised experience (at least 3000 hours of mental health practice) must be earned after issuance of your masters' degree.

NOTE: Each supervisor must submit verification of supervised experience.

1	Supervisor's Name:	First:	Middle:	Last:
2	Supervisor's Name:	First:	Middle:	Last:
3	Supervisor's Name:	First:	Middle:	Last:

**→ SUPERVISOR INFORMATION: Each supervisor must compete and you must submit:**

- Each supervisor must complete an affidavit attesting only to the hours they supervised your post masters mental health services for the period of time that they provided your supervision.

**SECTION E: CONVICTION, LICENSE, AND PRACTICE INFORMATION**

Failure to list any conviction(s) or disciplinary action(s), regardless of when the action occurred, could result in disciplinary action.

**CONVICTION INFORMATION:** You must list ALL misdemeanor or felony convictions (regardless of when they occurred or whether you previously listed them on a prior application); you are NOT required to list infractions, diversions or dismissals. Misdemeanor and felony convictions can either be processed through traffic or criminal court, so when you check with the county court/district court, you should ask for both traffic and criminal court misdemeanor and felony convictions.

1	Have you <b>EVER</b> been convicted of a misdemeanor or felony?	Type of Crime	Date of Action	Name of Court / Entity Taking Action
	Yes <input type="checkbox"/> No <input type="checkbox"/>			

**NOTE:** If you have any criminal charges or credential disciplinary actions pending that result in a conviction or credential discipline, you are required to report such action to the Investigative Unit **within 30 days of the conviction or disciplinary action**. Reporting forms can be obtained at: <http://dhhs.ne.gov/Investigations> or by phone 402-471-0175.

**→ CONVICTION INFORMATION: You must submit:**

- Conviction Information:** If you have **EVER** have ever received a ticket from law enforcement or animal control, check the court system to see if the ticket is on your record as a misdemeanor or felony conviction. Speeding tickets are not misdemeanors or felonies. You are required to list ALL convictions (regardless of when they occurred) on the application; you are NOT required to list infractions, diversions or dismissals. Misdemeanor and felony convictions can either be processed through traffic or criminal court, so when you check with the county court/district court, you should ask for both traffic and criminal court misdemeanor/felony convictions.

- (a) A copy of the court record for each conviction;
- (b) Your explanation of the events leading to each of the convictions (what, when, where, why) and a summary of actions you have taken to address the behaviors/actions related to the convictions;
- (c) If currently on probation, a letter from your probation officer addressing the terms and current status of your probation.

**NOTE:** To assist the Board and Department in review of any drug and/or alcohol conviction(s), if you had an alcohol and drug evaluation and/or completed treatment, the treatment provider must submit all evaluations/discharge summaries directly to the Department.

The following provides <b>SOME</b> examples of convictions; this is <b>NOT</b> a complete list	
<ul style="list-style-type: none"> <li>• MIP/ Tobacco Use by Minor</li> <li>• DUI / DWI</li> <li>• Controlled Substance</li> <li>• Open Container</li> <li>• Shoplifting / Theft / Burglary</li> <li>• Unauthorized use of a Financial Transaction</li> <li>• Disturbing the Peace</li> <li>• Assault / Prostitution</li> <li>• Disorderly Conduct / Disorderly House</li> <li>• Reckless Driving</li> </ul>	<ul style="list-style-type: none"> <li>• Driving under Suspension / Revocation</li> <li>• License Vehicle without Liability Insurance</li> <li>• Fail to Appear in Court</li> <li>• False Information or Reporting</li> <li>• Leave the Scene of an Accident</li> <li>• Operator not Carrying License</li> <li>• Unlawful Display of Plates/Renewal tabs</li> <li>• Park Rule Violation / Curfew Violation</li> <li>• Dog at Large / Fail to Vaccinate Animal</li> <li>• Littering / Fireworks / Bad Check</li> </ul>

**LICENSE INFORMATION:** The following questions relate to a license/certificate/registration that you currently **hold or have held** to provide health or environmental related services in a state/jurisdiction **other** than Nebraska.

2	Have you ever been denied the right to take a license examination?	If yes, please explain below.		
	Yes <input type="checkbox"/> No <input type="checkbox"/>			
3	What state(s) are/were you credentialed in?	What type of credential(s) do you hold or have you held?		
	You must provide a copy of the statutes and or regulations regulating to your profession in the other jurisdiction/state to prove they are equivalent to those required in Nebraska. This DOES NOT apply if basing application on 5 years of practice.			
4	If you hold/held a credential, has your credential ever been denied, refused renewal, limited, suspended, revoked or had other disciplinary measures taken against it?	Type of Licensure Action	Date of Action	Name of Entity Taking Action
	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	If you have disciplinary charges pending or if your credential has been revoked, suspended, limited, is on probation or disciplined in any way, please contact the state(s) taking the action and request a copy of the disciplinary action be sent to the Nebraska Licensure Unit.			

**→ LICENSE INFORMATION: You must submit:**

- Other Licensing Information:** If you currently hold or have held a credential to provide health related services in a state/jurisdiction **other than Nebraska**, you must submit verification of the license(s) even if that license is no longer current.
- Disciplinary Action:** If you have had any disciplinary action(s) taken against your credential, you must submit a copy of the disciplinary action(s), including charges and findings.

<b>SECTION F: PRACTICE PRIOR TO LICENSURE</b>						
If you practice prior to issuance of your license or represent yourself as a social worker, certified marriage and family therapist, or certified professional counselor, you are subject to assessment of an Administrative Penalty of \$10 per day up to \$1,000 and/or other action as provided in the statutes and regulations governing mental health practice.						
1	<p><b><u>Mental Health Practitioner:</u></b></p> <p><input type="checkbox"/> <b>No.</b> I <b>have NOT</b> practiced mental health in Nebraska without a credential before submitting this application?</p> <p><input type="checkbox"/> <b>Yes.</b> I <b>have</b> practiced mental health in Nebraska without a credential before submitting the application?</p>					
2	<p><b><u>Social Work, Marriage and Family Therapy, Professional Counseling:</u></b></p> <p><input type="checkbox"/> <b>No.</b> I <b>have NOT</b> used the title Social Worker, Certified Marriage and Family Therapist or Certified Professional Counselor in Nebraska without a credential before submitting this application?</p> <p><input type="checkbox"/> <b>Yes.</b> I <b>have</b> used the title Social Worker, Certified Marriage and Family Therapist or Certified Professional Counselor in Nebraska without a credential before submitting this application?</p>					
3	<table border="1" style="width: 100%;"> <tr> <td rowspan="4" style="width: 50%;">If yes to either question above, what are the actual number of days you practiced mental health or used the title SW, CMFT or CPC in Nebraska without a credential and what is the business name, location and telephone number of the practice:</td> <td>Number of days:</td> </tr> <tr> <td>Name of Business:</td> </tr> <tr> <td>City:</td> </tr> <tr> <td>Telephone #:</td> </tr> </table>	If yes to either question above, what are the actual number of days you practiced mental health or used the title SW, CMFT or CPC in Nebraska without a credential and what is the business name, location and telephone number of the practice:	Number of days:	Name of Business:	City:	Telephone #:
If yes to either question above, what are the actual number of days you practiced mental health or used the title SW, CMFT or CPC in Nebraska without a credential and what is the business name, location and telephone number of the practice:	Number of days:					
	Name of Business:					
	City:					
	Telephone #:					

**SECTION G: ATTESTATION**

For the purpose of meeting Neb. Rev. Stat. §4-108 through §4-114 and §38-129, **I attest that:**

(check only **ONE** of the boxes below)

I am a citizen of the United States.

**OR**

I am a qualified alien under the Federal Immigration and Nationality Act.

I am a nonimmigrant lawfully present in the United States.

Check this box if you are **NOT** a citizen of the United States, a nonimmigrant, nor a qualified alien under the Federal Immigration and Nationality Act.

**I further attest that:**

1. I have read the application or have had the application read to me; and
2. I am of good character and all statements on this application are true and complete.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Licensure Unit**

P. O. Box 94986 - Lincoln, NE 68509-4986  
 (402) 471-4905 [cindy.L.kelley@nebraska.gov](mailto:cindy.L.kelley@nebraska.gov)

**The Practicum or Internship Supervisor or Director  
 MUST complete this form.**

**MASTER'S/DOCTORATE PRACTICUM OR  
 INTERNSHIP VERIFICATION**

**NOTE: IF you have already submitted this form with your PLMHP, you are not required to resubmit.**

**This practicum or internship must have been completed as part of your degree program**  
**(Work experience gained after the degree was issued, is not acceptable towards the practicum/internship)**

**SUPERVISOR INFORMATION:**

Name of Supervisor: \_\_\_\_\_ License Type: \_\_\_\_\_ License #: \_\_\_\_\_

Name of Applicant: \_\_\_\_\_

The practicum/internship was completed at: \_\_\_\_\_ (name of business),  
 in \_\_\_\_\_ (city) \_\_\_\_\_ (state).

The applicant completed the following hours:

Total Clock Hours of Direct Client Contact: \_\_\_\_\_

Total Clock Hours of Face-to-Face Client Contact in a work setting: \_\_\_\_\_

(NOTE: During a practicum direct client contact is contact between the practicum student and a client system, including collateral contacts, while providing mental health services. Supervisory sessions involving only the practicum student and supervisor will not be considered as direct client contact.)

**Marriage and Family Therapy: Check this box if the applicant is also applying for a marriage and family therapy certification.**

**Marriage and Family Therapy:** If the applicant is also applying for certification as a Marriage and Family Therapist, the above named applicant has at least 300 clock hours of supervised direct client contact with individuals, couples and families. Of these 300 hours, no more than 150 hours were with individuals.

**ATTESTATION:** I state that I am the person completing this form and the statements are true and complete.

I further verify that the applicant has completed a **practicum/internship as part of his/her Master's Degree Program**, including the clock hours listed above, providing mental health services under supervision.

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 (Print/Type) Name of Supervisor or Internship Director

\_\_\_\_\_  
 SIGNATURE OF SUPERVISOR or INTERNSHIP DIRECTOR



**SECTION F: MENTAL HEALTH PRACTICE COURSEWORK**

**IF YOU HOLD OR HAVE HELD A PLMHP IN NEBRASKA, YOU ARE NOT REQUIRED TO COMPLETE THIS SECTION.**

**OR**

**ACCREDITED PROGRAMS:** If your program is accredited by one of the following, you **ARE NOT** required to complete the following coursework information.

- Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE)
- Council for Accreditation of Counseling and Related Educational Programs (CACREP)
- Council on Social Work Education (CSWE)
- Council on Rehabilitation Education (CORE)
- The American Psychological Association (APA) for a doctoral degree program enrolled in by a person who has a master's degree or its equivalent in psychology

**NON-ACCREDITED PROGRAM:** If you received a masters' or doctorate degree from a program **OTHER THAN** those listed as accredited:

1. Your degree must consist of course work and training which was primarily therapeutic mental health in content.
2. Your degree must be from an institution of higher education approved by the Council for Higher Education Accreditation (CHEA) or its successor.  
You must submit course descriptions for each course(s) listed below from the time you completed such course; a syllabus is preferred and must be from the time you completed each course.

***An official course description must be attached for each course listed.***

(LIST the name of the course, the course number and the name of the institution in which the course was completed).

**PRACTICUM OR INTERNSHIP** (must be part of your degree)

**Course Definition:** (If completed after September 1, 1995, the practicum or internship must include a minimum of 300 clock hours of direct client contact of which 150 clock hours must be face-to-face in a work setting under the supervision of a qualified supervisor – Any artificial situation where a person presents a problem, such as role playing, is not acceptable)

**Your supervisor or internship director must submit Page 5 of this application to verify completion of the practicum/internship requirement.**

Name of Course	Course Number	College/University

If your **practicum** was **completed prior to September 1, 1995**, there is no hour requirement and Page 5 of this application is not required to be completed or submitted; however, you must still list the practicum/internship above.

### Coursework Areas Required by Nebraska

**1. THEORIES AND TECHNIQUES OF HUMAN BEHAVIOR INTERVENTION: (6 semester hours or 9-quarter hours)**

**Course Definition:** Courses that cover therapeutic techniques and strategies for human behavioral intervention. This includes major contributions of the biological, behavioral, cognitive, and social sciences relevant to understanding assessment and treatment of the person and his/her environment with emphases on the social systems framework, personality theories and individual development through the life cycle, and their application.

Name of Course(s)	Course Number	College/University

**2. PROFESSIONAL ETHICS AND ORIENTATION: (3 semester hours or 4.5-quarter hours)**

**Course Definition:** The application of ethical and legal issues to the practice. Examples are: family law, codes of ethics, boundaries, peer review, record keeping, confidentiality, informed consent, and duty to warn.

Name of Course(s)	Course Number	College/University

**3. ASSESSMENT TECHNIQUES REQUIRED FOR MENTAL HEALTH PRACTICE: (3 semester hours or 4.5-quarter hours)**

**Course Definition:** Includes the process of collecting pertinent data about client or client systems and their environment and appraising the data as a basis for making decisions regarding treatment and/or referral. Examples are ability to make a clinical diagnostic impression, knowledge of psychopathology, and assessment of substance abuse and other addictions.

Name of Course(s)	Course Number	College/University

**4. HUMAN GROWTH AND DEVELOPMENT: (3 semester hours or 4.5-quarter hours)**

**Course Definition:** The integration of the psychological, sociological and biological approaches within the life cycle. Examples are awareness of culture, gender, or human sexuality at developmental levels, human behavior (normal and abnormal), personality theory, and learning theory.

Name of Course(s)	Course Number	College/University

**5. RESEARCH AND EVALUATION: (3 semester hours or 4.5-quarter hours)**

**Course Definition:** Includes such areas as statistics or research design and development of research and demonstration proposals.

Name of Course(s)	Course Number	College/University

**Undergraduate Courses:**

Undergraduate courses can only be considered if the Graduate program accepted an undergraduate course(s) as meeting the above graduate course criteria. The school must submit a notarized letter, on institutional letterhead, from an authorized person, i.e., the Department Chair of the program, stating the undergraduate course(s) was accepted to meet the educational requirement(s) of the master's degree.

For Office Use Only

Date reviewed: \_\_\_\_\_ by: \_\_\_\_\_

**SECTION E: MARRIAGE AND FAMILY THERAPY COURSEWORK**

COMPLETE THIS COURSEWORK INFORMATION IF YOU ARE REQUESTING CERTIFICATION AS A MARRIAGE AND FAMILY THERAPIST

**ACCREDITED COAMFTE PROGRAM:** If you graduated from a marriage and family therapy program that COAMFTE approved you **ARE NOT** required to complete the following coursework information.

**NON-ACCREDITED PROGRAM:** For related MFT programs or NON-COAMFTE programs, list the name of the course, the course number and the name of the institution in which the course was completed.

***An official course description must be attached for each course listed.***

**1. MARRIAGE AND FAMILY STUDIES (9 semester or 13.5 quarter or a combination of these hours)**

**Course Definition:** Courses in this area should be a fundamental introduction to systems theory. The student should learn to understand family structures and functioning within the social systems framework (including environmental context) and regarding diverse range of presenting issues (i.e. gender, cultural, substance abuse). Topic areas may include: systems theory, family development, family subsystems, blended families, gender issues in families, cultural issues in families, etc.

This area must have a major focus from systems theory orientation and encompass the social systems orientation. Survey or overview courses in which systems in one of several theories covered is not appropriate. Courses in which systems theory is the overarching framework and other theories are studied in relations to systems theory are appropriate.

Course Name	Course #	College/University

**2. MARRIAGE AND FAMILY THERAPY (9 semester or 13.5 quarter or a combination of these hours)**

**Course Definition:** Courses in this area should have a major focus on family systems theory and systemic therapeutic interventions. This area is intended to provide a substantive understanding of the major theories of systems change, the applied practices evolving from each theoretical orientation, including diagnosis/assessment of individuals, couples and families. Major theoretical approaches might include: strategic, structural, object relations, cognitive behavioral, intergenerational, and integrative models of therapy with individuals, couples, and families.

Course Name	Course #	College/University

**3. HUMAN DEVELOPMENT (9 semester or 13.5 quarter or a combination of these hours)**

**Course Definition:** Courses in this area should provide knowledge of individual personality development and its normal and abnormal manifestations. The student should have relevant course work in human development across the life span, which includes special issues that effect an individual's development (i.e. culture, gender, and human sexuality). Topic areas may include human development, child/adolescent development, psychopathology, personality theory, human sexuality, etc. This material should be integrated with systems concepts. Test and measurement courses are not accepted toward this area.

Course Name	Course #	College/University

**4. PROFESSIONAL STUDIES (3 semester or 4.5 quarter or a combination of these hours)**

**Course Definition:** Courses in this area are intended to contribute to the professional development of the therapist. Areas of study should include the therapist's legal responsibilities and liabilities, professional ethics relevant to marriage and family issues, professional values and socialization, and the role of the professional organization, licensure or certification legislation, independent practice and interpersonal cooperation. Religious ethics courses and moral theology courses are not accepted toward this area.

Course Name	Course #	College/University

**5. RESEARCH (3 semester or 4.5 quarter or a combination of these hours)**

**Course Definition:** Courses in this area should assist students in understanding and performing research. Topic areas may include research methodology, quantitative methods and statistics. Individual personality and test and measurement courses are not accepted toward this area.

Course Name	Course #	College/University

**PRACTICUM (minimum 6 semester hours or 9 quarter hours, 300 hours of supervised direct client contact with individuals, couples and families, and of this 300 hours, no more than 150 hours may be with individuals)**

Course Name	Course #	College/University

For Office Use Only  
Date reviewed: \_\_\_\_\_ by: \_\_\_\_\_

**SECTION F - PROFESSIONAL COUNSELOR COURSEWORK**

COMPLETE THIS COURSEWORK INFORMATION IF YOU ARE REQUESTING CERTIFICATION AS A PROFESSIONAL COUNSELOR

**ACCREDITED CACREP PROGRAM:** If your program is accredited by CACREP, you **ARE NOT** required to complete the following coursework information.

**NON-ACCREDITED CACREP PROGRAM:** The following must be completed by applicants applying with a master's degree from a non-CACREP counseling related field offered by a regionally accredited higher educational institution.

List the name of the course, the course number and the name of the institution in which the course was completed

***An official course description must be attached for each course listed.***

**COUNSELING THEORY (3 semester hours):** **Course Definition:** Includes a study of basic theories principles and techniques of counseling and their application to professional counseling settings.

Course Name	Course #	College/University

**SUPERVISED COUNSELING PRACTICUM: Course Definition:**

**Mental Health Practice Applicants:** Refers to supervised counseling experience in a work/community based setting of at least one semester in duration for a minimum of 3 hours academic credit as part of a master's program component

**Independent Mental Health Practice Applicants:** Must have completed at least **700 clock** hours of Practicum and/or Internship as part of his/her master's or doctoral degree program, which included at least 280 hours of direct service with clients.

Course Name	Course #	College/University

**In addition to the above 2 coursework areas, you must have completed at least 3 semester hours in 5 of the following areas.**

**1. HUMAN GROWTH AND DEVELOPMENT: Course Definition:** Includes studies that provide a broad understanding of the nature and needs of individuals at all developmental levels. Emphasis is placed on biopsychosocial approaches. Also included are such areas as human behavior (normal and abnormal), personality theory and learning theory.

Course Name	Course #	College/University

**2. SOCIAL AND CULTURAL FOUNDATIONS: Course Definition:** Includes studies of change, ethnic groups, subcultures, changing roles of women, sexism, urban and rural societies, population patterns cultural mores, use of leisure time and differing life patterns. Such disciplines as the behavioral sciences, economics and political science are involved.

Course Name	Course #	College/University

**3. HELPING RELATIONSHIP: Course Definition:** Includes philosophic bases of the helping relationship; consultation theory, practice, and application; and an emphasis on development of counselor and client (or consultee) self-awareness.

Course Name	Course #	College/University

**4. GROUP DYNAMICS, PROCESSING AND COUNSELING: Course Definition:** Includes theory and types of groups, as well as descriptions of group practices, methods, dynamics, and facilitative skills. This also includes supervised practice.

Course Name	Course #	College/University

**5. LIFESTYLE AND CAREER DEVELOPMENT: Course Definition:** Includes such areas as vocational choice theory, relationship between career choice and lifestyle, sources of occupational and educational information, approaches to career decision making processes and career exploration techniques.

Course Name	Course #	College/University

**6. APPRAISAL OF INDIVIDUALS: Course Definition:** Includes the development of framework for understanding the individual including methods of data gathering and interpretation, individual and group testing, case study approaches, and the study of individual differences. Ethnic, cultural and sex factors are also considered.

Course Name	Course #	College/University

**7. RESEARCH AND EVALUATION: Course Definition:** Includes such areas as statistics, research design and development of research and demonstration proposals. It includes understanding legislation relating to the development of research, program development and demonstration proposals, as well as the development and evaluation of program objectives.

Course Name	Course #	College/University

**8. PROFESSIONAL ORIENTATION: Course Definition:** Includes goals and objectives of professional organizations, codes of ethics legal considerations, standards of preparation, certification, licensing, and role identity of counselors and of other personal services specialists.

Course Name	Course #	College/University

For Office Use Only  
Date reviewed: \_\_\_\_\_ by: \_\_\_\_\_

Licensure Unit

P. O. Box 94986 - LINCOLN, NE 68509-4986
(402) 471-4905
Email: cindy.L.kelley@nebraska.gov

FOR MHP LICENSURE
POST-MASTER'S SUPERVISED EXPERIENCE VERIFICATION

Supervisors must complete this Attachment. Each supervisor MUST sign and date this form to attest to the experience earned. These hours MUST be earned after receipt of an approved masters' degree.

WHITE OUT IS NOT ACCEPTABLE:

Changes to information entered onto this form are not acceptable unless the supervisor initials the changed information.

PART I - SUPERVISOR INFORMATION:
Name of Supervisor: License #:
Name of Applicant:
Supervisor place a checkmark in the box by the license(s) you hold:
[ ] licensed mental health practitioner (LMHP) [ ] licensed independent mental health practitioner (LIMHP)
[ ] licensed psychologist [ ] qualified physician

PART II - MENTAL HEALTH PRACTICE EXPERIENCE: MHP Activities include: treatment, assessment, psychotherapy, counseling, or equivalent activities to individuals, couples, families, Or groups for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations.
SUPERVISORS: List only hours that you personally supervised the applicant providing mental health services
NOTE: direct and non-direct hours are reported separately:
1. Number of direct (face-to-face) client contact (clock) hours (when reporting partial hours, use .25 increments)
2. Number of non-direct clock hours
3. Total number of clock hours of mental health activities performed under my supervision.
4. List the dates the above hours of supervised mental health practice was completed (provide FULL dates):
from through
(month/day/year) (month/day/year)

Supervisor's Signature and Attestation
I state that I am the person completing this form and the statements on this form are true and complete
AND
I have met with the applicant face-to-face for at least 1 hour per week, for hours reported above.
(Print/type) SUPERVISOR Name and Title Date Signed :
Signature Telephone Number:
AGENCY/INSTITUTION
STREET ADDRESS CITY STATE ZIP

**FOR MARRIAGE AND FAMILY THERAPY  
 POST-MASTER'S SUPERVISED EXPERIENCE ERIFICATION**

**Licensure Unit**

P. O. Box 94986 - LINCOLN, NE 68509-4986  
 (402) 471-4905  
 Email: [cindy.L.kelley@nebraska.gov](mailto:cindy.L.kelley@nebraska.gov)

*Supervisors must complete this Attachment.* Each supervisor **MUST** sign and date this form to attest to the experience earned. **These hours MUST be earned after receipt of an approved masters' degree.**

**WHITE OUT IS NOT ACCEPTABLE:**

**Changes to information entered onto this form are not acceptable unless the supervisor initials the changed information.**

**PART I**

Name of Supervisor: \_\_\_\_\_ License #: \_\_\_\_\_

Name of Applicant: \_\_\_\_\_

**Supervisor place a checkmark in the box by the license(s) you hold:**

**Licensed Mental Health Practitioner**

**Psychologist**

**Marriage and Family Therapist** who has practiced for 5 years and has completed a five-hour supervision course that may be provided by an association which establishes standards for marriage and family therapy in conformity with accepted industry standards.

**SUPERVISORS: List only the hours that you personally supervised the applicant - note direct and non-direct hours are reported separately:**

1. \_\_\_\_\_ Number of direct (face-to-face) client contact (clock) hours (when reporting partial hours, use .25 increments)

2. \_\_\_\_\_ Number of **non-direct** clock hours

3. \_\_\_\_\_ Total number of clock hours of marriage and family therapy performed under my supervision.

4. List the dates the above hours of supervised marriage and family therapy **was completed (provide FULL dates)** under supervision within 5-years of this application. Dates from \_\_\_\_\_ through \_\_\_\_\_  
 (month/day/year) (month/day/year)

**Supervisor's Signature**

I state that I am the person completing this form and the statements on this form are true and complete  
**AND**  
 I have met with the applicant face-to-face for a at least 1 hour per week or 2 hours every 2-weeks, for the hours reported above  
**AND**  
 had at least 100 hours supervisor-supervisee contact hours.

\_\_\_\_\_  
 (Print/type) SUPERVISOR Name and Title

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 AGENCY/INSTITUTION

\_\_\_\_\_  
 STREET ADDRESS

Date Signed : \_\_\_\_\_

\_\_\_\_\_  
 CITY STATE ZIP



**Licensure Unit**

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Email: [cindy.L.kelley@nebraska.gov](mailto:cindy.L.kelley@nebraska.gov)

**FOR MASTER SOCIAL WORKER  
POST-MASTER'S SUPERVISED EXPERIENCE  
VERIFICATION**

**Supervisors must complete this Attachment.** Each supervisor **MUST** sign and date this form to attest to the experience earned. **These hours MUST be earned after receipt of an approved masters' degree and under the supervision of a Certified Master Social Worker.**

**WHITE OUT IS NOT ACCEPTABLE:**

**Changes to information entered onto this form are not acceptable unless the supervisor initials the changed information.**

**PART I - SUPERVISOR INFORMATION:**

Name of Supervisor: \_\_\_\_\_ CMSW #: \_\_\_\_\_

Name of Applicant: \_\_\_\_\_

If hours are earned in another state, identify the credential you hold:

Name of Credential:

License/Certificate No:

**PART II – MASTER SOCIAL WORK EXPERIENCE:**

**SUPERVISORS: List only the hours that you personally supervised** (when reporting partial hours, use .25 increments)

- Total number of clock hours of social work activities under my supervision: \_\_\_\_\_  
(total clock hours)
- Dates the above hours were completed under my supervision (**provide FULL dates**): from \_\_\_\_\_ to \_\_\_\_\_  
(month/day/year) (month/day/year)

**MSW Activities include:**

- Information, resource identification and development, and referral services
- Preparation & evaluation of psychosocial assessments & development of social work service plans
- Case management, coordination, and monitoring of social work service plans in the areas of personal, social, or economic resources, conditions, or problems
- Development, implementation, and evaluation of social work programs and policies
- Supportive contacts to assist individuals and groups with personal adjustment to crisis, transition, economic change, or a personal or family member's health condition
- Social casework for and prevention of psychosocial dysfunction, disability, or impairment
- Social work research, consultation, and education

**Supervisor's Signature**

I state that I am the person completing this form and the statements on this form are true and complete

**AND**

I have supervised the hours reported above.

\_\_\_\_\_  
(Print/type) SUPERVISOR Name and Title

Date Signed : \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
AGENCY/INSTITUTION

\_\_\_\_\_  
STREET ADDRESS

\_\_\_\_\_  
CITY STATE ZIP