



Department of Health and Human Services
Division of Public Health - Licensure Unit
P.O. Box 94986 – 301 Centennial Mall South
Lincoln, Nebraska 68509-4986
Telephone #: 402-471-4905
cindy.l.kelley@nebraska.gov

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

Licensure: (If applying for LMHP, check below)

Mental Health Practice License (Please print or type application)

FEE - Determine the month and year in which you are submitting your application.

YEAR	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Even Numbered Year	\$155	\$155	38.75	38.75	38.75	38.75	38.75	38.75	\$155	\$155	\$155	\$155
Odd Numbered Year	\$155	\$155	\$155	\$155	\$155	\$155	\$155	\$155	\$155	\$155	\$155	\$155

Certifications: (check the certification(s) you are wishing to obtain)

Fee

<input type="checkbox"/>	Certification as a Marriage and Family Therapist (must also be applying for or have a Mental Health Practice License)	\$50 \$25 (if applying March-August Even # Year)
<input type="checkbox"/>	Certification as a Professional Counselor (must also be applying for or have a Mental Health Practice License)	\$50 \$25 (if applying March-August Even # Year)
<input type="checkbox"/>	Certification as a Master Social Worker (must also be applying for or have a Mental Health Practice License)	\$50 \$25 (if applying March-August Even # Year)
<input type="checkbox"/>	Master Social Work Certification Only (not requesting a Mental Health Practice License) If you will not be providing mental health services and do not wish to apply for the license as a mental health practitioner check this category. (An applicant who holds the certification as a master social worker without being licensed may only practice within the confines of Neb. Rev. Stat. 71-1,311(1))	\$31.25 (if applying March-August Even # Year) \$125

Make payable to: Licensure Unit

**NOTE: All licenses expire 9/1 of even years
(renewal fee is \$155 for licensure / \$50 per certification)**

SECTION A – PERSONAL INFORMATION (All applicants must complete this section)

NOTE: All mailings will be sent to the address you indicate below– if you change your address, you must advise this office.

1	Legal Name:	First:	Middle/MI:	Last:
	Maiden Name:	Name:	Other Names you are known as (AKA):	
2	Address:	Street/PO/Route:		
		City:	State or Country:	Zip:

Additional information requested: (***This information is not displayed on the internet***)

3	Date of Birth:	Month/Day/Year:	Place of Birth:	City/State (or Country if not in U.S.):
4	Check the Appropriate Box(s):	<input type="checkbox"/> Social Security Number (SSN); <input type="checkbox"/> Alien Registration Number ("A#"); or <input type="checkbox"/> Form I-94 (Arrival-Departure Record) number:	SSN#	
			A#	
			I-94 #	
			If you have both a SSN and an A# or I-94 number, you must report both. Neb. Rev. Stat. §38-123 mandates disclosure of your social security number to DHHS. Although your number is NOT public information, DHHS may disclose it for child support enforcement purposes and to the Nebraska Department of Revenue.	
5	Phone #: (optional-not shared)	Fax #: (optional)	E-Mail Address: (optional-not shared)	

SECTION B - EXAMINATION CATEGORY (All applicants must complete this section) Check all that apply				
Please indicate which examination you have taken and the type of examination below by placing a "X" in the first column and a "X" in the type of examination if you took the NBCC examination or AASSWB examination:				
<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:			
	Date of Examination:		Score received:	
Was examination authorized by this office?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	If no, who authorized you to take the examination: _____ You must request Official Examination Scores be sent directly to this office.

SECTION C – EXPERIENCE: You must identify the date on which your EXPERIENCE began, this may or may not be the same as your date of hire. (Identify below the information on EACH piece of experience you claim as qualifying experience. The supervised experience must be earned after conference of the master's degree and within 5 years of the date of this application for licensure/certification) <i>EACH supervisor/s must submit Attachment A1 to verify this information.</i>				
Experience Dates:	From: (Month/Day/Year)		To: (Month/Day/Year)	
Provide a Brief Statement of the over-all Mental Health Practice Services you provided:				
Name of Direct Supervisor #1:				
Address where experience was gained:				

If you earned your experience under more than one supervisor...you must identify EACH piece of experience, if you had more than 3 supervisors, please attach a separate letter which identifies the name and location of additional experiences.

Name of Direct Supervisor #2:
Address where experience was gained:
Name of Direct Supervisor #3:
Address where experience was gained:

SECTION D – CONVICTION AND LICENSURE INFORMATION (All applicants must complete this section)
Failure to disclose any such conviction or disciplinary action, regardless of when the action occurred, could result in disciplinary action, including, but not limited to, payment of a civil penalty.

NOTE: If you have any criminal charges or license disciplinary actions pending that results in conviction or license discipline, you are required to report such actions to the Investigative Unit within 30 days <http://www.dhhs.ne.gov/reg/investi.htm> or by telephone at 402-471-0175.

Answer each of the following questions by placing a (✓) in the appropriate box (yes or no) and completing the information requested. All 'yes' responses MUST be explained in detail and you must submit the requested documentation (see page 5 of application).

Conviction Information:

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

Licensure Information:

The following questions relate to a credential that **you hold or have held** in health services, health-related services or environmental services in another jurisdiction. Even if the credential is no longer active/current, you must identify & obtain certification for each.

		Yes	No			
2	Are you licensed in any state?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what State(s) are you licensed in?	What type of license do you hold?	
3	Has your license ever been denied, refused renewal, limited, suspended, revoked or had other disciplinary measures taken against it?	<input type="checkbox"/>	<input type="checkbox"/>	Type of Licensure Action	Date of Action	Name of Entity taking Action
4	Have you ever been denied the right to take an examination?	<input type="checkbox"/>	<input type="checkbox"/>	Please Explain:		

SECTION E – PRACTICE PRIOR TO CREDENTIAL An individual who practices prior to issuance of a credential is subject to assessment of an Administrative Penalty of \$10 per day up to \$1,000, or such other action as provided in the statutes and regulations governing the credential.

1	I have practiced mental health in Nebraska before submitting the application? (this does not apply to the period of time in which you held an active provisional MHP license)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	If yes, what are the actual number of days you practiced in Nebraska and what is the business name, location and telephone number of the practice:	# of days: _____ Name of Business: _____ City: _____ Telephone #: _____

SECTION F - ATTESTATION

Lawful Presence in the United States Attestation:

For the purpose of complying with Neb. Rev. Stat. §38-129, I attest as follows:

Please check ONLY ONE of the boxes below:

- I am a citizen of the United States; or
- I am an alien lawfully admitted into the United States who is eligible for a credential under the Uniform Credentialing Act; or
- I am a non-immigrant lawfully present in the United States who is eligible for a credential under the Uniform Credentialing Act.

Alien or Non-immigrant Status: If you are a qualified alien lawfully admitted into the United States OR a non-immigrant lawfully present in the United States, you must submit evidence of lawful presence which may include a copy of:

- 1. A "Green Card" otherwise known as a Permanent Resident Card (Form I-551), both front and back of the card; or
- 2. An unexpired foreign passport with an unexpired Temporary I-551 stamp bearing the same name as the passport; or
- 3. A document showing an Alien Registration Number ("A#"), an Employment Authorization Card/Document is **NOT** acceptable; or
- 4. A Form I-94 (Arrival-Departure Record).

Your credential will **NOT** be issued until such proof is received by our office and your documents are verified by our office through the Department of Homeland Security. This process may take four to six weeks.

Application Attestation: I further attest that:

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

Print Name: _____

Signature: _____

Date: _____



NOTE: In order for your application to be considered complete, all applicants MUST also submit a copy of the following documents:

1. Age: Evidence of at least 19 years of age – Should appear on your birth certificate or passport. (If not, you must submit driver's license, marriage license, school transcript, US State ID card, Military ID, or similar documentation).
2. Citizenship, lawful permanent residence, and/or immigration status Information: You must submit a **copy** of at least one of the following documents:
 - (1) A U.S. Passport (unexpired or expired);
 - (2) A birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official Seal (a keepsake certificate is not acceptable);
 - (3) An American Indian Card (I-872);
 - (4) A Certificate of Naturalization (N-550 or N-570);
 - (5) A Certificate of Citizenship (N-560 or N-561);
 - (6) Certification of Report of Birth (DS-1350);
 - (7) A Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240);
 - (8) Certification of Birth Abroad (FS-545 or DS-1350);
 - (9) A United States Citizen Identification Card (I-197 or I-179);
 - (10) A Northern Mariana Card (I-873);
 - (11) An Alien Registration Receipt Card (Form I-551, otherwise known as a "Green Card");
 - (12) An unexpired foreign passport with an unexpired Temporary I-551 stamp bearing the same name as the passport;
 - (13) A document showing an Alien Registration Number ("A#") with Visa status; or
 - (14) A Form I-94 (Arrival-Departure Record) with Visa status.
3. Education: You must submit an official college/university transcript; In order to be official it must be on official school security paper and contain both the school seal and the signature of the Registrar. It may also be electronically submitted if emailed **directly to me, from your school**. My email address is-all lower case letters/middle initial is lower case "L": cindy.l.kelley@nebraska.gov. If you received a master's degree from a program other than those listed as accredited (see page 6), you must submit course descriptions for each course listed (course descriptions may be found in the college catalogue, bulletin, or syllabus and must be from the time you completed such course);
4. Examination: You must submit an **official** copy of your examination scores to this office. To be official they must come directly from the testing agency or another licensure board, on official letterhead.
5. Experience: Your supervisor/s must complete and submit Attachment A1.
6. Practicum/Internship: You must submit or have submitted the affidavit of practicum/internship (Attachment A2).
7. Coursework: You must submit or have submitted the coursework information on pages 6-9.
8. Conviction Information: If you have been convicted of a felony or misdemeanor, you must submit:
 - (1) A copy of the court record, which includes charges and disposition;
 - (2) Explanation from the applicant of the events leading to the conviction (what, when, where, why) and a summary of actions you have taken to address the behaviors/actions related to the convictions;
 - (3) All addiction/mental health evaluations and proof of treatment, if the conviction involved a drug and/or alcohol related offense and if treatment was obtained and/or required; and
 - (4) A letter from the probation officer addressing probationary conditions and current status, if you are currently on probation.
9. Other Credentialing Info: If you hold or have held a credential to provide health services, health-related services, or environmental services in another jurisdiction, you must have the licensing agency submit to the Department a certification of your credential.
10. Disciplinary Action: If you have had any disciplinary actions taken against your credential, you must submit a copy of the disciplinary action(s), including charges and disposition.
11. Fee: The required fee (see chart on page 1 of this application). **We're unable to accept electronic payments.** Check should be made payable to: Licensure Unit. Please note: payment is processed upon receipt. **Review of an application takes 2-4 weeks.**

Any documents written in a language other than English must be accompanied by a complete translation into the English language. The translation must be an original document and contain the notarized signature of the translator. An individual may not translate his/her own documents.

MENTAL HEALTH PRACTICE

COMPLETE THIS IF YOU HAVE NOT PREVIOUSLY SUBMITTED COURSEWORK

check if PREVIOUSLY SUBMITTED

SECTION G – Mental Health Practice COURSE WORK requirements

YOU MUST SUBMIT: An official transcript verifying receipt of your master’s or doctorate degree

Degree Received: _____ Major: _____ Date Received: _____

If you received a master’s degree from one of the following accredited programs, you do not have to complete the information listed below in coursework review:

Check applicable accreditation:

- 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)

COURSEWORK REVIEW

If you received a master’s degree from a program other than those listed as accredited, your degree must consist of course work and training which was primarily therapeutic mental health in content from an institution of higher education approved by for the Council for Higher Education Accreditation (CHEA) or its successor; and you must submit course descriptions for each course(s) listed below from the time you completed such course. (course descriptions may be copies found in the college catalogue, bulletin, or syllabus)

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

PRACTICUM OR INTERNSHIP *(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 Attachment A2 to verify fulfillment 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 Attachment A2 is not required – however, you must still list the practicum/internship above.

Coursework Area Required by Nebraska

1. THEORIES AND TECHNIQUES OF HUMAN BEHAVIOR INTERVENTION: At least 6 semester hours or 9-quarter hours. 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: At least 3 semester hours or 4.5-quarter hours. 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: At least 3 semester hours or 4.5-quarter hours. 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

SECTION G – <i>Mental Health Practice</i> COURSE WORK (Continued)		
4. HUMAN GROWTH AND DEVELOPMENT: At least 3 semester hours or 4.5-quarter hours. The intergration 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: At least 3 semester hours or 4.5-quarter hours. 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 Graduate programs accepting an undergraduate course(s) as meeting the above course criteria will be acceptable. 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: _____

MARRIAGE AND FAMILY THERAPIST

COMPLETE THIS INFORMATION IF YOU ARE REQUESTING MFT CERTIFICATION AND HAVE NOT PREVIOUSLY SUBMITTED COURSEWORK

check if PREVIOUSLY SUBMITTED

SECTION H - *Marriage and Family Therapy* COURSE WORK requirements

If you graduated from a marriage and family therapy program that **was approved by COAMFTE, you do not need to complete the following coursework.**

COURSEWORK REVIEW

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.***

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

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

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

SECTION H - Marriage & Family Therapy COURSE WORK (Continued)

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

RESEARCH (3 semester or 4.5 quarter or a combination of these hours) 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: _____

PROFESSIONAL COUNSELOR

COMPLETE THIS INFORMATION IF YOU ARE REQUESTING PC CERTIFICATION AND HAVE NOT PREVIOUSLY SUBMITTED COURSEWORK

check if PREVIOUSLY SUBMITTED

SECTION I - Professional Counseling COURSE WORK requirements

CACREP: If your program is accredited by **CACREP**, you are not required to complete the following coursework review 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

Please 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.**

COURSEWORK REVIEW - NON-ACCREDITED CACREP PROGRAM:

COUNSELING THEORY (At least 3 semester hours) 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 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		
Course Name	Course #	College/University

YOU MUST PROVIDE EVIDENCE OF AT LEAST 3 SEMESTER HOURS IN 5 OF THE FOLLOWING 8 AREAS:

HUMAN GROWTH AND DEVELOPMENT 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
SOCIAL AND CULTURAL FOUNDATIONS 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

SECTION I - Professional Counseling COURSE WORK (Continued)		
HELPING RELATIONSHIP 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
GROUP DYNAMICS, PROCESSING AND COUNSELING 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
LIFESTYLE AND CAREER DEVELOPMENT 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
APPRAISAL OF INDIVIDUALS 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
RESEARCH AND EVALUATION 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
PROFESSIONAL ORIENTATION 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: _____

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Public Health – Licensure Unit
 P. O. Box 94986 - LINCOLN, NE 68509-4986
 (402) 471-4905 cindy.l.kelley@nebraska.gov

This form must be completed by each supervisor at the conclusion of supervised hours. **These hours must be earned after receipt of an approved master's degree and within the 5 years immediately prior to the date the application for a full license is submitted.**

(Print or Type)

Licensure Type: (check the appropriate experience(s) below)

- Mental Health Practice
- Marriage and Family Therapy
- Social Work

**AFFIDAVIT OF SUPERVISED EXPERIENCE
 IN MENTAL HEALTH PRACTICE,
 MARRIAGE AND FAMILY THERAPY,
 PROFESSIONAL COUNSELING, AND/OR
 SOCIAL WORK**

PART I – Supervisors must complete this part – AFTER COMPLETION OF THE HOURS.

Name of Supervisor: _____ License #: _____

Name of Applicant: _____

PART II - Supervisors must complete Section A below, if applying for a license as a mental health practitioner; if in addition to the license the applicant is applying for an associated certification, the supervisor must also complete either B or C or both. If the applicant is applying only for certification as a master social worker, do not complete section A and B.

A. MENTAL HEALTH PRACTICE: (complete this section if applying for a mental health practice license)

Activities: 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.

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

The above named applicant has completed _____ **direct** (face-to-face) client contact hours and _____ **non-direct** hours totaling : _____ hours, of mental health activities under my supervision **within the past 5 years**. I further state that I have met with the applicant face-to-face for a minimum of one hour per week, for hours reported here: yes no. If no, please explain: _____.

Dates of supervision: from _____ to _____
 (month/day/year) (month/day/year) Provide FULL dates

Supervisor's Credentials (please check appropriate credential below):

(for hours earned **after** September 1, 1994):

- qualified physician **(must submit vitae showing specialized training in mental health or a copy of documentation showing the physician is a board certified psychiatrist)**
- licensed psychologist
- licensed mental health practitioner licensed independent mental health practitioner

Additional copies of this form may be reproduced if supervised by more than one supervisor

The supervisor must sign the signature section on the reverse side of this form. Changes to information entered onto this form invalidate the form unless the supervisor signs their name beside the changed information.

B. MARRIAGE AND FAMILY THERAPY: (complete this section if applying for both the mental health practice license and certification as a marriage and family therapist)

Activities: assessment and treatment of mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems through the professional application of psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such disorders.

I further state that the supervised experience: focused on raw data from the applicant's clinical work which was made directly available to me through such means as written clinical materials, direct observation, and video and audio recording; included a process which was distinguishable from personal psychotherapy or didactic instruction; and

consisted of _____ direct (face-to-face) client contact hours and _____ non-direct hours under my supervision

from _____ to _____. Additionally, the supervision did include face-to-face contact for a minimum of a cumulative ratio of 2 hours per week per 15 hours of supervisee's contact with clients – no more than 45 hours shall accumulate without supervision, and did not include more than 6 persons at one face-to-face supervisory setting: Yes No

Supervisor's Credentials: 'Approved Supervisor' designation certificate from the AAMFT
 Training in clinical supervision equivalent to 15 didactic hours, **AND**
3 years of experience supervising the provision of MFT.

C. MASTER SOCIAL WORKER: (complete this section if applying for both the mental health practice license and certification as a master social worker or if applying only for certification as a master social worker)

Yes No Activities: (check below the activities performed)

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Information, resource identification and development, and referral services |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Preparation & evaluation of psychosocial assessments & development of social work service plans |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Case management, coordination, and monitoring of social work service plans in the areas of personal, social, or economic resources, conditions, or problems |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Development, implementation, and evaluation of social work programs and policies |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Supportive contacts to assist individuals and groups with personal adjustment to crisis, transition, economic change, or a personal or family member's health condition |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Social casework for and prevention of psychosocial dysfunction, disability, or impairment |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Social work research, consultation, and education |

for _____ hours under my supervision from _____ to _____.

Supervisor's Credentials: Licensed Mental Health Practitioner and/or Licensed Independent Mental Health Practitioner and Certified Master Social Worker
 Certified Master Social Worker

PART III – Supervisor's Signature (All supervisors must complete this section)

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

(Print/type) SUPERVISOR Name and Title

Date Signed : _____

Signature

AGENCY/INSTITUTION

STREET ADDRESS

CITY STATE ZIP



Nebraska Department of Health and Human Services
Division of Public Health-Licensure Unit
P. O. Box 94986 - Lincoln, NE 68509-4986
(402) 471-4905
cindy.l.kelley@nebraska.gov

IF you have already submitted this form, you are not required to resubmit. If you have not, and your Masters practicum/internship was completed after September 1, 1995, this form MUST be completed by the on-site supervisor or internship director.

AFFIDAVIT OF SUPERVISED MASTERS PRACTICUM OR INTERNSHIP FOR MENTAL HEALTH PRACTICE

Name of Supervisor: License #:

Name of Applicant:

- Licensure Type: mental health practice, marriage and family therapy, social work, psychology

The applicant has completed a practicum/internship as part of his/her Master's Degree Program, which included a minimum of 300 clock hours of direct client contact of which 150 clock hours must be face-to-face in a work setting, providing mental health services under my supervision.

Mental Health Services means 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.

Marriage and Family Therapy: If the applicant is also applying for certification as a Marriage and Family Therapist, the following must be completed: I further verify that 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.

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

Form fields for Date, License/Certificate number of Supervisor, (Print/type) SUPERVISOR Name & Title, AGENCY/INSTITUTION, STREET ADDRESS, CITY, STATE, ZIP, and SIGNATURE OF SUPERVISOR or INTERNSHIP DIRECTOR.

You may make additional copies of this form if supervised by more than one supervisor