

Michigan Department of Community Health  
**Board of Marriage and Family Therapy**

P.O. Box 30670  
Lansing, Michigan 48909  
(517) 335-0918  
[www.michigan.gov/healthlicense](http://www.michigan.gov/healthlicense)

## **MARRIAGE AND FAMILY THERAPY RELICENSURE INSTRUCTIONS**

Authority: P.A. 368 of 1978, as amended  
This form is for information only.

**NOTE:** It is your responsibility to have all required documentation sent to the Board of Marriage and Family Therapy. Questions regarding your application can be directed to the Michigan Board of Marriage and Family Therapy at (517) 335-0918 three weeks after the date you sent the application. Please allow 6-8 weeks processing time.

### **GENERAL INSTRUCTIONS FOR RELICENSURE**

1. Type or print legibly on all forms and send the original application along with your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN**. Applications received without a fee will be returned to you and will not be considered until the proper fee has been received. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.
2. **Effective October 1, 2008**, all applicants for relicensure of a Michigan health profession license or registration that has been expired for **more** than 3 years are required to submit fingerprints and undergo a criminal background check. Please see the attached instructions. The Michigan Board is not able to accept fingerprints that have been obtained for any other purpose. Your license or registration will not be issued until this process is complete.
3. Verification of licensure from any state where you hold or have ever held a permanent marriage and family therapist license must be submitted. A form is enclosed for this purpose and may be copied as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required prior to sending them the form for completion. The Verification of Licensure form must be sent to the Michigan Board directly from the state(s) where you are or have been licensed.
4. If your license has been lapsed **more** than 3 years and you do not hold a current, unrestricted MFT license in another state, you will be required to pass the AMFTRB Examination in Marital and Family Therapy. Information about the examination content and how to register to take the examination will be sent to you after your relicensure application and fee are received.

## **GENERAL INFORMATION**

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes please notify the Board of Marriage and Family Therapy in writing. To change a name or address, you can download the [Data Change/Duplicate License Request Form](#) from our website [www.michigan.gov/healthlicense](http://www.michigan.gov/healthlicense) and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.
2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Marriage and Family Therapy in writing to request a refund.
3. **NOTE:** If you have ever been licensed in another state and you have a current disciplinary sanction on that license, (even if the license is inactive), you are **not** eligible for licensure in Michigan according to the Public Health Code, PA 368, as amended, Section 222.16174 (3). Sanctions include probation, limitation, suspension, revocation or fine. Upon resolution of the sanction and verification that the license is active with no disciplinary action in effect, you can proceed with the filing of an application for a Michigan license or registration.
4. ONCE RELICENSED, THE LICENSE IS VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE GOOD FOR A TWO-YEAR PERIOD.



STATE OF MICHIGAN

JENNIFER M. GRANHOLM  
GOVERNOR

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

JANET OLSZEWSKI  
DIRECTOR

## **CRIMINAL BACKGROUND CHECK FINGERPRINT REQUEST FORM INSTRUCTIONS- (Michigan locations only)**

Procedure to search criminal history records when fingerprints are required by law:

1. Complete the attached Livescan Fingerprint Request Form and schedule a fingerprinting appointment with Integrated Biometric Technology (IBT). A fee of \$65.25 is required for the fingerprinting process. The fee may be paid while registering on-line or at the fingerprinting appointment with either a business check or money order. Please note: The Agency ID Number needed for scheduling is 71734k.
2. To schedule a fingerprinting appointment on-line (Michigan locations only):  
  
Register with the approved fingerprinting vendor, IBT, at [www.ibtfingerprint.com](http://www.ibtfingerprint.com).  
  
Use the "click here to schedule by location" link to locate Michigan Livescan locations near you.  
  
Select Michigan as the State for which you are being fingerprinted, then complete the registration process and finalize your appointment.
3. To schedule a fingerprinting appointment by telephone (Michigan locations only):  
Call IBT toll-free at 1-866-226-2952 (8 am - 5 pm EST) and a representative will schedule the fingerprinting appointment and assist you in identifying a convenient location.
4. Please have the following with you upon arriving at your fingerprinting appointment:  
  
The attached completed Livescan Fingerprint Request Form.  
  
A driver's license or other state or federal issued picture identification (government ID, passport, military ID).  
  
A business check or money order for \$65.25 made payable in U.S. Funds to: Integrated Biometric Technology, unless you have made payment on-line.
5. A technician will scan your fingerprints and submit the data electronically to the Michigan State Police.
6. You will receive a signed receipt at the end of your fingerprinting session, which will include a TCN identification number that can be submitted to the Bureau of Health Professions for proof of fingerprinting.
7. If no criminal history information is found, the Bureau of Health Professions will be notified within 24-48 hours.
8. If criminal history information is found, the Michigan State Police will send the record directly to the Bureau of Health Professions for review.
9. IBT is under contract with the Michigan State Police (MSP) to provide fingerprint services. For questions, call MSP at (517) 322-1956.



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## **CRIMINAL BACKGROUND CHECK FINGERPRINT REQUEST FORM INSTRUCTIONS (out of state locations)**

Procedure to search criminal history records when fingerprints are required by law:

1. Contact a local law enforcement , governmental, or private fingerprinting agency to see if they can perform an ink fingerprint on an FBI (FD-258) card. The ink fingerprint must be completed on the FBI card.
2. Submit the FBI card with your fingerprints, the completed Livescan Fingerprint Request Form (attached) and a business check or money order for \$65.25 made payable in U.S. Funds to Integrated Biometric Technology at the following address:

IBT c/o Livescan  
1650 Wabash Ave. Ste. D  
Springfield, IL 62704

3. IBT will submit your fingerprints to the Michigan State Police for analysis.
4. If no criminal history information is found, the Bureau of Health Professions will be notified within 24-48 hours.
5. If criminal history information is found, the Michigan State Police will send the record directly to the Bureau of Health Professions for review.
6. Call IBT toll-free at 1-866-226-2952 (8 am - 5 pm EST) if you have any questions.
7. IBT is under contract with the Michigan State Police (MSP) to provide fingerprint services. For questions, call MSP at (517) 322-1956.

## LIVESCAN FINGERPRINT REQUEST FORM

Fingerprint Date:	TCN:
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Type of I.D. Presented:	Type of Licensure/Registration:
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**Applicant Instructions:** Take this completed form along with your picture I.D. to your scheduled appointment. Please print clearly.

First Name:	Middle Name:	Last Name:	
Street Address:			
City:	State:	ZIP Code:	
Daytime Telephone Number w/ Area Code:		State or Country of Birth:	
Date of Birth (MM/DD/YYYY):	Race:	Sex:	
Height:	Weight:	Eye Color:	Hair Color:

### REQUESTING AGENCY INFORMATION

Agency I.D. Number: <b>71734k</b>	Agency Name: <b>Department of Community Health, Bureau of Health Professions</b>
Reason Fingerprinted: <b>LHP - Licensed Health Care Professional</b>	Cost: <b>\$65.25</b>

**\*\*Disclaimer:** Any and all errors that result in dual fingerprinting (Duplicate transmission to MSP), multiple fingerprint codes, fingerprints processed with incorrect fingerprint codes/reasons, etc., are the responsibility of the **LIVESCAN AGENCY**. **MSP** will charge for dual fingerprinting (transmission), etc.

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### APPLICATION FOR RELICENSURE

Authority: Public Act 368 of 1978, as amended  
 If this form is not completed, a license will not be issued.

Type or Print Only

Board Use Only

License Number

Date of Relicensure

#### I AM APPLYING FOR THE FOLLOWING:

- Full License Relicensure Fee: \$105.00 71-4101-06
- Limited License Relicensure Fee: \$105.00 71-4101-06

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Daytime Phone Number (      )
Street Address		
City	State	ZIP Code
All Previous Names and/or Birth Name Used (if applicable)		E-Mail Address
Has your Michigan marriage and family therapist license been lapsed more than three years? <input type="checkbox"/> No <input type="checkbox"/> Yes	Michigan MFT Permanent I.D. Number and Expiration Date	

Check the appropriate answer to each of the following questions. **NOTE: Attach a detailed explanation for any Yes answer you check.**

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name
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8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified?  Yes  No

9. Do you hold or have you ever held a Marriage and Family Therapy license in any state? If so, list each state, the license number, the date issued, and how the license was obtained (either endorsement or examination). DO NOT LIST TEMPORARY LICENSES. You must have each state board verify licensure or registration directly to this board office. (Attach additional sheets if necessary.)  Yes  No

State	License/Registration Number	Date of Issue	How obtained (Endorsement or examination)

**CERTIFICATION**

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date
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**Michigan Department of Community Health**  
**Bureau of Health Professions**  
P.O. Box 30670  
Lansing, MI 48909

**VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE**

Authority: Public Act 368 of 1978, as amended.

**PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.**

<b>Check the profession for which you are requesting verification.</b>		
<input type="checkbox"/> Chiropractic <input type="checkbox"/> Counseling <input type="checkbox"/> Dentistry <input type="checkbox"/> Marriage & Family Therapy <input type="checkbox"/> Medicine	<input type="checkbox"/> Nursing <input type="checkbox"/> Nursing Home Adm. <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Optometry <input type="checkbox"/> Osteopathy	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Physician's Assistants <input type="checkbox"/> Podiatry <input type="checkbox"/> Psychology
<input type="checkbox"/> Sanitarians <input type="checkbox"/> Social Work <input type="checkbox"/> Veterinary		
First Name	Middle Name	Last Name
Previous Names Used	Date of Birth	U. S. Social Security Number
State Board	License Number	Date of Issue

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State. Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

**PART II: To be completed by the State Licensing Board.**

Basis for Issuance of License:		Type of License:
<input type="checkbox"/> Examination - Please indicate type of exam (National, Regional, State, etc.)	<input type="checkbox"/> Endorsement - Please indicate name of state	
License Status	Original Issue Date	Expiration Date
<input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive		
Has the applicant incurred any formal or informal actions in your State?		
<input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, Please attach certified copies of any actions.		
Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

**CERTIFICATION**

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Type or Print Name**

( S E A L )

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Full Name of Licensing Board**