

STATE BOARD OF PSYCHOLOGY

P.O. Box 2649
Harrisburg, PA 17105-2649

Telephone: (717) 783-7155
Fax: (717) 787-7769
Website: www.dos.pa.gov/psych
E-Mail: st-psychology@pa.gov

Courier Address:
2601 North Third Street
Harrisburg, PA 17110

APPLICATION TO REQUEST APPROVAL TO SIT FOR THE PSYCHOLOGY LICENSING EXAMINATIONS (App#863-104)

*This application is for first-time applicants who meet the following criteria **AND** were enrolled in the doctoral program prior to July 1, 2008:*

- Have received a doctoral degree from a program that is **NOT** accredited by the American Psychological Association (APA) or designated by the Association of State and Provincial Psychology Boards (ASPPB)/National Register Designation Project (**must have been enrolled in the program prior to July 1, 2008**).
- Have not yet completed supervised experience AND the supervised experience began on or after December 6, 2010.

CHECKLIST:

- Application to Request Approval to Sit for the Psychology Licensing Examinations

If any documentation submitted in connection with this application will be received in a name other than the name under which you are applying, you must submit a copy of the legal document(s) indicating the name change (i.e., marriage certificate, divorce decree which indicates the retaking of your maiden name; legal document indicating the retaking of a maiden name, or court order).

- \$105.00 Application Fee – Check or money order made payable to the Commonwealth of Pennsylvania. Fees are not refundable or transferable. If you do not receive the Board's approval to sit for the examinations within one year from the date your application is received, you will be required to submit another application fee. A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.
- The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services (DHS), is providing notice to all health-related licensees and funeral directors that are considered "mandatory reporters" under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete 3 hours of DHS-approved training in child abuse recognition and reporting requirements as a condition of licensure. Please review the Board website for further information on approved CE providers. Once you have completed a course, the approved provider will electronically submit your name, date of attendance, etc., to the Board. [Child Abuse Continuing Education Providers Information can be found here.](#)
- A Criminal Background Check from the state in which you reside must be submitted. The criminal background check must be completed within 90 days of submission of this application to the Board. Pennsylvania background checks may be obtained at <https://epatch.state.pa.us> or from the Pennsylvania State Police Central Repository, 1800 Elmerton Ave., Harrisburg, PA 17110-9758, (717) 783-5593.

(If you reside outside of Pennsylvania, you must contact the State Police from your jurisdiction.)

- A Child Abuse History Clearance completed by the Pennsylvania Department of Human Services. The report must be dated within 90 days from the date this application is received in the Board office. The Pennsylvania Child Abuse History Clearance Form (CY 113) is available on the Department of Human Services web site at www.dhs.pa.gov. To check on the status of a request for the Child Abuse Clearance call 717-783-6211.
- Provide a Self-Query from the National Practitioner Data Bank completed within 90 days of submission of this application to the Board. A Self-Query can be requested online at www.npdb.hrsa.gov. When you receive the "Self-Query Response" from the National Practitioner Data Bank, forward it to the Board office. (Verify that "Self-Query Response" is sent to the Board and not a discrepancy notice.)
- Internship Verification Form and Internship Job Description
- Official transcript of your doctoral degree received directly from the school in an official sealed school envelope. The Board is unable to accept transcripts marked "Issued to Student" or transcripts submitted by the applicant.
- Doctoral Program Information **(Documentation must be labeled as directed on the Doctoral Program Information form. Failure to submit the documentation as instructed may result in a delay with the Board's review of your application.)**
- If applicable, the Board must receive verification of any license, certificate, permit, registration or other authorization to practice any health-related profession directly from the state or jurisdiction. *PLEASE NOTE: The Board does NOT need to receive verification for licenses issued by one of the licensing boards within the Pennsylvania Bureau of Professional and Occupational Affairs.*

Once the Board receives the above documentation, it will determine eligibility to sit for the EPPP and the PPLE. If you are approved to sit for the examinations, your information will be submitted to ASPPB as an eligible to candidate to take the EPPP. You will receive an email from ASPPB with a link to activate your account. Additionally, your information will be sent to Professional Credentialing Services (PCS) for the PPLE. You will receive scheduling forms from PCS to schedule to sit for the PPLE.

Following completion of supervised experience, the Board must receive the following documentation:

- Application for License to Practice Psychology
- An updated Criminal Background Check from the state where the applicant resides completed by the State Police (see specific information above).
- An updated Child Abuse History Clearance completed by the Pennsylvania Department of Human Services, Child Line.
- Supervised experience began on or after December 6, 2010* - you must submit documentation of at least 12 months, consisting of at least 1750 hours, of acceptable supervised experience on the Board's Verification of Supervised Experience form.

Once the Board receives the above documentation, it will determine whether you have met the experience requirement to be licensed as a psychologist in Pennsylvania.

PLEASE NOTE: If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee.

In order to complete the application process, many of the supporting documents associated with the application cannot be more than six months from the date of issuance. All background check documents cannot be older than 90 days from the date of issuance.

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APPLICATION TO REQUEST APPROVAL TO SIT FOR THE PSYCHOLOGY LICENSING EXAMINATIONS (App#863-104)

****IF YOU HOLD AN ACTIVE LICENSE TO PRACTICE PSYCHOLOGY IN ANOTHER STATE, DO NOT COMPLETE THIS APPLICATION.**

INITIAL APPLICATION FEE: \$105.00 PAYABLE TO THE COMMONWEALTH OF PENNSYLVANIA. FEES ARE NOT REFUNDABLE OR TRANSFERABLE. IF YOU DO NOT RECEIVE THE BOARD'S APPROVAL TO SIT FOR THE EXAMINATIONS WITHIN ONE YEAR FROM THE DATE YOUR APPLICATION IS RECEIVED, YOU WILL BE REQUIRED TO SUBMIT ANOTHER APPLICATION FEE. A PROCESSING FEE OF \$20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER RETURNED UNPAID BY YOUR BANK, REGARDLESS OF THE REASON FOR NON-PAYMENT.

1. Name _____ (Last) (First) (Middle)	
2. Will any documentation submitted in connection with this application be received in a name other than the name under which you are applying? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please provide the other name or names: _____	
3. Address _____ (Street) _____ (City) (State) (Zip Code) <i>The address you provide is the address that will be associated with this application to which all correspondence will be mailed. Please note that licenses are not forwardable.</i>	
4. Telephone _____ Fax _____	
5. E-Mail Address _____	
6. Date of Birth _____	7. Social Security Number _____
8. Name of the College/University where doctoral degree was obtained _____ _____ Date of graduation (mm/yyyy) _____	
9. Have you previously passed the Examination for Professional Practice in Psychology (EPPP)? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please provide the state which authorized you to take the EPPP. _____ <i>You must request an EPPP Score Transfer from ASPPB (www.asppb.net).</i>	

		YES	NO
10.	<p>Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction?</p> <p>If you answered YES to the above question, please provide the profession and state or jurisdiction. Please do not abbreviate the profession.</p> <hr/> <hr/> <p>The Board must receive verification of any license, certificate, permit, registration or other authorization to practice any health-related profession directly from the state or jurisdiction. PLEASE NOTE: The Board does NOT need to receive verification for licenses issued by one of the licensing boards within the Pennsylvania Bureau of Professional and Occupational Affairs.</p>	<input type="checkbox"/>	<input type="checkbox"/>
If you answer YES to any of the following questions, provide complete details as well as copies of relevant documents to the Board office.		YES	NO
11.	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, include any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	<input type="checkbox"/>	<input type="checkbox"/>
15.	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Do you currently engage in or have you ever engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Have you ever had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Have you ever had practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility?	<input type="checkbox"/>	<input type="checkbox"/>
19.	Have you ever been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	<input type="checkbox"/>	<input type="checkbox"/>

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa.C.S. § 4304.1(a). At the request of the Department of Human Services (DHS), the licensing boards must provide to DHS information prescribed by DHS about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

Applicant's Statement:

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

Applicant's Signature

Date

INTERNSHIP VERIFICATION FORM

Intern's Name: _____

Dates of Experience: From: ____/____/____ To: ____/____/____

TO BE COMPLETED BY THE DIRECTOR OF INTERNSHIP

**** ATTACH A WRITTEN JOB DESCRIPTION FOR THE INTERN.**

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. The program was accredited by the American Psychological Association.
(If YES, complete only questions 1 and 11.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Upon entering the internship, the trainee had supervised training for 450 or more hours. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. The trainee carried out major professional functions under supervision. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. The trainee engaged in a range of assessment and interventions activities. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. During the internship, the trainee had a sequence of experiences designed to enhance professional attitudes, responsibilities and technical skills. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Reports leaving the agency were signed by the trainee and countersigned as "reviewed and approved" by the supervisor or other delegated professional. | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. The trainee received an average of at least two hours per week of individual supervision. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. The trainee participated in learning activities for an average of at least two hours per week (in addition to supervision referred to in #7 above). | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. The trainee interacted formally and informally with psychologists, other service providers, and other interns. | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. The internship extended for a year and included at least 1500 hours of experience with at least 25% of the time (375 hours) in direct client/patient contact and no more than 25% of the time in research, or the internship extended for two years and included at least 1500 hours. | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. At the end of internship training, check the level the intern demonstrated professional competencies and theoretical knowledge in the areas below? | | |

	Not demonstrated in this setting	Beginning	Intermediate	Advanced
a. Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Effective interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Consultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Evaluation of programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Supervision of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Strategies of scholarly inquiry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Cultural/individual diversity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Professional conduct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Most interns exhibit “intermediate” competence at the end of the internship year in the areas in which they have been trained. “Advanced” competence is expected of licensees in the areas in which they practice.

The licensed psychologist who was responsible for the integrity and quality of the internship and who completed this verification form was:

Name

Signature

Date

License Number: _____

State of Issuance: _____

Date Issued: _____

Expiration Date: _____

Additional supervision was provided by: _____ in _____
Name Setting

Additional supervision was provided by: _____ in _____
Name Setting

RETURN COMPLETED FORM AND JOB DESCRIPTION TO APPLICANT

DOCTORAL PROGRAM INFORMATION

DEGREE HOLDERS FROM A FOREIGN COLLEGE OR UNIVERSITY MUST HAVE AN EVALUATION COMPLETED BY THE NATIONAL REGISTER. THE CONTACT INFORMATION FOR THE NATIONAL REGISTER IS PROVIDED BELOW:

National Register
Attn: Laura Rhymes
1120 G Street, NW Ste 330
Washington, DC 20005

laura@nationalregister.org
202-783-7663 (Voice)
202-347-0550 (Fax)
www.nationalregister.org

FIRST-TIME APPLICANTS WHO WERE ENROLLED IN A DOCTORAL DEGREE PROGRAM THAT WAS NOT ACCREDITED BY THE AMERICAN PSYCHOLOGICAL ASSOCIATION (APA) OR DESIGNATED BY THE ASSOCIATION OF STATE AND PROVINCIAL PSYCHOLOGY BOARDS (ASPPB)/NATIONAL REGISTER DESIGNATION PROJECT AT A REGIONALLY ACCREDITED U.S. COLLEGE OR UNIVERSITY PRIOR TO JULY 1, 2008, MUST SUBMIT THE FOLLOWING INFORMATION. EACH ITEM LISTED BELOW MUST BE CLEARLY LABELED WITH THE ATTACHMENT NUMBER INDICATED. FAILURE TO SUBMIT THE DOCUMENTATION AS INSTRUCTED MAY RESULT IN A DELAY WITH THE BOARD'S REVIEW OF YOUR APPLICATION.

In order for the Board to determine whether the candidate's doctoral program meets the Board's regulations, the following documentation must be submitted:

- a) Pages from institutional catalog(s) for the year the applicant entered the program:
 - 1) demonstrating that education and training is available to prepare professional psychologists.
(label as Attachment 1)
 - 2) demonstrating that the program provides the education and training appropriate to the practice of psychology and that it stands as a recognized sequence in the administrative unit in which it is located.
(label as Attachment 2)
 - 3) demonstrating that the program comprises an integrated, organized sequence of study. (Advisory/advisee forms showing the sequence of core, specialty, and supervised training may supplement catalog copy.)
(label as Attachment 3)
 - 4) describing the residency requirement.
(label as Attachment 4)
- b) Name of the faculty member responsible for the doctoral program in psychology and a list of the faculty who teach core and specialty courses in the program (see c below). For each person, provide an abbreviated vita to illustrate how each is a psychologist and is qualified to teach the courses assigned. (Academic major in doctoral study, professional identifications, memberships in professional organizations, licensure, and publications and presentations are some indicators. Not every member of the faculty must be a psychologist.)
(label as Attachment 5)
- c) Complete the chart on page 3 providing the course prefix, title, catalogue description, number of credit hours by type, and name(s) of instructors for the following core and specialty curriculum areas:
 - * Ethics as related to scientific methods and professional standards,
 - * Research design and methodology,
 - * Statistics and psychometrics,
 - * Biological bases of behavior,
 - * Cognitive-affective bases of behavior,
 - * Social bases of behavior,
 - * Individual differences,
 - * Supervised practicum,
 - * Internship, and
 - * Specialty courses required.

When one course among several is available for one area, list information for each.

(labeled as Attachment 6)

If this is a program where the doctoral degree was obtained in a field related to psychology, also completed (d) and (e).

- d) Pages from institutional catalog for the year the applicant entered the program indicating that psychology faculty has authority and primary responsibility for the core and specialty courses and for the admission, evaluation, and recommendation of students for the degrees obtained in this program.
(label as Attachment 7)

- e) In tabular form, indicate the number of students enrolled for each of the last five years with cells for the years and whether the students were full or part time. If the year of graduation for the applicant was not within those five years, add columns for the years the applicant was enrolled.
(label as Attachment 8)

Attachment 6

Use the first two columns of one line for the area title and the number of hours required. On the following lines complete the other columns for courses in that area. This page may be reproduced locally as necessary.

Areas	S or Q Hours	Prefix	Title	Catalogue Description	Instructor	Text(s)

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APPLICATION FOR LICENSE TO PRACTICE PSYCHOLOGY

1. Name _____			
(Last)	(First)	(Middle)	
2. Address _____			
(Street)			

(City)	(State)	(Zip Code)	
<i>The address you provide is the address that will be associated with this application to which all correspondence will be mailed. Please note that licenses are not forwardable.</i>			
3. Telephone _____ Fax _____			
4. E-Mail Address _____			
5. Date of Birth _____		6. Social Security Number _____	
			YES
			NO
7.	Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction? If you answered YES to the above question, please provide the profession and state or jurisdiction. Please do not abbreviate the profession. _____ _____ The Board must receive verification of any license, certificate, permit, registration or other authorization to practice any health-related profession directly from the state or jurisdiction. <i>PLEASE NOTE: The Board does NOT need to receive verification for licenses issued by one of the licensing boards within the Pennsylvania Bureau of Professional and Occupational Affairs.</i>	<input type="checkbox"/>	<input type="checkbox"/>
If you answer YES to any of the following questions, provide complete details as well as copies of relevant documents to the Board office.			YES
			NO
8.	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>

<i>If you answer YES to any of the following questions, provide complete details as well as copies of relevant documents to the Board office.</i>		YES	NO
11.	Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, include any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	<input type="checkbox"/>	<input type="checkbox"/>
12.	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Do you currently engage in or have you ever engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Have you ever had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Have you ever had practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Have you ever been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	<input type="checkbox"/>	<input type="checkbox"/>

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa.C.S. § 4304.1(a). At the request of the Department of Human Services (DHS), the licensing boards must provide to DHS information prescribed by DHS about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

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I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

Applicant's Signature

Date

This form is required if your supervised experience began on or after 12/6/2010.

VERIFICATION OF SUPERVISED EXPERIENCE

After you complete Part A below, forward to your primary supervisor and/or delegated supervisor. All primary supervisor(s) and delegated supervisor(s) must be complete a Verification of Supervised Experience form. Please duplicate this form as needed. All Verification of Supervised Experience forms and attachments must be returned to the applicant in sealed envelopes with supervisor's signature over the envelope seal. You should then send the envelope(s) to the Board along with the application.

PART A – TO BE COMPLETED BY APPLICANT

Provide your employer for the time period documented on this form.

Name:

LAST FIRST MIDDLE

Address:

STREET

CITY STATE ZIP CODE

Employer: _____

PART B – TO BE COMPLETED BY PRIMARY SUPERVISOR/DELEGATED SUPERVISOR

Provide your employer and professional title for the time period documented on this form.

Name:

LAST FIRST MIDDLE

Mailing
Address:

STREET

CITY STATE ZIP CODE

Employer: _____

Business Telephone Number: _____ FAX Number: _____

Supervisor's Professional Title: _____

Did you serve as the applicant's primary supervisor or as a delegated supervisor? _____

Was applicant's professional title in this setting "Psychology Resident" or "Psychology Trainee"?

YES NO If no, please provide applicant's professional title and an explanation of how patients and others were informed of applicant's status as a resident/trainee: _____

Part B continued on back

PART B – CONTINUED – VERIFICATION OF SUPERVISED EXPERIENCE

Number of Years in Professional Practice: _____

Indicate Specialty (such as industrial psychology, clinical psychology, etc.): _____

Type of License Held: _____

License Number: _____ State of Issuance: _____

Date Issued: _____ Expiration Date: _____

Has any disciplinary action ever been taken against this license? YES NO

If YES, please give details on a separate 8½ x 11 sheet of paper.

VERIFICATION OF APPLICANT’S SUPERVISED EXPERIENCE

I attest that _____ has worked under my supervision, in the
 (NAME OF APPLICANT)
 capacity listed on page 1, for the following dates:

_____/_____/_____
 MONTH/DAY/YEAR TO _____
 MONTH/DAY/YEAR

PLEASE COMPLETE:

Total Number of Weeks <i>(Must be at least 52 weeks)</i>	MULTIPLY	Average Number of Hours per Week <i>(Must be at least 15 hours per week but no more than 45 hours per week)</i>	EQUALS – Initial Number of Hours	MINUS – number of hours of training missed during the period for such things as vacation, holidays, sick days, personal days, snow days, etc.	EQUALS – Total Number of Hours Earned
EXAMPLE 52 weeks	X	45 hours	= 2,340 hours	– 590 hours	= 1,750 hours
_____	X	_____ <i>This number must be equal to the TOTAL documented on page 4.</i>	= _____	– _____	= _____

If you were not the owner of, an employee of, or in contract status with the professional setting employing the supervisee, check here and explain the conditions for supervision in a statement attached to this form.

PART B – CONTINUED – VERIFICATION OF SUPERVISED EXPERIENCE

(Written clarification is required for questions not answered in accordance with §41.33 of the Board's regulations.)

PRIMARY AND DELEGATED SUPERVISORS MUST ANSWER QUESTIONS 1 – 13.

	YES	NO
1. Were you currently licensed while providing supervision?	<input type="checkbox"/>	<input type="checkbox"/>
2. Were you qualified by training and experience to practice in the psychology resident's areas of supervised practice?	<input type="checkbox"/>	<input type="checkbox"/>
3. Were you an owner, an employee of, or in contract status with the entity employing the psychology resident?	<input type="checkbox"/>	<input type="checkbox"/>
4. Did you review issues of practice and ethics with the psychology resident?	<input type="checkbox"/>	<input type="checkbox"/>
5. Did you maintain notes or records of scheduled supervisory sessions? (Please note, Board regulations require that you maintain notes or records of scheduled supervisory sessions until the psychology resident obtains a license or for at least 10 years, whichever is greater.)	<input type="checkbox"/>	<input type="checkbox"/>
6. Did you ensure that the psychology resident's status was made know to client/patients and to third-party payors?	<input type="checkbox"/>	<input type="checkbox"/>
7. Did you prepare written evaluations/progress reports at least quarterly delineating the psychology resident's strengths and weaknesses?	<input type="checkbox"/>	<input type="checkbox"/>
8. Were you subject to the psychology resident's control or influence?	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you related to the psychology resident by blood or marriage?	<input type="checkbox"/>	<input type="checkbox"/>
10. Were you or are you involved in a dual relationship, as defined in principle 6(b) of the code of ethics (49 Pa. Code § 41.61, principle (b)), with the psychology resident?	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you treating or have you treated the psychology resident?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you been the subject of an active suspension or revocation by a licensing board?	<input type="checkbox"/>	<input type="checkbox"/>
13. Did you accept fees, honoraria, favors or gifts from the psychology resident?	<input type="checkbox"/>	<input type="checkbox"/>

PRIMARY SUPERVISORS MUST ALSO ANSWER QUESTIONS 14 – 25.

14. Did you meet individually face-to-face with the psychology resident for an average supervisory total of at least 2 hours per week? If you answer NO, please complete number 15.	<input type="checkbox"/>	<input type="checkbox"/>
15. Did you delegate up to 1 hour per week of individual face-to-face supervision to a delegated supervisor? Name of delegated supervisor: _____	<input type="checkbox"/>	<input type="checkbox"/>
16. Did you monitor the supervision provided by any delegated supervisor?	<input type="checkbox"/>	<input type="checkbox"/>
17. Did you complete either a course in supervision from a psychology doctoral degree program or 3 hours of continuing education in supervision? (Required as of 12/1/2015.)	<input type="checkbox"/>	<input type="checkbox"/>
18. Did you develop with the psychology resident objectives to be achieved during supervision?	<input type="checkbox"/>	<input type="checkbox"/>
19. Were you accessible to the psychology resident for consultation and to clients/patients of the psychology resident to answer questions and respond to concerns?	<input type="checkbox"/>	<input type="checkbox"/>
20. Were you responsible to each client/patient for psychology services provided by the psychology resident?	<input type="checkbox"/>	<input type="checkbox"/>
21. Were you authorized to interrupt or terminate the services being provided by the psychology resident to a client/patient and, if necessary, to terminate the supervisory relationship?	<input type="checkbox"/>	<input type="checkbox"/>
22. Did you observe client/patient sessions of the psychology resident or review verbatim recordings of these sessions on a quarterly basis?	<input type="checkbox"/>	<input type="checkbox"/>
23. At least quarterly, in supervisory meetings, did you evaluate and apprise the psychology resident about areas of progress and needed improvement, recommend applicable professional literature and assist the resident in gaining a level of skill necessary for independent practice?	<input type="checkbox"/>	<input type="checkbox"/>
24. Did you assist the psychology resident in working with professionals in other disciplines as indicated by the needs of each client/patient and periodically observe these cooperative encounters?	<input type="checkbox"/>	<input type="checkbox"/>
25. Did you ensure that the psychology resident had access to multidisciplinary consultation, as necessary?	<input type="checkbox"/>	<input type="checkbox"/>
26. At the conclusion of the period of supervision, did you evaluate the psychology resident's level of professional competence and theoretical knowledge in the areas of assessment, diagnosis, effective interventions, consultation, evaluation of programs, supervision of others, strategies of scholarly inquiry, cultural/individual diversity and professional conduct?	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE COMPLETE THE FOLLOWING CHECKLIST INDICATING THE HOURS PER WEEK IN WHICH THE TRAINEE WAS ENGAGED IN PREPARING FOR THE PRACTICE OF PSYCHOLOGY:

Please refer to §41.32 of the Board's regulations for the specific requirements for supervised experience.

Duties performed by the trainee	Hours per week
1. Diagnosis	_____
2. Assessment	_____
3. Therapy	_____
4. Other Interventions	_____
5. Supervision/Consultation	_____
6. Individual supervision received as a supervisee	_____

At least half of the reported weekly experience must be in the categories above.

- 7. Teaching in association with:
 - a. an organized psychology program preparing practicing psychologists and/or _____
 - b. a postdoctoral training program _____
- 8. Psychological Research _____
(Provide detailed description of research)

TOTAL

This number must be equal to the Average Number of Hours per Week documented on page 2.

At the end of supervised training, check the level the trainee demonstrated professional competencies and theoretical knowledge in the areas below?

	Not demonstrated in this setting	Beginning	Intermediate	Advanced
a. Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Effective interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Consultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Evaluation of programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Supervision of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Strategies of scholarly inquiry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Cultural/individual diversity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Professional conduct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Submit a copy of the objectives established for the supervisee and a copy of written quarterly reports (with confidential information redacted).

On a separate sheet of paper describe your supervisory interactions with the applicant and your judgment of the applicant's potential as a psychologist. Please place your original signature and date on the description.

After completing this Verification of Supervised Experience form, please place it and ALL attachments in a sealed envelope, place your signature over the envelope seal and return it to the applicant.

VERIFICATION

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

Original Signature of Supervisor

Date