

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/APPLICATION FOR LICENSE TO PRACTICE PSYCHOLOGY (App#863-105)

This application is for first-time applicants who meet the following criteria:

- Have received a doctoral degree from a program that is either accredited by the American Psychological Association (APA) or designated by the Association of State and Provincial Psychology Boards (ASPPB)/National Register Designation Project.
- Have completed supervised experience that began on or before December 5, 2010.

CHECKLIST:

1. Application to Request Approval to Sit for the Psychology Licensing Examinations/Application for License to Practice Psychology

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).

2. \$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.
3. 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.](#)
4. 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.)

5. 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.
6. 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.)
7. 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.
8. Verification of Doctoral Program Accreditation/Designation Status and Pre-Doctoral Internship Form
9. 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.*
10. *Supervised experience began on or before December 5, 2010* - you must submit documentation of 1500 hours of acceptable supervised experience on the Board's Verification of Supervised Experience form.

Once the Board receives items 1 – 9 above, 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.

Once the Board receives item 10 above, 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/APPLICATION FOR LICENSE TO PRACTICE PSYCHOLOGY (App#863-105)

****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"/>
<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 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

This form is required if your supervised experience began on or before 12/5/2010.

VERIFICATION OF SUPERVISED EXPERIENCE

After you complete Part A below, forward to your supervisor. If experience was completed under more than one supervisor, the form should be duplicated and forwarded to each supervisor. 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 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: _____

Was applicant's professional title in this setting "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 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:

_____/_____/_____/ TO _____/_____/_____/

MONTH/DAY/YEAR MONTH/DAY/YEAR

PLEASE COMPLETE:

Total Number of Weeks	MULTIPLY	Average Number of Hours per Week	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 40 weeks	X	40 hours	= 1,600 hours	– 100 hours	= 1,500 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 §41.32 of the Board's regulations.)

	YES	NO
1. Were you qualified by training and experience to practice in the supervisee's areas of supervised practice?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you involved in a dual relationship that obliges you to the supervisee?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you subject in any way to the supervisee's control or influence?	<input type="checkbox"/>	<input type="checkbox"/>
4. Were you accessible to the supervisee for consultation?	<input type="checkbox"/>	<input type="checkbox"/>
5. Were you accessible to clients/patients of the supervisee for the purpose of answering questions and responding to concerns?	<input type="checkbox"/>	<input type="checkbox"/>
6. Were you responsible for the supervisee's service to each client/patient?	<input type="checkbox"/>	<input type="checkbox"/>
7. Were you empowered to interrupt or terminate the supervisee's activities in providing services to a client/patient and, if necessary, to terminate the supervisory relationship?	<input type="checkbox"/>	<input type="checkbox"/>
8. Were you a relative of the supervisee by blood or marriage?	<input type="checkbox"/>	<input type="checkbox"/>
9. Did you engage in psychological treatment of the supervisee?	<input type="checkbox"/>	<input type="checkbox"/>
10. Were you the subject of a disciplinary action by a licensing board?	<input type="checkbox"/>	<input type="checkbox"/>
11. Did you establish objectives to be achieved by the supervisee during supervision?	<input type="checkbox"/>	<input type="checkbox"/>
12. Did you review issues of practice and ethics with the supervisee?	<input type="checkbox"/>	<input type="checkbox"/>
13. Did you maintain notes or records of scheduled supervisory sessions?	<input type="checkbox"/>	<input type="checkbox"/>
14. Did you observe client/patient sessions of the supervisee or review verbatim recordings of these sessions on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>
15. In regularly scheduled supervisory meetings, did you discuss the supervisee's level of work – for example, the supervisee's areas of competence and areas of needed improvement?	<input type="checkbox"/>	<input type="checkbox"/>
16. Did you provide to the supervisee recommendations bearing on further development, encourage the supervisee to read widely in the professional literature and help the supervisee gain a level of skill necessary for independent practice?	<input type="checkbox"/>	<input type="checkbox"/>
17. Did you prepare written evaluations or reports of progress which delineated the supervisee's strengths and weaknesses?	<input type="checkbox"/>	<input type="checkbox"/>
18. Were these evaluations or reports discussed with the supervisee on at least a quarterly basis?	<input type="checkbox"/>	<input type="checkbox"/>
19. Did you ensure that the supervisee had access to consultation from another discipline as necessary?	<input type="checkbox"/>	<input type="checkbox"/>
20. Did you accept fees, honoraria, favors or gifts from the supervisee?	<input type="checkbox"/>	<input type="checkbox"/>
21. Did you ensure that the supervisee's status as a psychology trainee was made known to client/patients and to third-party payers?	<input type="checkbox"/>	<input type="checkbox"/>
22. Did you ensure that the supervisee had access to multidisciplinary consultation, as necessary?	<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 §41.31(c)(1) 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. 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. Supervision provided as a supervisor	_____
9. Professional development (Provide detailed description of professional development)	_____
10. 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