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#863-107)

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 after December 6, 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 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 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#863-107)

*****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 ☐ NO ☐

   If yes, please provide the other name or names: _____

3. Address _____
(Street)

   _____
(City) (State) (Zip Code)

   *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.***

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 ☐ NO ☐

   If yes, please provide the state which authorized you to take the EPPP. _____

   You must request an EPPP Score Transfer from ASPPB (www.asppb.net).

		YES	NO
10.	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. *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.*	☐	☐
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?	☐	☐
12.	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	☐	☐
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?	☐	☐
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.	☐	☐
15.	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	☐	☐
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?	☐	☐
17.	Have you ever had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	☐	☐
18.	Have you ever had practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility?	☐	☐
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?	☐	☐

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

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VERIFICATION OF DOCTORAL PROGRAM ACCREDITATION/DESIGNATION STATUS AND PRE-DOCTORAL INTERNSHIP

TO BE COMPLETED BY DIRECTOR OF CLINICAL TRAINING

After completing this Verification of Doctoral Program Accreditation/Designation Status and Pre-Doctoral Internship form, please place it and any attachment in a sealed envelope, place your signature over the envelope seal and return it to the applicant.

I certify that _____ completed
NAME OF APPLICANT

the _____ program at _____.
NAME OF DOCTORAL PROGRAM NAME OF INSTITUTION

1. The program completed by the above named applicant is:

   Accredited by the American Psychological Association (APA) ☐ YES ☐ NO

   Designated by the Association of State and Provincial Psychology Boards (ASPPB)/ National Register Designation Project ☐ YES ☐ NO

2. The above named applicant completed a pre-doctoral internship during the following time period:

   From: _____ To: _____*
   Month/Day/Year Month/Day/Year

   *Director of Clinical Training may also provide a copy of the internship certificate which contains the dates of the pre-doctoral internship.

_____
Name of Director of Clinical Training

_____
Signature of Director of Clinical Training

_____
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 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 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:

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

PLEASE COMPLETE:

Total Number of Weeks *(Must be at least 52 weeks)*	**MULTIPLY**	**Average Number of Hours per Week** *(Must be at least 15 hours per week but no more than 45 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 **52 weeks**	**X**	**45 hours**	**= 2,340 hours**	**– 590 hours**	**= 1,750 hours**
_____	**X**	_____ ***This number must be equal to the TOTAL documented on page 4.***	**=** _____	**–** _____	**=** _____

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?	☐	☐
2. Were you qualified by training and experience to practice in the psychology resident's areas of supervised practice?	☐	☐
3. Were you an owner, an employee of, or in contract status with the entity employing the psychology resident?	☐	☐
4. Did you review issues of practice and ethics with the psychology resident?	☐	☐
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.)	☐	☐
6. Did you ensure that the psychology resident's status was made know to client/patients and to third-party payors?	☐	☐
7. Did you prepare written evaluations/progress reports at least quarterly delineating the psychology resident's strengths and weaknesses?	☐	☐
8. Were you subject to the psychology resident's control or influence?	☐	☐
9. Are you related to the psychology resident by blood or marriage?	☐	☐
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?	☐	☐
11. Are you treating or have you treated the psychology resident?	☐	☐
12. Have you been the subject of an active suspension or revocation by a licensing board?	☐	☐
13. Did you accept fees, honoraria, favors or gifts from the psychology resident?	☐	☐
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.	☐	☐
15. Did you delegate up to 1 hour per week of individual face-to-face supervision to a delegated supervisor?	☐	☐
Name of delegated supervisor: _____		
16. Did you monitor the supervision provided by any delegated supervisor?	☐	☐
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.)	☐	☐
18. Did you develop with the psychology resident objectives to be achieved during supervision?	☐	☐
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?	☐	☐
20. Were you responsible to each client/patient for psychology services provided by the psychology resident?	☐	☐
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?	☐	☐
22. Did you observe client/patient sessions of the psychology resident or review verbatim recordings of these sessions on a quarterly basis?	☐	☐
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?	☐	☐
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?	☐	☐
25. Did you ensure that the psychology resident had access to multidisciplinary consultation, as necessary?	☐	☐
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?	☐	☐

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	☐	☐	☐	☐
b. Diagnosis	☐	☐	☐	☐
c. Effective interventions	☐	☐	☐	☐
d. Consultation	☐	☐	☐	☐
e. Evaluation of programs	☐	☐	☐	☐
f. Supervision of others	☐	☐	☐	☐
g. Strategies of scholarly inquiry	☐	☐	☐	☐
h. Cultural/individual diversity	☐	☐	☐	☐
i. Professional conduct	☐	☐	☐	☐

☐ **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