ASSOCIATION OF STATE AND PROVINCIAL PSYCHOLOGY BOARDS

ASPPB

State of Nevada Board of Psychological Examiners

APPLICATION CHECKLIST

(Items Needed from ASPPB for Review in Nevada)

APPLICANT NAME: _____

DATE: 04/22/2013

References	1 of 3		
Demographics	yes		
Credentials	n/a	Verification if yes:	n/a
Licensure	yes	Verification form if yes:	yes
Education	yes	Doctoral verification form:	yes
Courses	yes	Checked to Transcript:	yes
Doctoral Transcript:	yes		
Examination:	yes	Verification if yes:	yes
Internship: *(Minimum)*	yes	Attested	yes
Experience *(Minimum)*	yes	Attested	yes
Conduct	n/a	Explanation if yes:	n/a
Declaration:	yes		

DEMOGRAPHICS

Demographics

PERSONAL INFORMATION

Email Address:	
Last Name:	
First Name:	
Middle Name:	
Maiden Name:	
Suffix:	
Gender:	Female
Citizenship:	USA
Professional Name:	
Other Current Names:	
Other Names:	
Place of Birth:	Santa Fe, New Mexico
Date of Birth:	
SSN/SIN:	
Languages:	English
Disability Accommodations:	No

BUSINESS ADDRESS

Business Name:					
Address 1:					
Address 2:					
City:	Santa Ana	State/Province:	CA	Zip:	92701

HOME ADDRESS

†Address 1:					
Address 2:					
City:	Placentia	State/Province:	CA	Zip:	92870

PERMANENT ADDRESS

Address 1:					
Address 2:					
City:	Placentia	State/Province:	CA	Zip:	92870

† Checked for Preferred Mailing Address

PHONES AND FAX

Business Phone:		Fax:	
Home Phone:		Cell Phone:	

DECLARATION OF INTENDED PRACTICE

RECEIVED APR 1 1 2013

ASPPB Psychology Licensure Universal System Application and/or Documentation Deposit

Applicant Name *(Last, First, M.I.)*:

Declaration of Intended Psychological Practice

All applicants are asked to state their areas of intended practice in psychology. The declaration will be considered in the context of the competencies identified in the educational preparation and experience of the applicant.

A. Check the appropriate area(s) of intended psychological practice below:

1. Clinical Psychology	✓	8. Academic (teaching psychology)*	✓
2. Counseling Psychology		9. Industrial/Organizational	
3. School Psychology		10. Clinical Neuropsychology	
4. Forensic Psychology		11. Rehabilitation Psychology	
5. Cognitive & Behavior Psychology		12. Psychoanalysis Psychology	
6. Clinical Health Psychology		13. Research	
7. Correctional		14. Other (specify)	

*May not be considered an area of psychological practice in some jurisdictions

B. Once you have indicated your area(s) of practice, use the corresponding numbers above to identify the activities and services you intend to provide and the clients to whom you will provide these services.

Clients	Administration	Consultation	Assessment/ Evaluation**	Intervention/ Treatment***	Research	Other (specify)
Infants						
Children			1			
Adolescents	1	1	1	1		
Adults	1, 8	1	1	1		8
Elderly			1			
Families			1			
Groups						
Organizations						
Other (specify)						

** Includes interviewing and the administration, scoring and interpretation of psychological test batteries for the diagnosis of cognitive abilities and personality functioning

*** Includes the theory and application of a diverse range of psychological interventions for the treatment of mental, emotional, psychological and behavioral disorders

Association of State and Provincial Psychology Boards
P.O. Box 3079 • Peachtree City, GA 30269 • (678) 216-1175 • Fax (678) 216-1184 • E-mail cpq@asppb.org • www.asppb.net

LICENSURE VERIFICATION FORM

RECEIVED FEB . . 2013

LICENSURE/CERTIFICATION/REGISTRATION VERIFICATION FORM

SECTION 1: Instructions for Applicant: Print your name and information for the jurisdictional agency to which you are requesting verification. Forward this document along with any applicable fees for **every** jurisdiction where you have ever held a professional license to ASPPB. Please check directly with the jurisdiction to ascertain applicable fees.

Last Name | First Name: | Middle Initial:

Jurisdiction: CALIFORNIA

Type of License/Certification/Registration held: PSYCHOLOGIST

CL# 2246

License/Certification/Registration #: PSY

Social Security/Insurance Number:

Date of Birth:

I hereby waive all right to confidentiality to the jurisdiction reporting herein, for the purpose of reporting to the Association of State and Provincial Psychology Boards (ASPPB), the information requested below including any and all complaints adjudicated, stipulated, or pending against me including participation in any program to which I have acknowledged impairment (physical, mental or substance).

Signature | Date 2/19/13

Please complete Section 1 only and return form to:

ASPPB Mobility Program
P. O. Box 3079
Peachtree City, GA 30269

SECTION 2: TO BE COMPLETED BY THE JURISDICTIONAL LICENSING AGENCY

Licensing Agency

Licensee:

License Number: | Issue Date | Expiration Date

yes | no

Did your jurisdiction issue the original license/registration/certification?

Licensed by (check one):

Examination for Professional Practice in Psychology (EPPP)

Certification of Professional Qualification in Psychology (CPQ)

Professional Endorsement (specify):

Reciprocity between jurisdictions (specify jurisdictions).

Other (specify).

EDUCATIONAL INFORMATION

Education

INFORMATION ABOUT GRADUATE DEGREE PROGRAM				
Degree	Date Conferred	Institution	Department	Program
Ph.D.	06/14/1996	California School of Professional Psychology -San Diego	Psychology	Clinical Psychology

INFORMATION ABOUT DOCTORAL PROGRAM					
Training Director for Doctoral Program (this information has been verified):					
*Name:					
*Address:	Alliant International University San Diego 10455 Pomerado Road				
*City:	San Diego	*State/Province:	CA	*Zip:	92131
*Email:	[illegible]u		*Phone:	[illegible]3	

1.	Was your doctoral degree in psychology obtained from an institution of higher education that was regionally accredited by bodies recognized by the U.S. Department of Education and/or the Council of Higher Education Accreditation (CHEA) or holds a membership in the Association of Universities and Colleges of Canada to grant graduate degrees at the time you received your degree?	Yes
2.	Was your program accredited by the American Psychological Association or the Canadian Psychological Association at the time your doctoral degree was conferred?	Yes
3.	Was your program listed as a Designated Doctoral Program in Psychology by ASPPB/National Register at the time your doctoral degree was conferred?	Unknown
4.	Did your program require three (3) years of full-time (or equivalent) graduate study, not including internship or postdoctoral supervised experience, one year of which was in continuous residence on campus?	Yes
5.	Was your program clearly labeled and publicly identified as a psychology program (i.e., transcript, university catalog, etc.)?	Yes
6.	Did your program have an integrated, organized sequence of study?	Yes
7.	Did your program include at least one year of full-time continuous residency at the institution granting the doctoral degree? Dates of Residency: From 07/01/1989 To 06/01/1996	Yes
8.	Did your program have an identifiable full-time psychology faculty and a psychologist responsible for the program in residence at the institution, in size and breadth sufficient to carry out its responsibilities, employed by and providing instruction at the home campus of the institution?	Yes
9.	Did your program have supervised practicum, internship, field experience or laboratory training appropriate to the area of psychology practice and specialty with such experiences supervised by a psychologist?	Yes
10.	Did your program have an identifiable body of students in residence at the institution who were matriculated in that program for a degree?	Yes

COGNITIVE-AFFECTIVE BASES OF BEHAVIOR

Includes such courses as Learning, Thinking, Motivation, Emotion, Sensation, Perception, Cognition, Cognitive Psychology

Course Title	Institution	Year	Term	Course Number	Credit	Hours
Psychology of Learning	University of Nevada at Las Vegas	1988	Fall	PSY 420	3	45
Advanced Psychology of Cognition and Emotion	Alliant International University - CSPP San Diego	1990	Spring	T721a	2	30

SOCIAL BASES OF BEHAVIOR

Includes such courses as Social Psychology, Group Processes, Organizational and Systems Theory, Introduction to Community Psychology, Social Foundations of Psychology

Course Title	Institution	Year	Term	Course Number	Credit	Hours
Proseminar II: Social Psychology	Alliant International University - CSPP San Diego	1991	Spring	T721b	3	45

INDIVIDUAL DIFFERENCES

Includes such courses as Personality Theory, Human Development, Abnormal Psychology

Course Title	Institution	Year	Term	Course Number	Credit	Hours
Personality	University of Nevada at Las Vegas	1989	Spring	PSY 430	3	45
Theories of Personality, Pathology and Psychotherapy I: Psychoanalytic	Alliant International University - CSPP San Diego	1989	Fall	T501	3	45
Advanced Developmental Psychology	Alliant International University - CSPP San Diego	1990	Spring	T698	3	45
Theories of Personality, Pathology and Psychotherapy II: Existential	Alliant International University - CSPP San Diego	1990	Spring	T539	3	45
Humanities Forum: New Paradigm	Alliant International University - CSPP San Diego	1990	Spring	H480	2	30
Descriptive Psychopathology: DSM III-R	Alliant International University - CSPP San Diego	1990	Summer	T506	2	30
Theories of Personality, Pathology and Psychotherapy III: Behavioral/Social Learning	Alliant International University - CSPP San Diego	1991	Spring	T532	3	45
Creativity and Creative Writing	Alliant International University - CSPP San Diego	1991	Spring	H321	2	30
Individual Project in the Humanities (Independent Study)	Alliant International University - CSPP San Diego	1991	Summer	H200	2	30
Myth and Archetype	Alliant International University - CSPP San Diego	1991	Fall	H271	2	30
Advanced Psychopathology	Alliant International University - CSPP San Diego	1991	Fall	T801	3	45
Comparative Cultures: Ritual and Healing	Alliant International University - CSPP San Diego	1991	Winter	H471	2	30
Trickster Motif in Myth and Analysis	Alliant International University - CSPP San Diego	1993	Winter	H217	2	30

ASSESSMENT/EVALUATION

Includes such courses as Psychological Sssessment Techniques, Psychodiagnostic Assessment, Neuropsychological Assessment, Program Evaluation, IQ Testing, Projective Testing, Organizational Assessment

Course Title	Institution	Year	Term	Course Number	Credit	Hours
Psychodiagnostic Assessment: Assessment of Intelligence	Alliant International University - CSPP San Diego	1990	Spring	P516	4	60
Psychodiagnostic Assessment IV: Objective Testing	Alliant International University - CSPP San Diego	1990	Fall	P516d	3	45
Psychodiagnostic Assessment V:	Alliant International University -	1991	Fall	P516e	3	45

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UNLV

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Official Transcript

Student ID: Name: -)

02/19/2013 Page 1 of 1

Order Nbr: 000258776

1985 SPRING TERM
BACHELOR OF SCIENCE
WITH HIGH DISTINCTION
BIOLOGY (PRE-PROFESSIONAL)
MAY 26, 1985

Beginning of Graduate Record

1988 Spring

			Att	Erh	Grd
PSY	193	Stat Meth in Psy	4.00	0.00	A
		Grading Basis: Cross-Career: No Earned Hrs or GPA			

	Att	Earned	Points	GPA	GP Bal
Term Totals	4.00	0.00	0.00	0.00	0.00

1988 Summer

			Att	Erh	Grd
PSY	140	Rsch Meth in Psy	3.00	0.00	A
		Grading Basis: Cross-Career: No Earned Hrs or GPA			

	Att	Earned	Points	GPA	GP Bal
Term Totals	3.00	0.00	0.00	0.00	0.00

1988 Fall

			Att	Erh	Grd
PSY	406	Inferential Statistics	3.00	0.00	A
		Grading Basis: Cross-Career: No Earned Hrs or GPA			
PSY	420	Psychology Learning	3.00	0.00	A
		Grading Basis: Cross-Career: No Earned Hrs or GPA			
PSY	498	Independ Rsch	2.00	0.00	A
		Grading Basis: Cross-Career: No Earned Hrs or GPA			

	Att	Earned	Points	GPA	GP Bal
Term Totals	8.00	0.00	0.00	0.00	0.00

1989 Spring

			Att	Erh	Grd
PSY	430	Personality	3.00	0.00	A
		Grading Basis: Cross-Career: No Earned Hrs or GPA			
PSY	498	Independ Rsch	3.00	0.00	A
		Grading Basis: Cross-Career: No Earned Hrs or GPA			

	Att	Earned	Points	GPA	GP Bal
Term Totals	6.00	0.00	0.00	0.00	0.00

Graduate Career Totals

Cumulative Totals	21.00	0.00	0.00	0.00	0.00

Beginning of Undergraduate Record

Transfer/Test Credits

TRANSFER CREDIT FROM SIS	TRANSFER CREDIT		64.00

Archival Data

			Att	Erh	Grd
HARD	COPY	Hardcopy Summary/Earned	51.00	51.00	384
HARD	COPY	Hardcopy Summary/Su	1.00	1.00	S

	Att	Earned	Points	GPA	GP Bal
Term Totals	52.00	52.00	195.84	3.84	93.84

1984 Fall

			Att	Erh	Grd
BIO	444	Cell Physiology	3.00	3.00	A
BIO	448	Endocrinology	3.00	3.00	A
CHE	474	Biochemistry I	3.00	3.00	A

	Att	Earned	Points	GPA	GP Bal
Term Totals	9.00	9.00	36.00	4.00	18.00

1985 Spring

			Att	Erh	Grd
BIO	401	Prin of Genetics	4.00	4.00	A
CHE	472	Biochemistry Lab	2.00	2.00	A
CHE	475	Biochemistry II	3.00	3.00	A

	Att	Earned	Points	GPA	GP Bal
Term Totals	9.00	9.00	36.00	4.00	18.00

Undergraduate Career Totals

Cumulative Totals	70.00	134.00	267.54	3.82	129.84

End of Official Transcript

RECIPIENT

ASPPB Mobility Program
PO Box 3079
Peachtree City, GA 30269
United States

THIS OFFICIAL UNIVERSITY TRANSCRIPT DOES NOT REQUIRE A RAISED SEAL.

UNIVERSITY OF NEVADA LAS VEGAS

JOHN P. PANZICA
OFFICE OF THE REGISTRAR

Federal law prohibits access to this record by any party without written consent of student.

ALLIANT
INTERNATIONAL UNIVERSITY

STUDENT ACADEMIC RECORD

RECEIVED FEB 2 5 2013

Name: C . ID#
Addr: 3

Alliant International University
10455 Pomerado Road
San Diego, CA 92131

Matriculation Date:

Degree: Doctor of Philosophy Clinical Psychology(APA)

Class: Doctoral
School: CA School of Prof Psych

---------- Fall Semester 1989 ----------

H201	Ethics/Cultural Contexts & Heali	3.00	CR
I500a	Advanced Statistics I	3.00	CR
P001	Introduction to Prof. Psychology	1.00	CR
P501	Theory & Pract Psythrpy I: Intr	3.00	CR
T501	Thrys Persnlty Path: Psychoanaly	3.00	CR

	Reg Hrs	Passed	Quality	Q-Pts.	GPA
Sess	13.00	13.00	0.00	0.00	0.000
Cum	13.00	13.00	0.00	0.00	0.000

---------- Spring Semester 1990 ----------

H480	Humanities Forum: New Paradigm	2.00	CR
I500b	Advanced Statistics II	3.00	CR
P516	PsyAssmtII: Assmt. of Intelligen	4.00	CR
T539	Thyrs Persnlty: Existential	3.00	CR
T698	Advanced Developmental Psycholog	3.00	CR
T721e	Pro Seminar I: Cognition & Emoti	2.00	CR

	Reg Hrs	Passed	Quality	Q-Pts.	GPA
Sess	17.00	17.00	0.00	0.00	0.000
Cum	30.00	30.00	0.00	0.00	0.000

---------- Post-Session 1990 ----------

T506	Descriptive Psychopathology-DSM-	2.00	CR

	Reg Hrs	Passed	Quality	Q-Pts.	GPA
Sess	2.00	2.00	0.00	0.00	0.000
Cum	32.00	32.00	0.00	0.00	0.000

---------- Summer Term 1990 ----------

F600	Pract Prof Psy	0.00	CR

	Reg Hrs	Passed	Quality	Q-Pts.	GPA
Sess	0.00	0.00	0.00	0.00	0.000
Cum	32.00	32.00	0.00	0.00	0.000

---------- Fall Semester 1990 ----------

F600	Practicum in Professional Psycho	4.00	CR
I510	Principles of Research Design	3.00	CR
P516d	Psy Asmnt IV: Obj Tstng w/ Lab	3.00	CR
T721c	Pro Seminar III: Adv Physio Psyc	2.00	CR

	Reg Hrs	Passed	Quality	Q-Pts.	GPA
Sess	12.00	12.00	0.00	0.00	0.000
Cum	44.00	44.00	0.00	0.00	0.000

---------- Spring Semester 1991 ----------

F600	Practicum in Professional Psycho	4.00	CR
H321	Creativity & Creative Writing	2.00	CR
I701a	Dissertation Design Group	1.00	CR
P875	Clinical Aspects of Dream Interp	3.00	WD
T532	Thrys Persnlty: Behavioral/Socia	3.00	CR
T721b	Pro Seminar II: Social Psycholog	3.00	CR

	Reg Hrs	Passed	Quality	Q-Pts.	GPA
Sess	16.00	13.00	0.00	0.00	0.000
Cum	60.00	57.00	0.00	0.00	0.000

---------- Post-Session 1991 ----------

H471	Comp Cult:	2.00	CR

	Reg Hrs	Passed	Quality	Q-Pts.	GPA
Sess	2.00	2.00	0.00	0.00	0.000
Cum	62.00	59.00	0.00	0.00	0.000

---------- Summer Term 1991 ----------

H200	Ind Study: Mythic Drama: Clas &	2.00	CR

	Reg Hrs	Passed	Quality	Q-Pts.	GPA
Sess	2.00	2.00	0.00	0.00	0.000
Cum	64.00	61.00	0.00	0.00	0.000

---------- Fall Semester 1991 ----------

H271	Myth & Archetype:	2.00	CR
I801b	Doctoral Dissertation (Research	3.00	CR
P516e	Psy Assmnt V: Projective Testing	3.00	CR
P517	Projective Testing Laboratory	1.00	CR
P805	I & P Psythrpy: Indiv (Psychdyna	3.00	CR
T801	Advanced Psychopathology	3.00	CR

	Reg Hrs	Passed	Quality	Q-Pts.	GPA
Sess	15.00	15.00	0.00	0.00	0.000
Cum	79.00	76.00	0.00	0.00	0.000

---------- Spring Semester 1992 ----------

I801b	Doctoral Dissertation (Research	3.00	CR
P516f	Psych Asmnt VI: Clinical Infere	3.00	CR
P805	I & P Psythrpy: Indiv (Psychdyna	3.00	CR
P875	Clinical Aspects of Dream Interp	3.00	CR

	Reg Hrs	Passed	Quality	Q-Pts.	GPA
Sess	12.00	12.00	0.00	0.00	0.000
Cum	91.00	88.00	0.00	0.00	0.000

TO VERIFY: TRANSLUCENT GLOBES MUST BE VISIBLE FROM BOTH SIDES OF TRANSCRIPT WHEN HELD TOWARD A LIGHT SOURCE

Name: ID#

08/02/91 Advancement to Candidacy

08/02/91 Final Competency Exam Passed

CSPP - San Diego
Degree: Doctor of Philosophy
Awarded: Conferred:
Major: Clinical Psychology(APA)

University Registrar
Signed on: 02/20/2013

The Family Educational Rights and Privacy Act of
1974 prohibits the release of this information
without the student's written consent.

TO VERIFY: TRANSLUCENT GLOBES MUST BE VISIBLE FROM BOTH SIDES OF TRANSCRIPT WHEN HELD TOWARD A LIGHT SOURCE

Section II: Authorization to Release Information

Last Name: _____ First Name: _____ Middle Initial: J.

SSI/SSN: _____ Date of Birth: _____

Date of Graduation: _____

I am currently registering my credentials with the Association of State and Provincial Psychology Boards (ASPPB). As you may know, ASPPB acts as an agent to collect and verify credentials.

To facilitate this process, I hereby request:

- An official transcript which bears your institution's seal and the signature of an authorized representative; and
- Certification of the enclosed doctoral degree diploma, by affixing the institution's seal and the signature of an authorized representation onto the diploma; and
- The Head of the Doctoral Program, or an authorized representative, to complete Section II of this form.

Please send this information directly to ASPPB in the enclosed postage-page self-addressed envelope. If you have any questions about this process, please contact ASPPB toll-free at 1-800-

_____ _____

Signature Date

b. Require each student to complete at least two of the three years at the institution from which the degree was granted? ☑ Yes ☐ No

c. Require each student to compete at least one year in full-time residence on campus at the institution from which the degree was granted? (Residence means physical presence, in person, at the educational institution in a manner that facilitates the full participation and integration of the individual in the educational and training experience and includes faculty student interaction; Models that use face-to-face contact for shorter durations throughout a year or models that use video teleconferencing or other electronic means to meet the residency requirement are not acceptable as applies to the Mobility Program requirements) ☑ Yes ☐ No

From To

E5. Was there an identifiable full-time psychology faculty in residence at the institution, and employed by and providing instruction at the home campus of the institution? ☑ Yes ☐ No

State the number of full-time psychology faculty in residence at the institution: 15

E6. Was there a psychologist responsible for the graduate program either as the administrative head, or as the advisor, major professor, or committee for chair the above applicant: ☑ Yes ☐ No

If yes, provide the psychologist's name and role:

E7. Did the program maintain clear authority and primary responsibility for the core and specialty areas whether or not the program crossed administrative lines? ☑ Yes ☐ No

E8. Did the program have an identifiable body of students in residence at the institution who were matriculated in the program for a degree? ☑ Yes ☐ No

E9. Did the doctoral program include supervised practicum, internship, field experience or laboratory training appropriate to the area of psychology practice that was supervised by a psychologist: ☑ Yes ☐ No

C. If you answered "no" to at least one question listed in *Section B* above, the following documentation must be submitted:

A. Attach pages from institutional catalog(s) for the year the applicant entered the program which include a listing of the curriculum track or course of study for the program and course descriptions, and which document the following:

1. That the program of study provided the education and training appropriate for the practice of psychology;

SUPERVISED EXPERIENCE

Program Practicum Attestation Form

I. APPLICANT INFORMATION

Applicant Name:

Title/Position: Date Began: 10/12/2009 Date Ended: 07/30/2010

Duties:

Agency:

Address:

City: Chicago State/Province: IL Zip: 60605

II. PRIMARY SUPERVISOR INFORMATION

Name: Email Address: Phone:

Address:

City: Chicago State/Province: IL Zip: 60605

Degree: Ph.D. Year Conferred: 1994

Licensed? Yes Jurisdiction: IL License #:

Supervisor Degree Specialty Area: Clinical Psychology

Other Jurisdictions Licensed in: States of Illinois and Texas

Supervision Activities: Individual and group Psychotherapy, Psycholoigcal Assessment, Crisis intervention and medication management services.

III. PRACTICUM SUPERVISION HOURS

Total number of practicum hours (excluding all leave): 760

Total number of face-to-face patient/client contact hours: 327

Total number of hours of individual supervision by a Licensed Psychologist: 47

Total of number hours of group supervision by a Licensed Psychologist: 61

IV. PRACTICUM EXPERIENCE INFORMATION

Practicum Course Number & Title: Practicum and Seminar III & IV

Term & Year (i.e., Spring, 2010): Fall 2009, Spring and Summer 2010

Title/Position of Student: Extern

Practicum Dates: From 10/12/2009 To 07/30/2010

Total Number of Weeks of Practicum: 40 Average Hours Per Week of Practicum: 19

A. Total Number of Hours of Practicum: 760 B.Hours of Practicum in Service-Related Activities[1]: 650

Description of Duties/Responsibilities: Assisted my supervisor in pretrial psychological assessment of the male inmates at the facility, including competency to stand trial and mental status at the time of the offense. Conducted individual and group therapy of the men and women at the facility. Completed intake mental health screenings and brief mental health stability checks.

C. Total Number of Hours of Individual Supervision by a Licensed Psychologist: 47

D. Total Number of Hours of Group Supervision by a Licensed Psychologist: 61

E. Total Number of Hours of Individual Supervision by a Non-licensed Psychologist or Other Mental Health Professional: 0

F. Total Number of Hours of Group Supervision by a Non-licensed Psychologist or Other Mental Health Professional: 0

G. Total Number of Hours of Supervision (C+D+G+H): 108

H. Total Number of Hours of Supervision by a Licensed Psychologist (individual and group) (C+D): 108

Internship Verification Form

I. AGENCY INFORMATION

Applicant Name:					
Date Began:	08/15/1993	Date Ended:	08/14/1994		
Agency:			ıter		
Address:					
City:	Chula Vista	State/Province:	CA	Zip:	91911

II. MAIN SUPERVISOR INFORMATION

Name:		Email Address:		Phone:	
Address:					
City:	Cardiff	State/Province:	CA	Zip:	92007
Degree:	Ph.D.	Year Conferred:	1981		
Degree Specialty Area:		Clinical Child and Adolescent Psychology			
Licensed?	Yes	Jurisdiction:	CA	License #:	
Other Jurisdictions Licensed in:					
Supervision Activities:	Intern was supervised on assessment and psychological and neurosychological testing of children, adolescents, adults and older adults. report preperation, treatment planning, individual, group and family psycotherapy. Also worked in a partial hospitalization for adults SPMI.				

III. INTERNSHIP INFORMATION

Title of the Intern:	Senior Psychology Intern
Specialty Area of the Internship:	Clinical Psychology
Duties of the Internship:	Diagnostic interviews and assessment; diagnostic evaluation of children, adolescents, adults, and older adults using variety of psychological tests including neuropsychological measures; preparation of psychological reports;case conceptualization; treatment planning; case management; individual, group, and family psychotherapy; partial hospitalization program with seriously and persistently mentally ill adults.
Was this a formal internship required as part of your training?	Yes
Was the internship APA accredited when the applicant completed training?	No
Was the internship CPA accredited when the applicant completed training?	No
Was the internship a member of APPIC when the applicant completed training?	No
Describe the clientele served:	Children, adolescents, and adults psychiatrically hospitalized for acute symptoms; seriously and persistently mentally ill adults in a partial hospitalization program.
Remarks:	Please note that this webform does not allow for precise information input. My hours were accrued and calculated at the end of each semester, and there were some weeks in which I worked more hours and some less, so the total does not match that provided by your automated calculations. My total hours for this internship equal I will upload my internship evaluations to provide additional documentation.

IV. INDIVIDUAL SUPERVISION

Period of Time	Supervisor Information	Supervision Hours
08/01/1993 - 12/31/1993	ı, Ph.D., Licensed in CA	22 Weeks, 2 Hours Per Week
01/01/1994 -	, Ph.D., Licensed in CA	32 Weeks, 2 Hours Per Week

	services rendered directly by the intern?	
11	How many Licensed Psychologist supervisors were there for this applicant during this internship?	2
12	How many interns were in the program at the doctoral level during the entire period of training?	6
13	Was the internship accredited by APA or CPA when the applicant completed training?	
14	Was the internship a member of APPIC when the applicant completed training?	No
15	Did the internship take place in a health service setting?	Yes
16	Did the internship take place in a private practice setting?	No
17	Did this applicant successfully complete the internship at a satisfactory level of performance (explain if no)?	Yes
18	Did any of this applicant's supervisors have a familial or financial relationship with this applicant (explain if yes)?	No
19	Was any credit given to this applicant for activities completed before the starting date (explain if yes)?	No
20	Was any credit given to this applicant for activities which were not directly under the supervision and control by your organization or facility (explain if yes)?	No

IX. SUPERVISION FROM OTHER HEALTH CARE PROFESSIONALS

Professionals	Descriptions (Supervisor Names, and Hours per Week etc.)
Psychiatrists	
Physicians	
Social Workers	
Nurses	
Others	

I declare that all the information on this form to be true and correct.

Printed Name of Person Attesting to Experience

Electronically Signed by Attester
Signature of Person Attesting to Experience

Apr 16 2013 11:30AM
Date and time

V. GROUP SUPERVISION

Period of Supervision	Supervisor Information	Supervision Hours	Members
06/10/1996 - 03/30/1998	Ph.D., Licensed in CA	92 Weeks, 3 Hours Per Week	4

VI. SUPERVISION HOURS

1	Total number of weeks of supervised experience (excluding all leave):	92
2	Average number of hours per week of supervised experience:	30
3	Total number of hours of experience:	2760
4	Number of hours per week of individual supervision from all licensed psychologists:	1
5	Total number of hours of individual supervision from all licensed psychologists (#4 * #1)	92
6	Number of hours per week of group supervision from all licensed psychologists:	3
7	Number of hours per week of individual and group supervision from all other licensed professionals::	0
8	Number of hours per week of supervision received (individual & group) from licensed psychologists (#4 + #6):	4
9	Total number of hours of supervision (individual & group) from licensed psychologists (#8 * #1):	368
10	Number of hours in face-to-face patient/client contact per week:	20
11	Number of hours in direct psychological service-related activities per week:	8
12	Total number of hours of direct psychological services completed:	2004
13	Total number of hours of general or non-clinical psychological services completed:	2
14	Percentage of the applicant's supervision provided by Licensed Psychologist(s):	100%

VII. SUPERVISED EXPERIENCE YES/NO QUESTIONS

Were there any periods of extended leave (explain if yes)?	Yes
Was this experience completed on a full-time basis?	Yes
Were there any periods of extended leave (explain if yes)?	No
Did the experience take place in a health service setting?	Yes
Did the experience take place in a private practice setting?	No
Did this applicant successfully complete the supervised experience at a satisfactory level of performance (explain if no)?	Yes
Did any of this applicant's supervisors have a familial or financial relationship with this applicant (explain if yes)?	No
Was any credit given to this applicant for activities completed before the starting date (explain if yes)?	No
Was any credit given to this applicant for activities which were not directly under the supervision and control by your organization or facility (explain if yes)?	No
Do you recommend this applicant for licensure (explain if no)?	Yes

VIII. SUPERVISION FROM OTHER HEALTH CARE PROFESSIONALS

Professionals	Descriptions (Supervisor Names, and Hours per Week etc.)
Psychiatrists	
Physicians	
Social Workers	
Nurses	
Others	

EXAMINATION INFORMATION

Examination

PROFESSIONAL PRACTICE IN PSYCHOLOGY (EPPP)					
Have you taken Professional Practice in Psychology (EPPP)? Yes					
Name Registerred for EPPP	Exam Date	Jurisdiction	Candidate ID	Score	Form #
[illegible]	10/08/	CA		164	716470

STATE/PROVINCE/TERRITORY BOARD EXAMINATION				
Have you taken any State/province/territory Board Examination? Yes				
Exam Date	Name of Exam	Jurisdiction	Format/Content	Result
10/08/	EPPP	CA	Multiple Choice, paper	Passed
06/20/[illegible]	Oral Examination	CA	Assessment & Evaluation; Crisis Evaluation and Intervention; Diagnosis; Human Diversity; Professional Ethics; Legal Mandates and Related Issues; Limitations and Judgment; Treatment Planning & Implementation	Passed
03/02/	Oral Examination	SD	Oral examination	Passed

PROFESSIONAL CONDUCT HISTORY

Conduct History

PERSONAL/PROFESSIONAL CONDUCT HISTORY QUESTIONNAIRE		
1.	Has any jurisdiction (e.g., state, province, the District of Columbia, or U.S. possession or territory) rejected or denied your application for licensure/certification/registration as a psychologist or any other profession?	No
2.	Have you ever been disciplined (i.e., revocation, suspension, reprimand, censure, or any other publicly reported disciplinary action) by a psychology licensing body?	No
3.	Has any jurisdiction limited your practice in any way or by any other action?	No
4.	Have you ever been disciplined while holding any other professional license/registration/certificate?	No
5.	Have you ever been convicted of, or entered a plea of guilty or *nolo contendere* to a criminal offense, felony, or misdemeanor (other than a minor traffic violation)?	No
6.	Have you ever voluntarily surrendered or restricted your professional license/registration/certificate in any jurisdiction?	No
7.	Have you ever been censured, reprimanded, dismissed, suspended, terminated or asked to resign, or has any disciplinary action been taken against you during your education, training or employment as a mental health professional?	No
8.	Have you ever been refused renewal of any professional license/registration/certificate for any reason in any jurisdiction?	No
9.	Are you the subject of a current proceeding or outstanding/unresolved complaint or investigation in relation to the profession of psychology or any other profession?	No
10.	Have you ever aided or abetted another individual in practicing psychology without a license or an exemption in any jurisdiction?	No
11.	Have you ever practiced psychology without a license or exemption in any other jurisdiction?	No
12.	Are you registered in any jurisdiction as a sex offender?	No
13.	Are you physically or mentally incapable to render psychological services with reasonable skill, safety and competency at present?	No
14.	Do you use drugs and/or alcohol to an extent that affects your professional competency?	No
15.	Have you ever been party to a malpractice action or had a malpractice action brought against you or entered into a malpractice settlement?	No
16.	Have you ever been subject to an action by an ethics committee of any professional organization in any jurisdiction?	No
17.	Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended, or subjected to restrictions or been requested to withdraw or resign?	No
18.	Has any third party payor, including Medicare and Medicaid, terminated, suspended, restricted or revoked your status as a provider for reasons related to your professional practice?	No
19.	Have you ever had professional liability insurance cancelled?	No
20.	Has any government agency ever substantiated allegations made against you for physical, mental, emotional abuse or neglect, sexual abuse, or exploitation of (1) a child, (2) a resident of an adult care home, medical care facility, psychiatric hospital or state institution for the mentally retarded, or (3) an adult?	No

REFERENCES

RECEIVED MAR 0 0 2013

The Association of State and Provincial Psychology Boards

Psychology Licensure Universal System

P.O. BOX 3079 Peachtree City, GA 30269 (678) 216-1175 FAX (678) 216-1184
asppb@asppb.org

INSTRUCTIONS TO APPLICANT: Please complete the following and submit directly to the reference for return to ASPPB.

, PhD	
Personal Reference (Name/Title)	Applicant (Name)
Street Address	Street Address
Lake Forest, CA 92653	
City, State, ZIP	City, State, ZIP

I authorize the exchange of any and all information pertaining to this document between the named personal reference and ASPPB. I understand that the information may be released to me by ASPPB, but not to the general public.

Applicant — Date: 01/11/2013

INSTRUCTIONS TO REFERENCE: The above applicant has applied as a psychologist in Nevada and has identified you as a person with knowledge of his/her character and qualifications to practice psychology. Your accurate and timely provision of this information directly to the ASPPB will greatly facilitate the application process.

Character Reference

(Please print or type - Use additional sheet(s) if necessary)

1. During what period did you have enough contact with the applicant that you could form an impression of his/her ability to carry out professional responsibilities as a psychologist?	From: Month/Year 02/2009	To: Month/Year Present
2. What was the nature of your relationship? Dr. was initially my colleague but later reported to me.		
3. How well did you know applicant during that period and in that context? I initially knew her fairly well but got to know her better each year.		
4. Describe below the psychological duties which applicant performed and of which you had direct knowledge. Dr. audited client care records, provided supervision to psychology interns, provided consultation on documentation and billing standards and oversaw the quality helpdesk		
5. In your opinion, did this applicant at any time or in any way show evidence of behavior, judgement or performance problems, or other characteristics which would give rise to any question or doubt of his/her suitability for licensure as a psychologist?	Yes	No

Under penalty of perjury I herewith affirm that the information supplied herein is, to the best of my knowledge and belief, true, accurate, and complete.

Signed

Director of Quality Review + Training
Title & Organization

2-28-13
Date

State of California

County of Orange

Signed and sworn to (or affirmed) before me on (Date) 02/28/2013

Name of person making statement

Signature of Notary

(Notary Stamp)

CARL FRAGA
Commission # 1917936
Notary Public - California
Orange County
My Comm. Expires Jan 16, 2015

Revised 6/5/2012

Association of State and Provincial Psychology Boards

Psychology Licensure Universal System Application Form

DEMOGRAPHICS			
PERSONAL INFORMATION			
Email Address:	Login Password:		
Last Name*:	First Name*:		
Middle Name:	Maiden Name:		
Suffix:			
Gender*:	Citizenship:	☐ US ☐ Canada ☐ Other (Specify):	
Professional Name:			
Other Current Names:			
Other Names:			
Place of Birth (City, State/Province):	Date of Birth*:		
SSN/SIN*:			
Languages:	Disability Accommodations:	☐ Yes	☐ No
BUSINESS ADDRESS (Required for CPQ/IPC/Licensure Applications)			
Business Name:			
Address 1:			
Address 2:			
City:	State/Province:	Zip:	
☐ Check for Preferred Mailing Address			
HOME ADDRESS			
Address 1:			
Address 2:			
City:	State/Province:	Zip:	
☐ Check for Preferred Mailing Address			
PERMANENT ADDRESS			
Address 1:			
Address 2:			
City:	State/Province:	Zip:	
☐ Check for Preferred Mailing Address			
PHONES AND FAX			
Business Phone:	Ext.:	Fax:	
Home Phone*:	Cell Phone:		

*indicates a required field

CREDENTIALS	
STANDARD CREDENTIALS	
American Board of Professional Psychology (ABPP)	Date Granted:
	Specialty:
ASPPB Certificate of Professional Qualification in Psychology (CPQ)	Date Granted:
Canadian Register of Health Service Providers in Psychology (CRHSPP)	Date Granted:
National Register of Health Service Providers in Psychology (NRHSPP)	Date Granted:
OTHER CREDENTIALS	
Other	Date Granted:

Provide information on any professional psychology credential (ABPP, CPQ, National Register, etc.) that you currently hold or have held in the past. Applicants must make request that the issuing organization send verification of status of the credential directly to ASPPB.

Association of State and Provincial Psychology Boards

Psychology Licensure Universal System Application Form

LICENSURE/REGISTRATION HISTORY

LICENSES FOR PSYCHOLOGIST/MENTAL HEALTH PRACTITIONER

Are you or have you ever been **licensed as a psychologist**? ☐ Yes ☐ No

If yes, list all state/provinces/territories in which you have now or have ever held a license or certificate to practice as a Psychologist. Complete Section I of the Licensure/Certification/Registration Verification Form and return to the ASPPB via fax or email.

Jurisdiction:	Issue Date:
Licensure #:	License Type:

LICENSES FOR MENTAL OR NON-MENTAL HEALTH FIELD/PROFESSION

Are you or have you ever been **licensed/registered in any other mental or non-mental health field or profession**? ☐ Yes ☐ No

If yes, list all jurisdiction(s) and field and/or profession.

Jurisdiction:	Issue Date:
Licensure #:	Profession:

Status: ☐ Active ☐ Inactive

LICENSES FOR PSYCHOLOGIST/MENTAL HEALTH PRACTITIONER

Are you or have you ever been **licensed/certified by any state or government agency** other than a board of psychology or other mental health board such as Department of Public Instruction or Department of Education? ☐ Yes ☐ No

If yes, provide details below.

Provide information regarding all psychology or other mental health licenses/certificates/registrations that you currently hold or have previously held regardless of current status (i.e., active, inactive, lapsed, probationary, restricted, suspended, revoked, delinquent, etc.). Complete Section I of the Licensure/Certification/Registration Verification Form for each licensing entity listed and return the completed signed form to ASPPB by mail, fax, or email. ASPPB will verify all information directly with the licensing entity by utilizing the information provided in this section and on the Licensure/Certification/Registration Verification Form. Failure to provide accurate information will result in a delay in processing your application.

EDUCATION	
INFORMATION ABOUT GRADUATE DEGREE PROGRAM	
List all graduate education. An official transcript must be submitted directly to ASPPB by all institutions listed. If you completed respecialization training at another institution, submit official transcripts from both degree granting and respecialization training institutions. All doctoral level applicants must have their doctoral program verified. Please complete the applicable sections of the Verification of the Doctoral Education Program Form and return to ASPPB.	
Institution*:	
City:	State/Province:
Regional Accrediting Body:	Regional Accreditation Year:
Department*:	Program of Study*:
Degree*:	Date Degree Conferred*:
ASPPB Designation Year:	Year APA/CPA Approved:
Notes:	

*indicates a required field

An official transcript(s) must be sent directly to ASPPB from all institutions of higher education granting credit for graduate study used to satisfy requirements for all graduate degrees obtained.

NOTE:
1. If you have completed your degree requirements but have not officially graduated at the time of this application, a letter of completion from faculty or equivalent of graduate studies can be submitted directly to ASPPB along with a transcript of credits earned. Letters from Program Directors and/or Professors are not acceptable. This letter may not be accepted by licensing boards.
2. An official transcript showing the date the degree was conferred and the degree earned must be received before your application will be deemed complete.

COURSES

SCIENTIFIC & PROFESSIONAL ETHICS AND STANDARDS
(includes such courses as Professional Issues, Scientific & Professional Ethics in Psychology, Clinical Ethical Issues)

Course Title:		
Institution:		
Year Taken:	Academic Term: ☐ Semester ☐ Quarter	Semester/Quarter:
Course Number:	Number of Credits:	Hours of Instruction:
Brief Description of Course Content:		

RESEARCH DESIGN AND METHODOLOGY
(includes such courses as Research Design, Research Proposal Design)

Course Title:		
Institution:		
Year Taken:	Academic Term: ☐ Semester ☐ Quarter	Semester/Quarter:
Course Number:	Number of Credits:	Hours of Instruction:
Brief Description of Course Content:		

STATISTICS
(includes such courses as Statistics, Data Analysis, Quantitative Methods, Evaluation and Measurement)

Course Title:		
Institution:		
Year Taken:	Academic Term: ☐ Semester ☐ Quarter	Semester/Quarter:
Course Number:	Number of Credits:	Hours of Instruction:
Brief Description of Course Content:		

PSYCHOMETRIC THEORY
(includes such courses as Test Construction, Measurement, Psychological Assessment)

Course Title:		
Institution:		
Year Taken:	Academic Term: ☐ Semester ☐ Quarter	Semester/Quarter:
Course Number:	Number of Credits:	Hours of Instruction:
Brief Description of Course Content:		

BIOLOGICAL BASES OF BEHAVIOR
(includes such courses as Physiological Psychology, Comparative Psychology, Neuropsychology, Sensation and Perception, Psychopharmacology, Behavioral Neuroscience)

Course Title:		
Institution:		

Year Taken:	Academic Term: ☐ Semester ☐ Quarter	Semester/Quarter:
Course Number:	Number of Credits:	Hours of Instruction:
Brief Description of Course Content:		
COGNITIVE-AFFECTIVE BASES OF BEHAVIOR (includes such courses as Learning, Thinking, Motivation, Emotion, Sensation, Perception, Cognition, Cognitive Psychology)		
Course Title:		
Institution:		
Year Taken:	Academic Term: ☐ Semester ☐ Quarter	Semester/Quarter:
Course Number:	Number of Credits:	Hours of Instruction:
Brief Description of Course Content:		
SOCIAL BASES OF BEHAVIOR (includes such courses as Social Psychology, Group Processes, Organizational and Systems Theory, Introduction to Community Psychology, Social Foundations of Psychology)		
Course Title:		
Institution:		
Year Taken:	Academic Term: ☐ Semester ☐ Quarter	Semester/Quarter:
Course Number:	Number of Credits:	Hours of Instruction:
Brief Description of Course Content:		
INDIVIDUAL DIFFERENCES (includes such courses as Personality Theory, Human Development, Abnormal Psychology)		
Course Title:		
Institution:		
Year Taken:	Academic Term: ☐ Semester ☐ Quarter	Semester/Quarter:
Course Number:	Number of Credits:	Hours of Instruction:
Brief Description of Course Content:		
ASSESSMENT/EVALUATION (includes such courses as Psychological Assessment Techniques, Psychodiagnostic Assessment, Neuropsychological Assessment, Program Evaluation, IQ Testing, Projective Testing, Organizational Assessment)		
Course Title:		
Institution:		
Year Taken:	Academic Term: ☐ Semester ☐ Quarter	Semester/Quarter:
Course Number:	Number of Credits:	Hours of Instruction:
Brief Description of Course Content:		

TREATMENT/INTERVENTION (includes such courses as Psychotherapy, Counseling, Behavior Modification, Intervention Techniques, Career Counseling, Psychological Consulting, Organizational Consulting, Group Therapy Techniques, Organizational Change)		
Course Title:		
Institution:		
Year Taken:	Academic Term: ☐ Semester ☐ Quarter	Semester/Quarter:
Course Number:	Number of Credits:	Hours of Instruction:
Brief Description of Course Content:		

SUPERVISED PRACTICAL EXPERIENCE IN RENDERING PSYCHOLOGICAL SERVICES (includes such courses as Practica, Field Work, Internship, etc., as part of the doctoral program of studies)		
Course Title:		
Institution:		
Year Taken:	Academic Term: ☐ Semester ☐ Quarter	Semester/Quarter:
Course Number:	Number of Credits:	Hours of Instruction:
Brief Description of Course Content:		

When documenting graduate coursework in the core areas, submit catalog pages for the period of enrollment in the doctoral program. For any non-psychology courses on your transcript, you may also submit any back-up documentation, such as:
1) Course descriptions in a graduate catalog,
2) Copies of course syllabi, or
3) Letters from professors or department chairs. Note: You may be asked to provide additional information to verify that coursework meets the core area requirement. A course may be used to satisfy each core area requirement only once and, therefore, may not be repeated in any of the other areas. In regard to a typical semester course, three (3) credit hours is usually 45 instruction hours. Five (5) quarter hours is equivalent to three (3) semester hours. Fifteen (15) hours of classroom instruction is equal to one (1) semester credit.

Association of State and Provincial Psychology Boards

Psychology Licensure Universal System Application Form

EXAMINATION	
THE EXAMINATION FOR PROFESSIONAL PRACTICE IN PSYCHOLOGY (EPPP)	
Have you taken the Examination for Professional Practice in Psychology (EPPP)?	☐ Yes ☐ No
Jurisdiction Exam Taken for:	
Name Registered for Exam:	
Date Exam Taken:	Form ID:
Candidate ID:	Score:
Exam Administration: ☐ Computer ☐ Paper	
STATE/PROVINCE/TERRITORY BOARD EXAMINATION	
Have you taken any State/Province/Territory Board Examination?	☐ Yes ☐ No
Name of Exam:	
Jurisdiction Exam Taken for:	
Date Exam Taken:	
Format/Context:	
Exam Result: ☐ Passed ☐ Failed	
BOARD CERTIFICATION EXAMINATIONS	
Have you passed the Board Certified Behavior Analyst Examination? ☐ Yes ☐ No	If yes, Date Passed:
Have you passed the Board Certified Assistant Behavior Analyst Examination? ☐ Yes ☐ No	If yes, Date Passed:

Provide all information regarding the Examination for Professional Practice in Psychology (EPPP) if you have already taken it. If you have not previously taken the EPPP, approval and/or eligibility to sit for the exam from a licensing board is required before testing. After you have submitted a completed application for licensure with all supporting documentation, the licensing board will determine if you meet the eligibility requirements to be allowed to take the EPPP. ASPPB does not make this determination.

Provide information regarding any other exams you have taken while obtaining licensure/registration in the State/Province/Territory Board Exam section.

Association of State and Provincial Psychology Boards

Psychology Licensure Universal System Application Form

PRACTICUM TRAINING INFORMATION		
I. AGENCY INFORMATION		
Title/Position*:		
Agency*:		
Address*:		
City*:	State/Province*:	Zip*:
II. ATTESTING SUPERVISOR INFORMATION		
Name*:	Title:	
Email*:	Phone*:	
III. PRACTICUM SUPERVISION HOURS		
Total number of practicum hours (excluding all leave):		
Total number of face-to-face patient/client contact hours:		
Total number of hours of individual supervision by a Licensed Psychologist:		
Total number of hours of group supervision by a Licensed Psychologist:		
IV. PRACTICUM INFORMATION		
Practicum Course Title & Course Number*:		
Title/Position of Student*:	Term & Year (i.e. Spring, 2010)*:	
Practicum from Date*:	Practicum to Date*:	
Total Number of Weeks of Practicum*:	Average Hours Per Week of Practicum*:	
A. Total Number of Hours of Practicum:		
B. Total Number of Hours of Practicum in Service-Related Activities*[1]:		
Description of Duties/Responsibilities*:		
C. Total Number of Hours of Individual Supervision by a Licensed Psychologist*:		
D. Total Number of Hours of Group Supervision by a Licensed Psychologist*:		
E. Total Number of Hours of Individual Supervision by a Non-licensed Psychologist or Other Mental Health Professional:		
F. Total Number of Hours of Group Supervision by a Non-licensed Psychologist or Other Mental Health Professional:		
G. Total Number of Hours of Supervision (C+D+E+F):		
H. Total Number of Hours of Supervision by a Licensed Psychologist (individual and group) (C+D):		
I. Total Number of Hours of Supervision by a Non-licensed Psychologist or Other Mental Health Professional (individual and group) (E+F):		
J. Percentage of Total Supervision by Licensed Psychologist (H/G*100):		
K. Percentage of Total Supervision by a Non-Licensed Psychologist or Other Mental Health Professional (I/G*100):		
☐ Ready for attestation (Check if this form is ready for attestation by supervisor)		

*indicates a required field

[1] Service-Related Activities are defined as treatment/intervention, assessment, interviews, report-writing, case presentations, and consultations.

Note: ASPPB will send verification form directly to your supervisor by email based on the information above. Provide information on all practicum settings.

Association of State and Provincial Psychology Boards

Psychology Licensure Universal System Application Form

PRE-DOCTORAL INTERNSHIP TRAINING INFORMATION

I. TRAINING AGENCY INFORMATION

Agency*:		
Address*:		
City*:	State/Province*:	Zip*:
Was this a formal internship required as part of your training?		☐ Yes ☐ No
Was the internship APA accredited when the applicant completed training?		☐ Yes ☐ No
Was the internship CPA accredited when the applicant completed training?		☐ Yes ☐ No
Was the internship a member of APPIC when the applicant completed training?		☐ Yes ☐ No

II. DIRECTOR OF INTERNSHIP INFORMATION

Name*:	Title:
Email*:	Phone*:

III. INTERNSHIP INFORMATION

Applicant's Title/Position*:	
Date Began*:	Date Ended*:
Number of interns in the program during the same period of your internship:	
Specialty Area:	
Duties and Responsibilities:	
Describe the clientele served:	
Remarks (optional):	

IV. INDIVIDUAL SUPERVISION

Supervisor's Name (List Primary First)	Supervisor Degree	Was Supervisor Licensed?		Weeks of Individual Supervision A	Hours per Week of Individual Supervision B	Total Hours of Supervision (A x B)	Period of Supervision	
							From MM/YY	To MM/YY
		☐ Yes	☐ No					
		☐ Yes	☐ No					
		☐ Yes	☐ No					

IV. GROUP SUPERVISION

Supervisor's Name (List Primary First)	Supervisor Degree	Was Supervisor Licensed?		Weeks of Supervision A	Hours per Week of Supervision B	Total Hours of Supervision (A x B)	Number of Interns in Group	Period of Supervision	
								From MM/YY	To MM/YY
		☐ Yes	☐ No						

		☐ Yes	☐ No						
		☐ Yes	☐ No						

VI. INTERNSHIP SUPERVISION HOURS	
1. Total number of weeks of internship (excluding all leave)*:	
2. Average number of hours per week of internship*:	
3. Total number of hours of internship:	
4. Number of hours per week of individual supervision from all licensed psychologists*:	
5. Total number of hours of individual supervision from all licensed psychologists (#4 * #1):	
6. Number of hours per week of group supervision from all licensed psychologists*:	
7. Number of hours per week of individual and group supervision from all other licensed professionals*:	
8. Number of hours per week of supervision (individual & group) from licensed psychologists (#4 + #6):	
9. Total number of hours of supervision (individual & group) from licensed psychologists (#8 * #1):	
10. Number of hours in face-to-face patient/client contact per week*:	
11. Number of hours per week in psychological service-related activities, excluding face-to-face contact provided in question 10 above but includes report writing, scoring and analysis and documentation of treatment services*:	
12. Total number of hours of direct psychological services completed during this internship*:	
13. Total number of hours of general psychological services completed during this internship (General service may include such activities of applied research, program evaluation, program/personal consultation, teaching in areas pertinent to clinical practice, assessing public options, activities not included in Question 10 or 11 above, etc.)*:	
14. Percentage of the applicant's supervision provided by licensed psychologist(s)*:	

IX. SUPERVISION FROM OTHER HEALTH CARE PROFESSIONALS	
Professionals	**Descriptions (Supervisor Names and Hours per Week etc.)**
Psychiatrists	
Physicians	
Social Workers	
Nurses	
Others	
☐ Ready for attestation (Check if this form is ready for attestation by internship director)	

*indicates a required field

Provide all information regarding your internship experience.

Your official transcript should document credit hours awarded for internship. If the internship is not documented on your transcript, you must also submit verification from the head of your Department or Graduate School which includes the location, the nature and the length of your internship. If your program did not require an internship, you should note that information.

NOTE: Information in this section will be used by ASPPB to send the Internship Verification Form directly to the internship site training director. If complete contact information is not provided, your application will be delayed.

POSTDOCTORAL EXPERIENCE INFORMATION

I. TRAINING AGENCY INFORMATION

Agency*:		
Address*:		
City*:	State/Province*:	Zip*:

II. ATTESTING SUPERVISOR INFORMATION

Supervisor Name*:	Title:
Email*:	Phone*:

III. SUPERVISED EXPERIENCE INFORMATION

Title/Position*:	
Date Began*:	Date Ended*:
Training Type*:	
Specialty Area:	
Describe the clientele served:	
Your duties and responsibilities:	
Remarks (optional):	

IV. INDIVIDUAL SUPERVISION

Supervisor's Name (List Primary First)	Supervisor Degree	Was Supervisor Licensed?		Weeks of Individual Supervision A	Hours per Week of Individual Supervision B	Total Hours of Supervision (A x B)	Period of Supervision	
							From MM/YY	To MM/YY
		☐ Yes	☐ No					
		☐ Yes	☐ No					
		☐ Yes	☐ No					

V. GROUP SUPERVISION

Supervisor's Name (List Primary First)	Supervisor Degree	Was Supervisor Licensed?		Weeks of Supervision A	Hours per Week of Supervision B	Total Hours of Supervision (A x B)	Number of Interns in Group	Period of Supervision	
								From MM/YY	To MM/YY
		☐ Yes	☐ No						
		☐ Yes	☐ No						
		☐ Yes	☐ No						

VI. EXPERIENCE SUPERVISION HOURS

1. Total number of weeks of experience (excluding all leave)*:	

2. Average number of hours per week of experience*:	
3. Total number of hours of experience:	
4. Number of hours per week of individual supervision from all licensed psychologists*:	
5. Total number of hours of individual supervision from all licensed psychologists (#4 * #1):	
6. Number of hours per week of group supervision from all licensed psychologists*:	
7. Number of hours per week of individual and group supervision from all other licensed professionals*:	
8. Number of hours per week of supervision received (individual & group) from licensed psychologists (#4 + #6):	
9. Total number of hours of supervision (individual & group) from licensed psychologists (#8 * #1):	
10. Number of hours in face-to-face patient/client contact per week*:	
11. Number of hours per week in psychological service-related activities, excluding face-to-face contact provided in the question 10 above but includes report writing, scoring and analysis and documentation of treatment services*:	
12. Total number of hours of direct psychological services completed during this experience*:	
13. Total number of hours of general psychological services completed during this supervision (General service may include such activities of applied research, program evaluation, program/personal consultation, teaching in areas pertinent to clinical practice, assessing public options, services not included in questions 10 or 11 above, etc.)*:	
14. Percentage of the applicant's supervision provided by licensed psychologist(s)*:	

VII. SUPERVISION FROM OTHER HEALTH CARE PROFESSIONALS

Professionals	**Descriptions (Supervisor Names and Hours per Week etc.)**
Psychiatrists	
Physicians	
Social Workers	
Nurses	
Others	

☐ Ready for attestation (Check if this form is ready for attestation by supervisor)

*indicates a required field

This section would include any formal postdoctoral training, supervised experience (that is, in addition to internship or practicum), other experience not yet documented, and/or pre-doctoral supervised training. Provide all information regarding your supervised experience, if applicable.

NOTE: Information in this section will be used by ASPPB to send the Supervised Experience Verification Form directly to the identified supervisor. If complete contact information is not provided, your application will be delayed.

POST LICENSURE WORK EXPERIENCE HISTORY

INFORMATION ON EMPLOYMENT		
*Title/Position:		
Self-Employed: ☐ Yes ☐ No	Fulltime: ☐ Yes ☐ No	
*Date Begun:	Date Ended*:	Hours per Week:
Duties and Responsibilities:		

INFORMATION ABOUT THE EMPLOYER		
Employer:		
Address:		
City:	State/Province:	Zip:

ATTESTER CONTACT INFORMATION	
Name*:	Title:
Email*:	Phone*:
☐ Ready of attestation	

*indicates a required field

Provide all information regarding your professional work experience starting with your most recent employer. DO NOT provide information regarding internship or postdoctoral supervised experience in this section.

Note: ASPPB will contact the attester directly for employment verification based on the information provided above.

Association of State and Provincial Psychology Boards

Psychology Licensure Universal System Application Form

CONDUCT		
PERSONAL/PROFESSIONAL CONDUCT HISTORY QUESTIONNAIRE		
1. Has any jurisdiction (e.g., state, province, the District of Columbia, or U.S. possession or territory) rejected or denied your application for licensure/certification/registration as a psychologist or any other profession?	☐ Yes	☐ No
2. Have you ever been disciplined (i.e., revocation, suspension, reprimand, censure, or any other publicly reported disciplinary action) by a psychology licensing body?	☐ Yes	☐ No
3. Has any jurisdiction limited your practice in any way or by any other action?	☐ Yes	☐ No
4. Have you ever been disciplined while holding any other professional license/registration/certificate?	☐ Yes	☐ No
5. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* to a criminal offense, felony, or misdemeanor (other than a minor traffic violation)?	☐ Yes	☐ No

Date:	Place of Conviction (City, State/Province):
Offense:	

Imprisonment	From:	To:	Probation	From:	To:

6. Have you ever voluntarily surrendered or restricted your professional license/registration/certificate in any jurisdiction?	☐ Yes	☐ No
7. Have you ever been censured, reprimanded, dismissed, suspended, terminated or asked to resign, or has any disciplinary action been taken against you during your education, training or employment as a mental health professional?	☐ Yes	☐ No
8. Have you ever been refused renewal of any professional license/registration/certificate for any reason in any jurisdiction?	☐ Yes	☐ No
9. Are you the subject of a current proceeding or outstanding/unresolved complaint or investigation in relation to the profession of psychology or any other profession?	☐ Yes	☐ No
10. Have you ever aided or abetted another individual in practicing psychology without a license or an exemption in any jurisdiction?	☐ Yes	☐ No
11. Have you ever practiced psychology without a license or exemption in any other jurisdiction?	☐ Yes	☐ No
12. Are you registered in any jurisdiction as a sex offender?	☐ Yes	☐ No
13. Are you physically or mentally incapable to render psychological services with reasonable skill, safety and competency at present?	☐ Yes	☐ No
14. Do you use drugs and/or alcohol to an extent that affects your professional competency?	☐ Yes	☐ No
15. Have you ever been party to a malpractice action or had a malpractice action brought against you or entered into a malpractice settlement?	☐ Yes	☐ No
16. Have you ever been subject to an action by an ethics committee of any professional organization in any jurisdiction?	☐ Yes	☐ No
17. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended, or subjected to restrictions or been requested to withdraw or resign?	☐ Yes	☐ No
18. Has any third party payor (including Medicare and Medicaid), terminated, suspended, restricted or revoked your status as a provider for reasons related to your professional practice?	☐ Yes	☐ No
19. Have you ever had professional liability insurance cancelled?	☐ Yes	☐ No
20. Has any government agency ever substantiated allegations made against you for physical, mental, emotional abuse or neglect, sexual abuse, or exploitation of (1) a child, (2) a resident of an adult care home, medical care facility, psychiatric hospital or state institution for the mentally retarded, or (3) an adult?	☐ Yes	☐ No

If you answer "yes" to any of the questions above, provide brief explanation in corresponding comment area and complete the Personal/Professional Conduct History Information Form. Fax and email the completed form to ASPPB.

Association of State and Provincial Psychology Boards

Psychology Licensure Universal System Application Form

DECLARATION

A. INTENDED PSYCHOLOGICAL PRACTICE

Check the appropriate area(s) of intended psychological practice below.

1. Clinical Psychology	☐	11. Rehabilitation Psychology	☐
2. Counseling Psychology	☐	12. Psychoanalysis Psychology	☐
3. School Psychology	☐	13. Research	☐
4. Forensic Psychology	☐	14. Clinical/Assessment Evaluation	☐
5. Cognitive & Behavior Psychology	☐	15. Consultation	☐
6. Clinical Health Psychology	☐	16. Treatment Services	☐
7. Correctional	☐	17. Applied Behavior Analysis Services	☐
8. Academic (teaching psychology)[1]	☐	18. Remote Services	☐
9. Industrial/Organizational	☐	19. Other (specify)	☐
10. Clinical Neuropsychology	☐		

B. ACTIVITIES AND SERVICES

Once you have indicated your area(s) of practice, use the corresponding numbers above to identify the activities and services you intend to provide and the clients to whom you will provide these services.

Client	Administration	Consultation	Assessment/Evaluation[2]	Intervention/Treatment[3]	Research	Other Service
Infants						
Children						
Adolescents						
Adults						
Elderly						
Families						
Groups						
Organizations						
Other Client						

C. LANGUAGES

You declare you are competent to provide services in the following languages:

☐ English

☐ Spanish

☐ French

☐ Others (specify)

[1] May not be considered an area of psychological practice in some jurisdictions
[2] Includes interviewing and the administration, scoring and interpretation of psychological test batteries for the diagnosis of cognitive abilities and personality functioning
[3] The theory and application of a diverse range of psychological interventions for the treatment of mental, emotional, psychological and behavioral disorders

All applicants are asked to state their areas on intended practice in psychology. The declaration will be considered in the context of the competencies identified in the educational preparation and experience of the applicant.

Association of State and Provincial Psychology Boards

Licensure/Certification/Registration Verification Form

SECTION 1: Instructions for Applicant – Print your name and information of the jurisdictional agency to which you are requesting verification. Duplicate as needed. Return document(s), along with any fees required by the licensing agency (check payable directly to individual licensing entity) to the ASPPB.		
Last Name:	First Name:	M.I.:
Social Security/Insurance Number:	Date of Birth:	
Type of License/Certification/Registration Held:	License/Certification/Registration #:	
Jurisdiction and address of licensing entity:		
I hereby waive all right to confidentiality to the jurisdiction reporting herein, for the purpose of reporting to the Association of State and Provincial Psychology Boards (ASPPB), the information requested below including any and all complaints adjudicated, stipulated, or pending against me including participation in any program to which I have acknowledged impairment (physical, mental or substance).		
Signature:	Date:	
Please complete Section 1 only and return form to: **ASPPB Mobility Program** **P.O. Box 3079** **Peachtree City, GA 3269**		

Association of State and Provincial Psychology Boards

Licensure/Certification/Registration Verification Form

SECTION 2: TO BE COMPLETED BY THE JURISDICTIONAL LICENSING AGENCY

Licensing Agency:	
Licensee:	License Number:
Issue Date:	Expiration Date:

Did your jurisdiction issue the original license/registration/certification? ☐ Yes ☐ No

Licensed by (check one):

☐ Examination for Professional Practice in Psychology (EPPP)

☐ Certification of Professional Qualification in Psychology (CPQ)

☐ Professional Endorsement (specify): _____

☐ Reciprocity between jurisdictions (specify jurisdictions): _____

☐ Other (specify): _____

Is the license current? ☐ Yes ☐ No

If "No", explain:

Has license/certification/registration been continuous since date of original license/registration/certification? ☐ Yes ☐ No

If "No", explain:

Has this individual ever acknowledged any impairment (physical, mental or substance) or participated in any impaired psychologist agreement/procedure? ☐ Yes ☐ No

If "Yes", attach any public record or details.

Highest degree in psychology on which current license/registration/certificate is based:

Does the applicant have any:

a. current or previous restrictions, terms or limitations on his/her practice ☐ Yes ☐ No

b. unresolved complaints ☐ Yes ☐ No

c. complaints referred to discipline hearing or alternate resolution ☐ Yes ☐ No

d. sanctions or censures ☐ Yes ☐ No

e. past or current revocations or suspensions of licensure/registration ☐ Yes ☐ No

f. other past disciplinary actions not covered above ☐ Yes ☐ No

If answering "Yes" to any above, please provide details on a separate page and attach copies of any relevant documentation.

Is there any other information pertinent to this individual? ☐ Yes ☐ No

If "Yes", provide a written explanation below:

_____

_____

Association of State and Provincial Psychology Boards

Licensure/Certification/Registration Verification Form

SECTION 3: CERTIFICATION	
Licensing Agency:	
Person Completing Form:	
Title:	
Signature:	Date:
Please Affix Board Seal Here:	
Mail completed form to: **ASPPB Mobility Program** **P.O. Box 3079** **Peachtree City, GA 3269**	

Association of State and Provincial Psychology Boards

Verification of Doctoral Program Form

Please complete Sections I & II only and return form to:
ASPPB Mobility Program
P.O. Box 3079
Peachtree City, GA 3269

SECTION I: Contact Information – Please provide the contact information for the Head of the Doctoral Program. This form will be mailed based on the information provided.

Name of the Head/Chair of the Program/Director of Program/Major Advisor:

University:

Mailing Address:

Telephone Number:

Fax Number:

Email (if known):

SECTION II: Authorization to Release Information

Last Name:	First Name:	M.I.:
SSI/SSN:	Date of Birth:	
Date of Graduation:		

I am currently registering my credentials with the Association of State and Provincial Psychology Boards (ASPPB). As you may know, ASPPB acts as an agent to collect and verify credentials.

To facilitate this process, I hereby request:

- The Head of the Doctoral Program, or an authorized representative, to complete Section III of this form.

Please send this information directly to ASPPB in the enclosed postage-page self-addressed envelope. If you have any questions about this process, please contact ASPPB toll-fee at 1-800-678-216-1175.

Signature:	Date:

Association of State and Provincial Psychology Boards

Verification of Doctoral Program Form

SECTION III: TO BE COMPLETED BY THE HEAD OF THE DOCTORAL PROGRAM:

I confirm that _____
graduated from the _____ program (Official Major Program of Study)
housed in the _____ Academic Department (Official University Title) at
_____. Date degree was awarded: _____

The above named applicant requests your cooperation in verifying the following components of his/her program. Please respond to the following based upon the doctoral degree program requirements during the time when the applicant was enrolled.

A. The program completed by the above named applicant was, at the time of the individual's graduation:

Accredited by the American Psychological Association (APA) ☐ Yes ☐ No

Accredited by the Canadian Psychological Association (CPA) ☐ Yes ☐ No

Designated by the Association of State and Provincial Psychology Boards/National Register ☐ Yes ☐ No

B. Answer E1 – E9, regardless of accreditation/designation status of the program.

E1. Was the above graduate degree in psychology received from an institution of higher education that was regionally accredited by an institution of higher education that was regionally accredited by bodies approved by the Commission on Recognition of Postsecondary Accreditation or its successor or a member of the Association of Universities and Colleges of Canada to grant doctoral degrees at the time the applicant received his/her degree? ☐ Yes ☐ No

E2. Was the program publicly identified and clearly labeled as a psychology program, specifying in pertinent institutional catalogs its intent to educate and train individuals to engage in the activities which constitute the practice of psychology? ☐ Yes ☐ No

State the title: _____

E3. Was the program an integrated, organized sequence of study as demonstrated by an identifiable curriculum track or tracks wherein course sequences were outlined? ☐ Yes ☐ No

E4. Did the program:

a. Require three years of full-time academic study or equivalent? ☐ Yes ☐ No

b. Require each student to complete at least two of the three years at the institution from which the degree was granted? ☐ Yes ☐ No

c. Require each student to compete at least one year in full-time residence on campus at the institution from which the degree was granted? (Residence means physical presence, in person, at the educational institution in a manner that facilitates the full participation and integration of the individual in the educational and training experience and includes faculty student interaction; Models that use face-to-face contact for shorter durations throughout a year or models that use video teleconferencing or other electronic means to meet the residency requirement are not acceptable as applies to the Mobility Program requirements) ☐ Yes ☐ No

From: _____ To: _____

E5. Was there an identifiable full-time psychology faculty in residence at the institution, and employed by and providing instruction at the home campus of the institution? ☐ Yes ☐ No

State the number of full-time psychology faculty in residence at the institution: _____

E6. Was there a psychologist responsible for the graduate program either as the administrative head, or as the advisor, major professor, or committee for chair the above applicant: ☐ Yes ☐ No

If yes, provide the psychologist's name and role: _____

E7. Did the program maintain clear authority and primary responsibility for the core and specialty areas whether or not the program crossed administrative lines? ☐ Yes ☐ No

E8. Did the program have an identifiable body of students in residence at the institution who were matriculated in the program for a degree? ☐ Yes ☐ No

E9. Did the doctoral program include supervised practicum, internship, field experience or laboratory training appropriate to the area of psychology practice that was supervised by a psychologist: ☐ Yes ☐ No

Association of State and Provincial Psychology Boards

Verification of Doctoral Program Form

C. If you answered "no" to at least one question listed in *Section B* above, the following documentation must be submitted:

A. Attach pages from institutional catalog(s) for the year the applicant entered the program which include a listing of the curriculum track or course of study for the program and course descriptions, and which document the following:
   1. That the program of study provided the education and training appropriate for the practice of psychology;
   2. That the program stood as a recognized entity in the administrative unit in which it is located having responsibility for core and specialty areas;
   3. That the program of study provided a description of the residency requirement.

B. Name of the faculty member(s) responsible for the applicant's graduate program in psychology and a list of the faculty who taught core and specialty courses in the program.

I certify that I have personal knowledge of the program evaluated above, in which the applicant received his/her graduate degree and that all answers marked on this form and any other information attached hereto are true and correct to the best of my knowledge.

_____
Name of the Head of the Program/Director of the Program/Major Advisor

_____ _____
Name and Title of the person completing this form | Telephone Number

_____ _____
Signature of person completing this form | Date

Additional Information about the Reference	
Are you a licensed as a psychologist?	State(s)/Provinces:
Are you certified as a Health Service Provider?	State(s)/Provinces:
What is your specialty area?	

Return this signed and completed form to:
ASPPB PLUS
P.O. Box 3079
Peachtree City, GA 3269

Association of State and Provincial Psychology Boards

Practicum Verification Form

Practicum Verification Form (Sections I though IV to be filled out by applicant, except for highlighted items in Section II)		
I. AGENCY INFORMATION		
Applicant Name:		
Title/Position:		
Agency:		
Address:		
City:	State/Province:	Zip:
II. ATTESTING SUPERVISOR INFORMATION		
Name:	Title:	
Email:	Phone:	
Address:		
City:	State/Province:	Zip:
Degree:	Year Conferred:	Specialty Area:

III. PRACTICUM SUPERVISION HOURS	
Total number of practicum hours (excluding all leave):	
Total number of face-to-face patient/client contact hours:	
Total number of hours of individual supervision by a Licensed Psychologist:	
Total number of hours of group supervision by a Licensed Psychologist:	

IV. PRACTICUM INFORMATION			
Practicum Course Title & Course Number:			
Title/Position of Student:		Term & Year (i.e. Spring, 2010):	
Practicum from Date:		Practicum to Date:	
Total Number of Weeks of Practicum:		Average Hours Per Week of Practicum:	
A. Total Number of Hours of Practicum:			
B. Total Number of Hours of Practicum in Service-Related Activities:			
Description of Duties/Responsibilities:			
C. Total Number of Hours of Individual Supervision by a Licensed Psychologist:			
D. Total Number of Hours of Group Supervision by a Licensed Psychologist:			
E. Total Number of Hours of Individual Supervision by a Non-licensed Psychologist or Other Mental Health Professional:			
F. Total Number of Hours of Group Supervision by a Non-licensed Psychologist or Other Mental Health Professional:			
G. Total Number of Hours of Supervision (C+D+E+F):			
H. Total Number of Hours of Supervision by a Licensed Psychologist (individual and group) (C+D):			
I. Total Number of Hours of Supervision by a Non-licensed Psychologist or Other Mental Health Professional (individual and group) (E+F):			

J. Percentage of Total Supervision by Licensed Psychologist (H/G*100):	
K. Percentage of Total Supervision by a Non-Licensed Psychologist or Other Mental Health Professional (I/G*100):	
V. ATTESTATION INFORMATION (SECTION V TO BE FILLED OUT BY ATTESTER)	
A. Is the above information provided by the applicant correct? If "No", explain:	☐ Yes ☐ No
B. Did this setting have, as part of its organizational mission, a goal of training professional psychologists?	☐ Yes ☐ No
C. Did this setting have a licensed/registered psychologist identified as the person responsible for maintaining the integrity and quality of the experience of the practicum student?	☐ Yes ☐ No
D. Did the applicant's graduate training program provide oversight for this practicum experience?	☐ Yes ☐ No
E. Was the practicum experience based on appropriate academic preparation of the student?	☐ Yes ☐ No
F. Was the practicum part of an organized, sequential series of supervised experiences of increasing complexity for the student?	☐ Yes ☐ No
G. Was there a written training plan between the student, the practicum training site, and the graduate training program?	☐ Yes ☐ No
H. Was the practicum training an extension of the applicant's academic coursework?	☐ Yes ☐ No
I. Did the student successfully complete the practicum?	☐ Yes ☐ No

Association of State and Provincial Psychology Boards

Internship Verification Form

Internship Verification Form

(Sections I though VI and IX to be filled out by applicant)

I. TRAINING AGENCY INFORMATION		
Applicant Name:		
Agency:		
Address:		
City:	State/Province:	Zip:
Was this a formal internship required as part of your training?		☐ Yes ☐ No
Was the internship APA accredited when the applicant completed training?		☐ Yes ☐ No
Was the internship CPA accredited when the applicant completed training?		☐ Yes ☐ No
Was the internship a member of APPIC when the applicant completed training?		☐ Yes ☐ No

II. DIRECTOR OF INTERNSHIP INFORMATION	
Name:	Title:
Email:	Phone:

III. INTERNSHIP INFORMATION	
Applicant's Title/Position:	
Date Began:	Date Ended:
Number of interns in the program during the same period of your internship:	
Specialty Area:	
Duties and Responsibilities:	
Describe the clientele served:	
Remarks (optional):	

IV. INDIVIDUAL SUPERVISION

Supervisor's Name (List Primary First)	Supervisor Degree	Was Supervisor Licensed?		Weeks of Individual Supervision A	Hours per Week of Individual Supervision B	Total Hours of Supervision (A x B)	Period of Supervision	
							From MM/YY	To MM/YY
		☐ Yes	☐ No					
		☐ Yes	☐ No					
		☐ Yes	☐ No					

Association of State and Provincial Psychology Boards

Internship Verification Form

IV. GROUP SUPERVISION									
Supervisor's Name (List Primary First)	Supervisor Degree	Was Supervisor Licensed?		Weeks of Supervision A	Hours per Week of Supervision B	Total Hours of Supervision (A x B)	Number of Interns in Group	Period of Supervision	
								From MM/YY	To MM/YY
		☐ Yes	☐ No						
		☐ Yes	☐ No						
		☐ Yes	☐ No						

VI. INTERNSHIP SUPERVISION HOURS	
1. Total number of weeks of internship (excluding all leave):	
2. Average number of hours per week of internship:	
3. Total number of hours of internship:	
4. Number of hours per week of individual supervision from all licensed psychologists:	
5. Total number of hours of individual supervision from all licensed psychologists (#4 * #1):	
6. Number of hours per week of group supervision from all licensed psychologists:	
7. Number of hours per week of individual and group supervision from all other licensed professionals:	
8. Number of hours per week of supervision (individual & group) from licensed psychologists (#4 + #6):	
9. Total number of hours of supervision (individual & group) from licensed psychologists (#8 * #1):	
10. Number of hours in face-to-face patient/client contact per week:	
11. Number of hours per week in psychological service-related activities, excluding face-to-face contact provided in question 10 above but includes report writing, scoring and analysis and documentation of treatment services:	
12. Total number of hours of direct psychological services completed during this internship:	
13. Total number of hours of general psychological services completed during this internship (General service may include such activities of applied research, program evaluation, program/personal consultation, teaching in areas pertinent to clinical practice, assessing public options, activities not included in Question 10 or 11 above, etc.):	
14. Percentage of the applicant's supervision provided by licensed psychologist(s):	

IX. SUPERVISION FROM OTHER HEALTH CARE PROFESSIONALS	
Professionals	**Descriptions (Supervisor Names and Hours per Week etc.)**
Psychiatrists	
Physicians	
Social Workers	
Nurses	
Others	

VII. OPTIONAL COMMENTS REGARDING SECTIONS IV, V, AND VI

VIII. QUESTIONNARIE		
Applicant's Title/Position:		
1. Is the information provided by the applicant correct? If "No", explain:	☐ Yes	☐ No
2. Was all coursework (except dissertation) completed prior to internship beginning?	☐ Yes	☐ No
3. Was the internship a planned, programmed sequence of training experiences with a primary focus assuring both breadth and quality of training in contrast to simply supervised experience or on-the-job training?	☐ Yes	☐ No
4. Did the internship provide training in a range of assessment and treatment activities conducted directly with patients or clients seeking psychological services?	☐ Yes	☐ No
5. Was this experience completed on a full-time basis?	☐ Yes	☐ No
6. Were there any periods of extended leave? If "Yes", explain:	☐ Yes	☐ No
7. Was at least 25 percent of the trainee's time in direct patient or client content?	☐ Yes	☐ No
8. Was the internship at the post-clerkship, post-practicum, and post-externship level?	☐ Yes	☐ No
9. Was a written statement and brochure describing the goals and content of the internship, and stating clear expectations for the quality and quantity of the trainee's work furnished to all prospective interns?	☐ Yes	☐ No
10. Was a licensed and clearly designated staff psychologist of the internship agency responsible for the integrity and quality of the training program?	☐ Yes	☐ No
11. Was at least half of all the supervision in regularly scheduled, formal, face-to-face individual meetings with licensed psychologist supervisors with the intent of dealing with psychological services rendered directly by the intern?	☐ Yes	☐ No
12. How many licensed psychologist supervisors were there for this applicant during this internship?		
13. How many interns were in the program at the doctoral level during the entire period of training?		
14. Did the internship take place in a health service setting?	☐ Yes	☐ No
15. Did the internship take place in a private practice setting?	☐ Yes	☐ No
16. Did this applicant successfully complete the internship at a satisfactory level of performance? If "No", explain:	☐ Yes	☐ No
17. Prior to, or during the training, did any of this applicant's supervisors have a familial or financial relationship with this applicant or was the applicant the employee or employer of a supervision? If "Yes", explain:	☐ Yes	☐ No
18. Was any credit given to this applicant for activities completed before the starting date? If "Yes", explain:	☐ Yes	☐ No
19. Was any credit given to this applicant for activities performed which were not directly under the supervision and control by your organization or facility? If "Yes", explain:	☐ Yes	☐ No

Association of State and Provincial Psychology Boards

Supervised Experience Verification Form

Supervised Experience Verification Form

(Sections I though VII to be filled out by applicant)

I. TRAINING AGENCY INFORMATION

Applicant Name:		
Agency:		
Address:		
City:	State/Province:	Zip:

II. ATTESTING SUPERVISOR INFORMATION

Supervisor Name:	Title:
Email:	Daytime Phone:

III. SUPERVISED EXPERIENCE INFORMATION

Applicant's Title/Position:	
Date Began:	Date Ended:
Training Type:	
Specialty Area:	
Describe the clientele served:	
Your duties and responsibilities:	
Remarks (optional):	

IV. INDIVIDUAL SUPERVISION

Supervisor's Name (List Primary First)	Supervisor Degree	Was Supervisor Licensed?		Weeks of Individual Supervision A	Hours per Week of Individual Supervision B	Total Hours of Supervision (A x B)	Period of Supervision	
							From MM/YY	To MM/YY
		☐ Yes	☐ No					
		☐ Yes	☐ No					
		☐ Yes	☐ No					

V. GROUP SUPERVISION

Supervisor's Name (List Primary First)	Supervisor Degree	Was Supervisor Licensed?		Weeks of Supervision A	Hours per Week of Supervision B	Total Hours of Supervision (A x B)	Number of Interns in Group	Period of Supervision	
								From MM/YY	To MM/YY
		☐ Yes	☐ No						
		☐ Yes	☐ No						
		☐ Yes	☐ No						

Association of State and Provincial Psychology Boards
P.O. Box 3079 • Peachtree City, GA 30269 • (678) 216-1175 • Fax (678) 216-1184 • www.asppb.net

Association of State and Provincial Psychology Boards

Supervised Experience Verification Form

VI. EXPERIENCE SUPERVISION HOURS	
1. Total number of weeks of experience (excluding all leave):	
2. Average number of hours per week of experience:	
3. Total number of hours of experience:	
4. Number of hours per week of individual supervision from all licensed psychologists:	
5. Total number of hours of individual supervision from all licensed psychologists (#4 * #1)	
6. Number of hours per week of group supervision from all licensed psychologists:	
7. Number of hours per week of individual and group supervision from all other licensed professionals:	
8. Number of hours per week of supervision received (individual & group) from licensed psychologists (#4 + #6):	
9. Total number of hours of supervision (individual & group) from licensed psychologists (#8 * #1):	
10. Number of hours in face-to-face patient/client contact per week:	
11. Number of hours per week in psychological service-related activities, excluding face-to-face contact provided in the question 10 above but includes report writing, scoring and analysis and documentation of treatment services:	
12. Total number of hours of direct psychological services completed during this experience:	
13. Total number of hours of general psychological services completed during this supervision (General service may include such activities of applied research, program evaluation, program/personal consultation, teaching in areas pertinent to clinical practice, assessing public options, services not included in questions 10 or 11 above, etc.):	
14. Percentage of the applicant's supervision provided by licensed psychologist(s):	

VII. SUPERVISION FROM OTHER HEALTH CARE PROFESSIONALS	
Professionals	**Descriptions (Supervisor Names and Hours per Week etc.)**
Psychiatrists	
Physicians	
Social Workers	
Nurses	
Others	

VIII. EXPERIENCE ATTESTATION (SECTION VIII TO BE FILLED OUT BY ATTESTER)	
1. Is the information provided by the applicant correct? If "No", explain:	☐ Yes ☐ No
2. Was this experience completed on a full-time basis?	☐ Yes ☐ No
3. Were there any periods of extended leave?	☐ Yes ☐ No
4. Did the experience take place in a health service setting?	☐ Yes ☐ No
5. Did the experience take place in a private practice setting?	☐ Yes ☐ No
6. Did this applicant successfully complete the supervised experience at a satisfactory level of performance? If "No", explain:	☐ Yes ☐ No
7. Prior to, or during the training, did any of this applicant's supervisors have a familial or financial relationship with this applicant or was the applicant the employee or employer of a supervisor? If "Yes", explain:	☐ Yes ☐ No
8. Was any credit given to this applicant for activities completed before the starting date? If "Yes", explain:	☐ Yes ☐ No

9. Was any credit given to this applicant for activities which were not directly under the supervision and control by your organization or facility? If "Yes", explain:	☐ Yes ☐ No
10. Do you recommend this applicant for licensure? If "No", explain:	☐ Yes ☐ No

Association of State and Provincial Psychology Boards

Personal/Professional Conduct History Information Form

Personal/Professional Conduct History Information Form

If you responded "yes" to any question in the PERSONAL/PROFESSIONAL CONDUCT HISTORY section on the Demographic Application Form, you must complete this form. The information requested on this form may be used to determine whether your application should be granted, approved with limitations, or denied. The information you provide on this form may be verified against criminal information records. Omission of information on this form may be considered a false statement on an application. I also understand that the jurisdiction to which I am applying may require additional information regarding any offense listed below.

Last Name:	First Name:	M.I.:
Home Address:		
City:	State/Province:	Zip:
Home Phone:	Date of Birth:	
Email Address:		
SSN/SSI:		

CONVICTIONS AND PENDING CHARGES

Date:	Place of Conviction (City, State/Province):
Offense:	

Imprisonment	From:	To:	Probation	From:	To:

ADDITIONAL INFORMATION FOR QUESTIONS ON DEMOGRAPHIC FORM

Question #	Comments

I state that I am the person referred to in this document and that all the information which I provided above is true in every respect. I understand that false or forged statements made in this document in connection with my application for a credential, or failing to provide relevant information, may be grounds for denial of the application, and/or revocation of any credential granted me based on this information.

Signature:	Date:

Association of State and Provincial Psychology Boards
P.O. Box 3079 • Peachtree City, GA 30269 • (678) 216-1175 • Fax (678) 216-1184 • www.asppb.net

Association of State and Provincial Psychology Boards

Application and/or Documentation Deposit Form

Declaration of Intended Psychological Practice

Applicant Name (Last, First, M.I.):

All applicants are asked to state their areas of intended practice in psychology. The declaration will be considered in the context of the competencies identified in the educational preparation and experience of the applicant.

A. Check the appropriate area(s) of intended psychological practice below:

1. Clinical Psychology	☐	11. Rehabilitation Psychology	☐
2. Counseling Psychology	☐	12. Psychoanalysis Psychology	☐
3. School Psychology	☐	13. Research	☐
4. Forensic Psychology	☐	14. Clinical/Assessment Evaluation	☐
5. Cognitive & Behavior Psychology	☐	15. Consultation	☐
6. Clinical Health Psychology	☐	16. Treatment Services	☐
7. Correctional	☐	17. Applied Behavior Analysis Services	☐
8. Academic (teaching psychology)[1]	☐	18. Remote Services	☐
9. Industrial/Organizational	☐	19. Other (specify)	☐
10. Clinical Neuropsychology	☐		

[1] May not be considered an area of psychological practice in some jurisdictions

B. Once you have indicated your area(s) of practice, use the corresponding numbers above to identify the activities and services you intend to provide and the clients to whom you will provide these services.

Client	Administration	Consultation	Assessment/Evaluation[2]	Intervention/Treatment[3]	Research	Other (specify)
Infants						
Children						
Adolescents						
Adults						
Elderly						
Families						
Groups						
Organizations						
Other (specify)						

[2] Includes interviewing and the administration, scoring and interpretation of psychological test batteries for the diagnosis of cognitive abilities and personality functioning

[3] The theory and application of a diverse range of psychological interventions for the treatment of mental, emotional, psychological and behavioral disorders

C. You declare you are competent to provide services in the following languages:

☐ English

☐ Spanish

☐ French

☐ Others (specify)

Association of State and Provincial Psychology Boards

Application and/or Documentation Deposit Form

D. Describe the areas in which you believe you are competent to offer psychological services by virtue of your education and training. Specify each area by using descriptive phrases such as: "Individual diagnostic evaluations using objective and projective techniques;" "Play therapy with young children;" "Group validation of personnel selection instruments." Briefly support each area of competence with relevant coursework, training, supervision or continuing professional education. You may list as many competencies as you wish. Any area of competence may be selected and used as a part of your oral examination. Duplicate if necessary.		
Declared Competency:		
Course Number and Title:		
Content as described in official catalog or syllabus:		
Supervised Experience Site:		Dates From: To:
Supervisor:		Total Hours:
Supervised Experience Site:		Dates From: To:
Supervisor:		Total Hours:
Applicant's Signature:		Date:
Mail completed form to: **ASPPB Mobility Program** **P.O. Box 3079** **Peachtree City, GA 3269**		