Reset Form

APPLICATION FOR ENDORSEMENT AS A HEALTH SERVICE PROVIDER IN PSYCHOLOGY (HSPP)

State Form 20231 (R19 / 11-21)

INDIANA STATE PSYCHOLOGY BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2054
E-mail: pla8@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:

1. *The fee for this application is $100.00, payable to the Indiana Professional Licensing Agency, in accordance with 868 IAC 1.1-12-1.5.*
2. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
3. *All fees are non-refundable and non-transferable.*
4. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

FOR OFFICE USE ONLY			
Date reviewed *(month, day, year)*	License number	Decision	Initials
Fee	Date fee paid *(month, day, year)*	Receipt number	HSPP endorsement issuance date *(month, day, year)*

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant *(last, first, middle, maiden)*	Social Security Number*
Address *(number and street or rural route, city, state, and ZIP code)*	*City, state, and ZIP code*
Date of birth *(month, day, year)*	Telephone number *(daytime)* ( )
Email address	

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select one of the following.)*

☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 1641). ☐ I am authorized by the Federal Government to work in the United States.

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)* ☐ Yes ☐ No	Are you an active duty member of the military? *(Optional)* ☐ Yes ☐ No

STATES LICENSED

*List all states, **including Indiana**, in which you have been licensed to practice any regulated health occupation. Verification of all listed licenses must be submitted directly from the state licensing board.*

TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	STATE	NUMBER	DATE ISSUED *(month, day, year)*	CURRENT STATUS

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency or any of its authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions from any liability with regard to such inspection or furnishing of any information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I affirm, under penalties for perjury, that the foregoing representations are true.

Signature of applicant	Date *(month, day, year)*

APPLICATION FOR ENDORSEMENT AS A HEALTH SERVICE PROVIDER IN PSYCHOLOGY (HSPP) *(continued)*

State Form 20231 (R19 / 11-21)

POST-INTERNSHIP OR POST-DOCTORAL EXPERIENCE
FORM 1

INSTRUCTIONS: Applicants must complete this form and submit it to the board by upload, email, or mail.

APPLICANT INFORMATION			
1. Name *(last, first, middle, maiden)*			
2. Home address *(number and street or rural route)*	City	State	ZIP code
3. License number	Date of issuance *(month, day, year)*	Date of birth *(month, day, year)*	

EXPERIENCE IN A SUPERVISED HEALTH SERVICE SETTING *(Post-Internship or Post-Doctoral)*		
Attach additional sheets for multiple settings.		
Name of facility		
Address *(number and street or rural route, city, state, and ZIP code)*		
Your title	Name of supervisor	Supervisor's degree
Inclusive dates *(month, day, year)* FROM: TO:		Number of hours of supervised experience
Number of hours per week of direct face-to-face supervision *(individual, not group)* you received		Number of hours you engaged in direct patient contact
Number of hours you supervised others	If you supervised others, were they: ☐ Psychology graduate students ☐ Other *(describe)*	
Number of hours you engaged in teaching	Number of hours you engaged in research	

AFFIRMATION	
I affirm, under penalties for perjury, that the foregoing representations are true.	
Signature of applicant	Date *(month, day, year)*

APPLICATION FOR ENDORSEMENT AS A HEALTH SERVICE PROVIDER IN PSYCHOLOGY (HSPP) *(continued)*

State Form 20231 (R19 / 11-21)

VERIFICATION OF INTERNSHIP EXPERIENCE
FORM A

INSTRUCTIONS – ALL APPLICANTS:

1. *Complete the top section.*
2. *Make copies and send this form to the Director of Training of your experience (internship).*
3. *Direct the individual(s) to send this form directly to the Professional Licensing Agency.*
4. *If the Director of Training is not available, another psychologist associated with the internship may complete the form.*
5. *If a psychologist is not available, you must provide a written explanation to the Board.*

1. Name *(last, first, middle, maiden)*			
2. Home address *(number and street or rural route)*	City	State	ZIP code
3. License number	Date of issuance *(month, day, year)*	Date of birth *(month, day, year)*	

I authorize _____ to furnish the Indiana State Psychology Board / Professional Licensing Agency with the following information.

Signature of applicant	Date of signed *(month, day, year)*

TO:

Please verify that _____ has received acceptable, supervised experience *(internship)* by providing the following information.

1. Name and address of the agency providing the training program

2. Your name and current address

3. Your title at the agency at the time the applicant was in the program

4. What role did you play in the internship?

5. Did you directly supervise the applicant? ☐ Yes ☐ No
   If No, what was your relationship to the applicant?

6. Type of patient / client population

7. When did the applicant receive training in your program / internship? *(please provide exact beginning and ending dates)*
   FROM: TO:

   a. Was the internship APA approved at the time of completion? ☐ Yes ☐ No

   b. Was the internship APPIC approved at the time of completion? ☐ Yes ☐ No

   c. Number of hours per week applicant worked in this setting

   d. Number of hours per week applicant received individual, not group, supervision

   e. Duration of the supervision *(number of weeks or months)*

   f. Total number of hours the applicant worked in this setting

8. Number of interns in the program when the applicant was in the program

9. NAME AND DEGREES OF SUPERVISING PSYCHOLOGISTS		
Name	**Degree *(at the time the applicant was in the program)***	**State Where Certified / Licensed**

10. Please give a description of the applicant's internship experience

11. Was the internship satisfactorily completed? ☐ Yes ☐ No

If No, please attach an explanation.

12. At the time of supervision

A. Were you licensed or certified in Indiana? ☐ Yes ☐ No

B. If you were licensed or certified in Indiana, were you endorsed as a health service provider in psychology? ☐ Yes ☐ No

If you were not licensed or certified in Indiana and HSPP, or were not listed in the National Register, has your resume been attached? ☐ Yes ☐ No

VERIFICATION FORM AFFIRMATION	
I swear or affirm, under penalties for perjury, that the statements made in this verification are true, complete and correct.	
Signature of applicant	Date signed *(month, day, year)*

Please respond as soon as possible so that the application may be completed without delay.
Please send all responses to:

INDIANA STATE PSYCHOLOGY BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204

Thank you for your assistance in this matter.

APPLICATION FOR ENDORSEMENT AS A HEALTH SERVICE PROVIDER IN PSYCHOLOGY (HSPP) *(continued)*

State Form 20231 (R19 / 11-21)

VERIFICATION OF PRACTICUM EXPERIENCE
FORM B

INSTRUCTIONS – ALL APPLICANTS:

1. *Complete the top section.*
2. *Make copies and send this form to the Doctoral Training Director (or his / her designee).*
3. *Direct the individual(s) to send this form directly to the Professional Licensing Agency.*
4. *If the Doctoral Training Director is not available, another psychologist associated with the training program may complete the form.*

1. Name *(last, first, middle, maiden)*			
2. Home address *(number and street or rural route)*	City	State	ZIP code
3. License number	Date of issuance *(month, day, year)*	Date of birth *(month, day, year)*	

I authorize _____ to furnish the Indiana State Psychology Board / Professional Licensing Agency with the following information.

Signature of applicant	Date of signed *(month, day, year)*

TO:	

NOTE: Applicant MUST have completed a minimum of 400 hours of master's level, basic practicum training prior to beginning doctoral level, advanced practicum. Each semester of doctoral practicum experience MUST correspond with a practicum course listed on the applicant's transcript for that semester.

Please verify that _____ has received acceptable, supervised experience in a doctoral level practicum by providing the following information.

1. Name and address of the agency providing the training program

2. Your name and current address

3. Your title at the agency at the time the applicant was in the program

4. Date of completion of master's degree *(month, day, year)* or forty-eight (48) semesters / seventy-two (72) quarter hours

5. Number of hours of practicum / internship completed during Master's training *(If less than 400 hours were completed during the Master's training, please indicate the term in which 400 hours of training was completed.)*

6. When did the applicant receive training in the practicum *(please provide exact beginning and ending dates)*

FROM: TO:

a. Number of hours per week applicant worked in this setting

b. Number of hours per week applicant received direct face-to-face supervision

c. Duration of the supervision *(number of weeks or months)*

d. Total number of hours of direct patient contact in this practicum setting

e. Total number of hours of supervised experience completed in this setting

See Reverse Side.

7. NAME AND DEGREES OF SUPERVISING PSYCHOLOGISTS		
Name	**Degree *(at the time the applicant was in the program)***	**State Where Certified / Licensed**

8. Please give a description of the training program's oversight of the setting

9. Was the practicum satisfactorily completed? Yes ☐ No

If No, please attach an explanation.

VERIFICATION FORM AFFIRMATION	
I swear or affirm, under penalties for perjury, that the statements made in this verification are true, complete and correct.	
Signature of Director of Training	Date signed *(month, day, year)*
Printed name of Director of Training	

Please respond as soon as possible so that the application may be completed without delay.
Please send all responses to:

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Thank you for your assistance in this matter.

APPLICATION FOR ENDORSEMENT AS A HEALTH SERVICE PROVIDER IN PSYCHOLOGY (HSPP) *(continued)*

State Form 20231 (R19 / 11-21)

VERIFICATION OF POST-INTERNSHIP EXPERIENCE
FORM C

INSTRUCTIONS – ALL APPLICANTS:

1. *Complete the top section.*
2. *Make copies and send this form to each individual who supervised your experience in a health service setting (post-internship).*
3. *Direct the individual(s) to send this form directly to the Professional Licensing Agency.*

1. Name *(last, first, middle, maiden)*			
2. Home address *(number and street or rural route)*	City	State	ZIP code
3. License number	Date of issuance *(month, day, year)*	Date of birth *(month, day, year)*	

I authorize _____ to furnish the Indiana State Psychology Board / Professional Licensing Agency with the following information.

Signature of applicant	Date of signed *(month, day, year)*

TO:	

Please verify that _____ has received acceptable, supervised experience post-internship by providing the following information.

1. Name and address of the facility in which the experience was obtained

2. Your name and current address

3. Your title in the health service setting during the time you supervised the applicant

4. Type of patient / client population

5. INCLUSIVE DATES AND NUMBER OF HOURS PER WEEK THE APPLICANT WORKED IN THIS SETTING

Dates *(month, day, year)*	**Hours**

a. Number of hours per week you directly supervised applicant *(individual, not group, supervision)*

b. When did you supervise the applicant? *(Provide exact beginning and ending dates.)*

c. Number of hours of experience completed by the applicant while under your supervision

d. Number of hours of direct patient contact by the applicant while under your supervision

See Reverse Side.

6. Briefly describe the nature of the applicant's work

7. Was the supervised experience satisfactorily completed by the applicant? ☐ Yes ☐ No

If No, please attach an explanation.

8. At the time of supervision

A. Were you licensed or certified in Indiana? ☐ Yes ☐ No

B. If you were licensed or certified in Indiana, were you endorsed as a health service provider in psychology? ☐ Yes ☐ No

If you were not licensed or certified in Indiana and HSPP, or were not listed in the National Register, has your resume been attached? ☐ Yes ☐ No

VERIFICATION FORM AFFIRMATION

I swear or affirm, under penalties for perjury, that the statements made in this verification are true, complete and correct.

Signature of Director of Training	Date signed *(month, day, year)*
Printed name of supervisor	

Please respond as soon as possible so that the application may be completed without delay.
Please send all responses to:

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