Reset Form

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

State Form 20231 (R16 / 1-15)
Approved by State Board of Accounts, 2015


**INDIANA STATE PSYCHOLOGY BOARD**
**PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2043
E-mail: psych@pla.IN.gov


* 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 (*last, first, middle, maiden*) | | | Social Security number * | |
| Home address (*number and street or rural route*) | | City | State | ZIP code |
| Telephone number (*daytime*) ( ) | Date of birth (*month, day, year*) | Place of birth | E-mail address | |

| MASTER'S EDUCATION *(Leave blank if not applicable.)* | | |
|---|---|---|
| Name of school | Department | Title of program |
| Street address (*number and street, city, state, and ZIP code*) | | |
| Dates attended (*month, day, year*) | Degree earned | Number of hours completed |

**TRAINING IN AN ORGANIZED HEALTH SERVICE TRAINING PROGRAM *(Pre-Doctoral Internship)***

A. Name and address of internship program

| B. APA approved at the time of completion? ☐ Yes ☐ No | C. APPIC approved at the time of completion? ☐ Yes ☐ No |
|---|---|
| D. Inclusive dates of internship (*month, day, year*) FROM: TO: | Total hours worked |

E. Names of supervising psychologists and their certification - licensure status

| Director of Training | Location of practicum *(number and street, city, state, and ZIP code)* | Dates *(month, day, year)* | Hours Earned | Direct Client Contact Hours |
|---|---|---|---|---|
| | | | | |
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| F. Number of interns in program at the time you were in the program | G. Approximate number of hours of direct supervision per week (*individual, not group supervision*) | H. Number of seminar hours per week |
|---|---|---|

| DOCTORAL EDUCATION | | |
|---|---|---|
| Name of school | Department | Title of program |
| Street address (*number and street, city, state, and ZIP code*) | | |
| Dates attended (*month, day, year*) | Degree earned | APA approved at time of graduation? ☐ Yes ☐ No |

## 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, city, state, and ZIP code*) | | |
| Your title | Name of supervisor | Supervisor's degree |
| Inclusive dates (*month, day, year*)<br>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:<br>☐ Psychology graduate students ☐ Other (*describe*) | |
| Number of hours you engaged in teaching | Number of hours you engaged in research | |

If your answer is "Yes" to any of the following, explain in a notarized affidavit, including all related details. Describe the event including location, date, and disposition. If malpractice, provide name of plaintiff. Falsification of any of the following is grounds for permanent revocation of an endorsement issued pursuant to this application.

| | | |
|---|---|---|
| 1. | Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? | ☐ Yes ☐ No |
| 2. | Have you ever been denied a license, certificate, registration, permit, or endorsement to practice psychology, or any regulated health occupation in any state or country (*including Indiana*). | ☐ Yes ☐ No |
| 3. | Are you now being, or have you ever been, treated for drug or alcohol abuse? | ☐ Yes ☐ No |
| 4. | *Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*<br>(1) have you ever been arrested;<br>(2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;<br>(3) have you ever been convicted of any offense, misdemeanor, or felony in any state;<br>(4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or<br>(5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state? | ☐ Yes ☐ No |
| 5. | 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 any restrictions, probation or other type of discipline or limitations? | ☐ Yes ☐ No |
| 6. | Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? | ☐ Yes ☐ No |
| 7. | Have you ever had a malpractice judgment against you or settled any malpractice action? | ☐ Yes ☐ No |

## APPLICATION AFFIRMATION

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

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

## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organizations 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 endorsement.

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

I further authorize the Professional Licensing Agency, or the Indiana State Psychology Board to disclose to the aforementioned organizations, persons and institutions any information which is material to my application, and I hereby specifically release the Agency and Board from any and all liability in connection with such disclosures.

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

## AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to the same.

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

***YOU MUST COMPLETE FORMS A, B, AND C (attached).***

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

State Form 20231 (R16 / 1-15)

## 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

*See Reverse Side*

| 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 hereby swear or affirm, under the penalty of perjury, that the statements made in this verification are true, complete and correct.

| Signature | 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 (R16 / 1-15)

## VERIFICATION OF PRACTICUM EXPERIENCE FORM B

*INSTRUCTIONS - ALL APPLICANTS:*

1. *Complete the top section.*
2. *Make copies of this form for each practicum experience and send 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 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 practicum

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 masters 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 brief 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 hereby swear or affirm, under the penalty of perjury, that the statements made in this verification are true, complete and correct. | |
| Signature of Director of Training | Date *(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:

**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 (R16 / 1-15)

## 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 hereby swear or affirm, under the penalty of perjury, that the statements made in this verification are true, complete and correct.

| Signature of supervisor | Printed name of supervisor | 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:

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