

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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) 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: <input type="checkbox"/> Psychology graduate students <input type="checkbox"/> 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 fully in a sworn affidavit, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been denied a license, certificate, registration or permit to practice psychology, or any regulated health occupation in any state or country (including Indiana).	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you have any condition or impairment (including a history of alcohol or substance abuse) that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court, (1) have you ever been arrested;	<input type="checkbox"/> Yes <input type="checkbox"/> No
(2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;	<input type="checkbox"/> Yes <input type="checkbox"/> No
(3) have you ever been convicted of any offense, misdemeanor, or felony in any state;	<input type="checkbox"/> Yes <input type="checkbox"/> No
(4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or	<input type="checkbox"/> Yes <input type="checkbox"/> No
(5) have you ever pled <i>nolo contendere</i> to any offense, misdemeanor, or felony in any state?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever had a malpractice judgment against you or settled any malpractice action?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

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 (R18 / 5-19)

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Was the internship APPIC approved at the time of completion? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <i>(at the time the applicant was in the program)</i>	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 <i>(month, day, year)</i>
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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 (R18 / 5-19)

**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:	
<i>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.</i>	
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	

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)
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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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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 (R18 / 5-19)

**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	

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 (<i>month, day, year</i>)

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.