Reset Form

APPLICATION FOR LICENSURE TO PRACTICE PSYCHOLOGY IN INDIANA BY EXAMINATION

State Form 27522 (R16 / 8-17)
Approved by State Board of Accounts, 2017

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
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. *If applying for a temporary permit, please include your fee of $50.00 in accordance with 868 IAC 1.1-12-1.5.*
3. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
4. *All fees are non-refundable and non-transferable.*
5. *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.
**This information is being requested for workforce statistical purposes only; disclosure is voluntary

FOR AGENCY USE ONLY		
Date received (*month, day, year*)	Decision	Initials

PSYCHOLOGY LICENSE				
Application fee	Date fee paid (*month, day, year*)	Receipt number	License number	License issuance date (*month, day, year*)

TEMPORARY PERMIT				
Application fee	Date fee paid (*month, day, year*)	Receipt number	Permit number	Permit issuance date (*month, day, year*)

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)		Social Security number *
Date of birth (*month, day, year*)	Place of birth (*city and state or country*)	
Address of applicant (*number and street or rural route*)	City, state, and ZIP code	
Telephone number (*daytime*) ( )	E-mail address *(required)*	
Gender ** ☐ Male ☐ Female	Ethnicity **	Race **

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).

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
Do you desire a temporary license? ☐ Yes ☐ No	Have you previously taken the Examination for the Professional Practice of Psychology (EPPP)? ☐ Yes ☐ No

If "Yes", how many times?	Dates of testing *(month,year)*	Where taken *(state, country)*

Have you previously filed an application for licensure as a psychologist in the State of Indiana? ☐ Yes ☐ No	If "Yes", when was the application filed (*month, day, year*)?
Do you currently hold, or have you ever held, a Basic Certificate or Limited License to practice psychology in Indiana? ☐ Yes ☐ No	If "Yes", state the Certificate / License number

Describe the nature of the practice of psychology in which you intend to engage:

APPLICANT INFORMATION *(continued)*

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? ☐ Yes ☐ 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*). ☐ Yes ☐ 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? ☐ Yes ☐ 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; ☐ Yes ☐ No
   (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or ☐ Yes ☐ No
   (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

*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

GRADUATE EDUCATION *(Doctoral)*

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 required for degree (*excluding dissertation hours*)?	APA approved at the time of graduation? ☐ Yes ☐ No	
Which were the hours? ☐ Semester ☐ Quarter		

PREDOCTORAL INTERNSHIP

Was an Internship required for graduation? ☐ Yes ☐ No

Name of internship program

Address of internship program (*number and street, city, state and ZIP code*)

APA or CPA approved at the time of completion? ☐ Yes ☐ No	*If no, please complete page 3 and provide supplemental documents.*	
APPIC approved at the time of completion? ☐ Yes ☐ No	Inclusive dates of internship (*month, day, year*)	Total hours worked

Director of internship training

POST DOCTORAL EDUCATION

Name of school	Department	Title of program
Address (*number and street, city, state, and ZIP code*)		Dates attended (*month, day, year*)

POST DOCTORAL INTERNSHIP / FELLOWSHIP

Name of Internship/Fellowship

Address of Internship/Fellowship *(number and street, city, state and ZIP code)*

Inclusive dates of Internship/Fellowship *(month, day, year)*	Total hours worked

Name of Supervising Psychologist

PROFESSIONAL IDENTITY BASED UPON DOCTORAL TRAINING

(Check only one or attach explanation)

☐ Clinical Psychology ☐ Experimental ☐ School ☐ Organizational / Industrial
☐ Counseling Psychology ☐ Developmental ☐ Social ☐ Other (*specify*): _____

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, or the State Psychology Board, any files, documents, records or other information pertaining to the undersigned requested by the Agency, or the Board, or any of their authorized representatives, in connection with processing my application for licensure.

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

I further authorize the Professional Licensing Agency, or the 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 the Board, 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.

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 (*month, day, year*)

COURSEWORK INFORMATION

For graduates of doctoral programs that were <u>not</u> APA or CPA approved at the time of completion, please provide the following:
List the course number and course title of the graduate coursework you have completed in the required content areas as they appear on your transcript. If the course titles as stated on your transcript do not clearly reflect the required content areas, provide additional supporting documentation such as course syllabus, term papers, etc. You may use the same course for more than one content area. Also, each content area may contain more than one course.

BIOLOGICAL BASES OF BEHAVIOR

NAME OF EDUCATIONAL INSTITUTION	COURSE NUMBER	COURSE TITLE	CREDIT HOURS	Semester / Quarter

COGNITIVE-AFFECTIVE BASES OF BEHAVIOR

NAME OF EDUCATIONAL INSTITUTION	COURSE NUMBER	COURSE TITLE	CREDIT HOURS	Semester / Quarter

SOCIAL BASES OF BEHAVIOR

NAME OF EDUCATIONAL INSTITUTION	COURSE NUMBER	COURSE TITLE	CREDIT HOURS	Semester / Quarter

INDIVIDUAL DIFFERENCES

NAME OF EDUCATIONAL INSTITUTION	COURSE NUMBER	COURSE TITLE	CREDIT HOURS	Semester / Quarter