For Office Use Only	☐ $60

Application for Health Service Provider in Psychology
Iowa Department of Public Health/Bureau of Professional Licensure

PLEASE PRINT **Instructions are found on page 4**

1. _____ 2. _____
Last Name *First Name and Middle Name*

3. _____
Mailing Address

4. _____ 5. _____
City, State, Zip Code *E-Mail Address*

6. _____ 7. _____ 8. _____-_____-_____
Daytime Phone (Including Area Code) *Date of Birth* *Social Security Number**

9. ☐ Male ☐ Female 10. _____
Gender (optional question) *If any of your documentation is in a name other than your current name, list the previous names of record*

The following questions must be answered. If you answer "Yes" to the next six questions, (1) attach a signed letter of explanation providing the details of the incident, (2) attach a copy of any court ordered evaluations, showing completion and recommendations, and (3) attach a copy of all official court documents regarding your conviction/malpractice suit, including final disposition and/or settlement. You must answer "Yes" even when a conviction or judgment has been deferred or expunged from your record.

11. Been convicted, found guilty of or entered a plea of guilty or no contest to a felony or misdemeanor crime (Other than minor traffic violations with fines under $500)?	Yes No
12. Had any judgments or settlements paid on your behalf as a result of a malpractice suit or claim against you?	Yes No
13. Been investigated by a licensing, registration, or certification authority or organization; or had a licensing, registration, or certification authority or organization institute disciplinary action against you related to your professional practice? (If the investigation or action was instituted by this licensing board you may answer "NO" to this question).	Yes No
14. Been disciplined or sanctioned by any licensing, registration, or certification authority or organization related to your professional practice? (If this licensing board took the disciplinary action, you may answer "NO" to this question).	Yes No
15. Developed a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? (If you are currently a participant in the Impaired Practitioner Review Committee, you may answer "NO" to this question.)	Yes No
16. Been engaged in illegal or improper use of drugs or other chemical mood altering substances? (If you are currently a participant in the Impaired Practitioner Review Committee, you may answer "NO" to this question.)	Yes No

17. Are you currently licensed as a psychologist in Iowa? ☐ Yes ☐ No
If yes, state your license number _____

18. If not licensed, have you submitted an application for Iowa psychology licensure? ☐ Yes ☐ No

If yes, date of application. _____

19. Are you listed in the National Register of Health Service Providers? ☐ Yes ☐ No
If yes, submit proof of national registration. A notarized copy of the original will be accepted.

If you <u>are not</u> listed in the National Register of Health Service Providers, provide proof of two years of supervised clinical experience in a recognized health service setting. *[645 IAC 240.7(1) and 240.7(2).]* List below all supervised experience in health service in psychology, starting with postdoctoral experience.

20. **POSTDOCTORAL SUPERVISED CLINICAL EXPERIENCE IN PSYCHOLOGY**
(List most recent first)

A. _____
Name of Facility *City* *State*

Name & title of the director of health service setting: _____

Name & title of direct supervisor: _____

Your designated title during supervision: _____

Nature of training: _____

Duration of supervision: _____ ☐ Part Time ☐ Full Time
FROM (mm/dd/yyyy) *TO (mm/dd/yyyy)*

Number of hours of face to face/individual supervision weekly: _____

Total number of hours of direct patient contact: _____

Total number of supervised experience hours: _____

B. _____
Name of Facility *City* *State*

Name & title of the director of health service setting: _____

Name & title of direct supervisor: _____

Your designated title during supervision: _____

Nature of training: _____

Duration of supervision: _____ ☐ Part Time ☐ Full Time
FROM(mm/dd/yyyy) *TO(mm/dd/yyyy)*

Number of hours of face to face/individual supervision weekly: _____

Total number of hours of direct patient contact: _____

Total number of supervised experience hours: _____

C. _____
Name of Facility *City* *State*

Name & title of the director of health service setting: _____

Name & title of direct supervisor: _____

Your designated title during supervision: _____

Nature of training: _____

Duration of supervision: _____ ☐ Part Time ☐ Full Time
FROM(mm/dd/yyyy) *TO(mm/dd/yyyy)*

Number of hours of face to face/individual supervision weekly: _____

Total number of hours of direct patient contact: _____

Total number of supervised experience hours: _____

Add separate sheet(s) if needed for additional supervised experience.

21. **ORGANIZED HEALTH SERVICE TRAINING PROGRAM**

A. _____
Name of Facility

_____
City *State* *Zip Code*

Was the training program APA accredited or APPIC member? ☐ Yes ☐ No

Name & title of the director of training: _____

License number: _____ State of Licensure: _____

Name & title of direct supervisor(s): _____

License number(s): _____ State of Licensure: _____

Your designated title during training: _____

Nature of training: _____

Duration of training: _____ _____
From *To*

Number of hours of direct supervision weekly: Individual _____ Group/Other _____

Total number of hours of direct patient contact: _____

Total number of training experience hours: _____

B. _____
Name of Facility

_____
City *State* *Zip Code*

Was the training program APA accredited or APPIC member? ☐ Yes ☐ No

Name & title of the director of training: _____

License number: _____ State of Licensure: _____

Name & title of direct supervisor(s): _____

License number(s): _____ State of Licensure: _____

Your designated title during training: _____

Nature of training: _____

Duration of training: _____ _____
From *To*

Number of hours of direct supervision weekly: Individual _____ Group/Other _____

Total number of hours of direct patient contact: _____

Total number of training experience hours: _____

I certify that I have carefully read the questions on this application and have answered them completely and truthfully. I declare under penalty of perjury that my answers, and all other statements or information submitted by me in this application process, are true and correct. If it is determined at any time that I have provided misleading or false information on or in support of this application, I understand that my application may be denied or that I may be subject to disciplinary action and criminal prosecution if I am already licensed.

I understand that I am required to update answers or information submitted herewith if the response or the information changes during the time period the application is pending. I also understand that this application is a public record in accordance with Iowa Code, Chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law. Finally in submitting this application, I consent to any reasonable inquiry that may be necessary to verify the information I have provided on or in conjunction with this application.

*This information is collected pursuant to Iowa Code Chapters 252J, 261 & 272C. Failure to provide mandatory information will result in license denial. Privacy Act Notice: Disclosure of your Social Security Number on this license application is required by 42 U.S.C. § 666(a)(13) and Iowa Code § 252J.8(1). The number will be used in connection with the collection of child support obligations and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code § 421.18.

22. _____ _____

Applicant must sign here in ink **Date**

INSTRUCTIONS/CHECKLIST

To complete the application, answer each question completely in ink. The following is a list of the supporting documents and fees required for licensure. It is the applicant's responsibility to see that all required documents and fees reach the board office.

- ☐ Non-refundable application fee of $60. Make check or money order payable to the Iowa Board of Psychology.
- ☐ Proof of certification from the National Register of Health Service Providers; **or**
- ☐ Verification of two years clinical experience
  - ☐ Organized health service training program
  - ☐ Postdoctoral supervised work experience

Applications must be complete and signed to be processed. No application will be considered complete until all required supporting documents and fees have been received in the board office. Questions regarding the application process may be directed to 515-281-4287 or karla.hoover@idph.iowa.gov. An applicant who has been denied licensure by the board may appeal the denial and request a hearing on the issues related to licensure denial by serving a notice of appeal and request for hearing upon the board not more than 30 days following the date of mailing of the notification of licensure denial to the applicant. **Mail the original completed application bearing signature in ink to:**

Iowa Board of Psychology
Bureau of Professional Licensure
Lucas State Office Building, 5th Floor
321 E 12th St.
Des Moines, IA 50319-0075

www.idph.state.ia.us/licensure License search: www.licensediniowa.gov

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Application Status Checklist:

☐ Fee Paid Application fee - **$60**
☐ Health Service Provider certificate; OR ☐ Verification of clinical training and experience.

Approved: _____ **Date:** _____

Comments:

License No: _____

Date Issued: _____

Staff Initials: _____

Checked By: _____