

FOR OFFICE USE ONLY

Psychology Checklist

- Temporary
- Endorsement Examination
- App. & Fee
- Date: _____ Check _____
- Transcript
- Exam Results from EPPP
- Lic. Verification from other States
- Supervised Practice Forms:
 - Pre-Doctoral
 - Post-Doctoral
- Curriculum Summary Forms (Non-APA)



**Rhode Island
Board of Psychology**

Room 104
3 Capitol Hill
Providence, RI 02908-5097

FOR OFFICE USE ONLY

License Number: _____

Issue Date: _____

Approved for EPPP _____

Approved for Licensure: _____

Signature of Board Member _____

Signature of Board Administrator _____

ID#: _____

Receipt #: _____

**Instructions and Application For
License As A
Psychologist**

Temporary Permit
Only for Examination applicants

Endorsement **Examination**
(From Another State)

License # _____

Name _____

MILITARY STATUS ELIGIBILITY

*(Documentation Required)
see next page for instructions*

Please check ONE of the following criteria for expedited application:

- I am in active military duty or a reservist
- I am a military veteran with honorable discharge
- I am the spouse of someone in active military duty or the spouse of a reservist

Applicant - Print Name

LAST NAME

FIRST NAME

MI

Phone: (401) 222-2828

TTY/TDD: (800) 745-5555

Fax: (401) 222-1272

LICENSURE REQUIREMENTS

- Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.
- Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **\$230.00** (an **additional** fee of **\$120.00** is required for Temporary Permit - Endorsement applicants are **NOT** eligible for the Temporary Permit.- Please refer to the Rules and Regulations to determine eligibility) and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE. Please be advised that this is an application fee and includes the first license **only** up until the next expiration date. All Psychologists licenses expire every 2 years on June 30th.
- Official transcripts sent **directly** from your accredited school of Psychology. No student copies will be accepted
- Scores/Certification sent directly from the **Association of State and Provincial Psychology Boards (ASPPB)** (Telephone 1-678-216-1175 or Toll Free 1-800-448-4069) (Website: <http://www.asppb.net>) sent directly to this office.
- Pre-Doctoral Supervised Practice Form - (Form included in this application to be used for that purpose) must be presented in sealed envelopes, either by mail directly from the reference, or submitted by the applicant in an envelope sealed with the reference's signature across the sealed flap.
- Post-Doctoral Supervised Practice Form - (Form included in this application to be used for that purpose) must be presented in sealed envelopes, either by mail directly from the reference, or submitted by the applicant in an envelope sealed with the reference's signature across the sealed flap.
- If you were in a non-APA Program you must submit the Curriculum Summary Form (Form included in this application to be used for that purpose)
- If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that purpose) The Verification Form from the State of original licensure must include test scores obtained on the appropriate level of the EPPP examination (or test scores may be sent directly from EPPP). If test scores are provided, you do not need to contact the EPPP to request the test scores. In addition to test scores, if the required Supervised Practice Prerequisite is provided by the Endorsement State(s) (Refer to Rules & Regulations), then you are not required to submit the Supervised Practice Forms.
- If applying for expedited military status you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

Licensure Information

Please visit the RIDOH website at <http://www.health.ri.gov/licenses> to Verify your license, download Rules and Regulations/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.

License Certificates

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of \$30.00 made payable to RI General Treasurer.

- I would like to receive a license certificate. I have enclosed a separate check in the amount of \$30.00



State of Rhode Island and Providence Plantations Board of Psychology

Application for License as a Psychologist/Temporary Permit

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/Permit/Certificate. Do not use nicknames, etc.

NOTE:
It is your responsibility to notify the Department of Health Board of any name changes.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden Name, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

 - -

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State."

3. Gender

 Male Female

4. Date of Birth

 / /

Month

Day

Year

5. Home Address

It is your responsibility to notify the board of all address changes.

No professional licensee's address (residence or business/employment) will be posted on the Department's Web site.

1st Line Address (Apartment/Suite/Room Number, etc.)

2nd Line Address (Number and Street)

City

State

 -

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

 -

Home Phone

 -

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

 -

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

 -

Business Phone

Extension

 -

Business Fax

7. Preferred Mailing Address Please check <u>ONE</u>	<input type="checkbox"/> Please use my Home Address as my preferred mailing address <input type="checkbox"/> Please use my Business Address as my preferred mailing address NOTE: The preferred mailing address that you indicate is the address that will be released for all requests for that information.
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8. Qualifying Education Please list the name and information about the school that you attended that qualifies you for this license.	<table style="width:100%"><tr><td colspan="12" style="border: 1px solid black; height: 15px;"></td></tr><tr><td colspan="12" style="font-size: small;">Type of School (University, College, Technical School, etc.)</td></tr><tr><td colspan="12" style="border: 1px solid black; height: 15px;"></td></tr><tr><td colspan="12" style="font-size: small;">Name of School</td></tr><tr><td colspan="3">Date Graduated</td><td colspan="3" style="border: 1px solid black; width: 40px;"></td><td colspan="3" style="border: 1px solid black; width: 40px;"></td><td colspan="3">Degree Received:</td><td colspan="3"><input type="checkbox"/> Doctorate in Psychology</td></tr><tr><td colspan="3"></td><td colspan="3" style="font-size: x-small; text-align: center;">Month</td><td colspan="3" style="font-size: x-small; text-align: center;">Year</td><td colspan="3"></td><td colspan="3"></td></tr><tr><td colspan="12"></td><td colspan="3">Is School Accredited by the American Psychology Association (APA)?</td><td colspan="3"><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr></table>													Type of School (University, College, Technical School, etc.)																								Name of School												Date Graduated									Degree Received:			<input type="checkbox"/> Doctorate in Psychology						Month			Year																					Is School Accredited by the American Psychology Association (APA)?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
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			Month			Year																																																																																											
												Is School Accredited by the American Psychology Association (APA)?			<input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																		

9. Other State License(s) Please answer the question and list state(s), if applicable	Have you <u>ever</u> held, or do you currently hold, a license in another state? <input type="checkbox"/> Yes <input type="checkbox"/> No If the answer to this question is “yes” , enter <u>all other state licenses</u> in Question 10 (below):
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10. Licensure List all states or countries in which you are now, or ever have been licensed to practice your profession*.	<table style="width:100%"><tr><td>State/Country: _____</td><td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td><td>State/Country: _____</td><td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td></tr><tr><td>_____</td><td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td><td>_____</td><td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td></tr><tr><td>_____</td><td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td><td>_____</td><td><input type="checkbox"/> Active <input type="checkbox"/> Inactive</td></tr></table> <p align="center">DOCUMENTATION: You must send a Interstate Verification Form to each entity.</p>	State/Country: _____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	State/Country: _____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
State/Country: _____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	State/Country: _____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive										
_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive										
_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive										

11. Criminal Convictions Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided. If necessary, you may continue on a separate 8½ x 11 sheet of paper.	Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? <input type="checkbox"/> Yes <input type="checkbox"/> No Abbreviation of State and Conviction ¹ (e.g. CA - Illegal Possession of a Controlled Substance): _____ _____ _____
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	Month		Year	

12. Disciplinary Questions Check either Yes or No for each question.	<table style="width:100%"><tr><td>1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are any formal charges pending?</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr><tr><td colspan="2" style="border-top: 1px dashed black; height: 20px;"></td></tr><tr><td>2. Have you ever been denied a license, certificate, registration or permit in any state?</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr></table> Note: If you answer “Yes” to any question, you are required to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper. _____ _____	1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are any formal charges pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No			2. Have you ever been denied a license, certificate, registration or permit in any state?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are any formal charges pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
2. Have you ever been denied a license, certificate, registration or permit in any state?	<input type="checkbox"/> Yes <input type="checkbox"/> No						

13. Affidavit of Applicant

Complete this section and sign.

Make sure that you have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Licensed Psychologist in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Psychology of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant

Date of Signature (MM/DD/YY)



Substitute forms are not acceptable, One (1) form is required for each state in which you hold, or have held a license. Copy this form as needed.

Rhode Island Board of Psychology

Room 104, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2828

INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S) (One form for each state)

I am applying for a license to practice as a Psychologist/Temporary Permit in the State of Rhode Island. The Rhode Island Board of Psychology requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Psychology at the above address.

Print/Type Full Name _____	Signature _____	Date _____
Previous Names Used _____	Social Security Number _____	Date of Birth _____
License Number _____	Date Issued _____	

THIS SECTION TO BE COMPLETED BY THE PSYCHOLOGY BOARD

Directions for State Board: Please complete and return this form to the address above *Please verify requirements met in your state:*

Ph.D from APA Accredited School? <input type="checkbox"/> Yes <input type="checkbox"/> No	Licensed by Examination? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not by examination, how was license obtained? Endorsement _____ (State) Other _____ (Ex-plain)
Applicant has completed and passed the National Certification (EPPP) Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No Score _____	License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	Original Date Issued: _____ Expiration Date: _____

*Two years supervised experience (One of which shall be Post-Doctoral)?
 Yes No If YES, please indicate the total number of pre-doctoral and post-doctoral Ph.D. supervised hours: Pre-Doctoral _____ Post-Doctoral _____

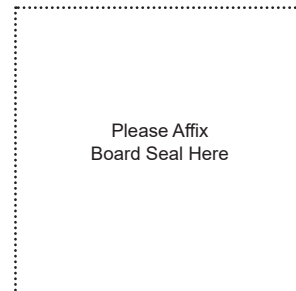
Questions:

- Has this licensee ever been investigated by your Board? Yes No
- Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? Yes No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? Yes No
- Do you know of any information that may discredit this person? Yes No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

Certification:

Signature _____	Date _____
Type or Print Name _____	
Title _____	
Full Name and State of Licensing Board _____	



Please return directly to the Board at the above address. Thank you for your prompt cooperation.



Rhode Island Board of Psychology

Room 104, 3 Capitol Hill
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(401) 222-2828

PRE-DOCTORAL SUPERVISED PRACTICE FORM - CERTIFICATION OF EXPERIENCE

The individual named below is applying for certification as a Licensed Psychologist in the State of Rhode Island. Prior to certifying the applicant, it is necessary to verify his/her past clinical supervision and/or clinical experience while supervised by you. The applicant has completed Section I and is requesting that you complete Section II. By signing below, the applicant attests that the information is correct to the best of his/her knowledge.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

Dates of Clinical Experience under supervision of the practitioner completing Section II. FROM: _____ TO: _____
Month Day Year Month Day Year Total number of Pre-Doctoral Supervised Hours _____

Description of Applicant's Primary Responsibilities and position:

INSTRUCTIONS TO APPLICANT: If you have had more than one supervisor, and evidence is needed from two or more supervisors to document the minimum level of supervised clinical experience required for Licensure, the applicant must complete Section I on each form forwarded to the individual supervisors. It is the responsibility of the applicant to gather all forms completed by supervisors in sealed envelopes with supervisor's signature across the back flap (seal) and mail in one packet to the Rhode Island Board of Psychology.

EXPERIENCE REQUIREMENTS FOR PSYCHOLOGISTS: The "Rules and Regulations pertaining to the Licensing of Psychologists", (R5-44-PSY), establishes experience requirements which must be met prior to application for the Psychologist License. "Supervised experience" shall mean the practical application of principles, methods and procedures of the science of psychology, for at least two (2) years, (one year of which must be post-doctoral), full time (35 hours per week) or its equivalent of 1500 clock hours per year for a minimum of 3000 hours and under the supervision of a psychologist certified or licensed pursuant to the statutory provisions for the state in which the supervised experience was obtained.

SECTION II - THIS SECTION TO BE COMPLETED BY SUPERVISOR

Instructions to supervisor: Please complete Section II of this form and return to the applicant. The Rhode Island Board of Psychology requests that the supervisor carefully review the applicant's statements under Section I prior to responding to Items in Section II. Insert completed form in an envelope and seal signing your name across the seal. Return to applicant. Applicant has been instructed to include your sealed envelope in his/her application packet.

Supervisor's Professional Degree, Discipline and License Information:
Degree: _____
Discipline: _____
License Level: _____
License #: _____
License State: _____

Agency and State in which Supervision Occurred: _____ Agency _____ State _____

Describe the nature of the Supervision: _____

Length and frequency (time-frame) of Supervision: _____

Certification: I hereby attest the above information in Section II is correct, to the best of my knowledge.

Signature _____ Date _____

Type or Print Name _____ Title _____

Supervisor's Address: _____

Please return this form to the applicant.

Thank you for your cooperation.



Rhode Island Board of Psychology

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POST-DOCTORAL SUPERVISED PRACTICE FORM - CERTIFICATION OF EXPERIENCE

The individual named below is applying for certification as a Licensed Psychologist in the State of Rhode Island. Prior to certifying the applicant, it is necessary to verify his/her past clinical supervision and/or clinical experience while supervised by you. The applicant has completed Section I and is requesting that you complete Section II. By signing below, the applicant attests that the information is correct to the best of his/her knowledge.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

Dates of Clinical Experience under supervision of the practitioner completing Section II. FROM: _____ TO: _____
Month Day Year Month Day Year Total number of Post-Doctoral Supervised Hours _____

Description of Applicant's Primary Responsibilities and position:

INSTRUCTIONS TO APPLICANT: If you have had more than one supervisor, and evidence is needed from two or more supervisors to document the minimum level of supervised clinical experience required for Licensure, the applicant must complete Section I on each form forwarded to the individual supervisors. It is the responsibility of the applicant to gather all forms completed by supervisors in sealed envelopes with supervisor's signature across the back flap (seal) and mail in one packet to the Rhode Island Board of Psychology.

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Supervisor's Professional Degree, Discipline and License Information: Degree: _____ Discipline: _____ License Level: _____ License #: _____ License State: _____
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Agency and State in which Supervision Occurred: _____ Agency _____ State _____

Describe the nature of the Supervision: _____

Length and frequency (time-frame) of Supervision: _____

Certification: I hereby attest the above information in Section II is correct, to the best of my knowledge.

Signature _____ Date _____

Type or Print Name _____ Title _____

Supervisor's Address: _____

Please return this form to the applicant.

Thank you for your cooperation.



Rhode Island Board of Psychology

Room 104, 3 Capitol Hill
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Substitute forms are not acceptable
Copy this form as needed.

CURRICULUM SUMMARY FORM (NON-APA PROGRAMS ONLY)

Applicant: Please complete this form which provides a brief summary of your credentials and file it with your application.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

1. Doctoral Degree (Check one):
 Ph.D Psy.D Ed.D Other (Specify) _____

2. Major field of concentration as indicated on official transcript being filed

3. Date doctoral requirements were satisfied, including successful defense of dissertation as indicated on transcript:

4. If major field was in clinical, counseling, school or industrial/organizational psychology, was the program an APA approved one? Yes No

5. Dates in which full-time graduate study was pursued:

6. Title of courses in which credits were earned that satisfy the following basic requirements:

(a) Professional ethics and standards:

(b) Statistical methods:

(c) Research methods:

(d) History and systems of psychology:

7. Title of courses in which credits were earned that satisfy the following core requirements:

(a) Biological Bases of Behavior (Physiological psychology, comparative psychology, neuropsychology, sensation and perception, psychopharmacology):

(b) Cognitive-Affective Bases of Psychology (Learning, thinking, emotion and motivation):

(c) Social Bases of Behavior (Group processes, organizational and systems theory):

(d) Individual Differences (Personality theory, human development, abnormal psychology):

8. Title of courses in which credits were earned within the specialty area of the major field of concentration:

9. Location, dates and nature of supervised experience and internship (Indicate if APA-Approved):

10. Name, title and license/certification number of supervising psychologists:

11. Total number of hours of supervised experience:	Practice	One-to-one Weekly Conferences
a) Pre-doctoral:		
b) Post-doctoral:		

12. Possession of ABPP Diploma? Yes No (If "Yes", date and field of diploma.)