



Psychology License Application Packet

Contents:

1. 668-067....Contents List/SSN Information/Mailing Information. 1 page
2. 668-068....Application Instructions Checklist..... 4 pages
3. 668-069....Psychologist License Application 13 pages
4. 668-041....Professional Reference Form 5 pages
5. 668-043....License Verification Form..... 2 pages
6. RCW/WAC and Online Website Links 1 page

Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. [42 U.S.C. § 666\(a\)\(13\)](#); [RCW 26.23.150](#). It will be used under the state’s child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the [Declaration of No Social Security Number Form](#). Please call the Customer Service Center at 360-236-4700 if you have questions.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Board of Psychology Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

(This page intentionally left blank.)

Application Instructions Checklist

All information should be handwritten clearly in blue or black ink. It is your responsibility to submit the forms required.

Application Fee. This fee is non-refundable. You can check the online [fee page](#) for current fees.

Select one method for licensure:

- National Written Examination and State Jurisprudence Examination (Must have completed doctoral program).
- Transfer of National Written Examination and State Jurisprudence Examination (Must have already taken and passed the EPPP. For more information on this visit ASPPB Web page at: www.asppb.org).

Select if the following applies:

Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information:

Social Security Number: You must list your social security number on your application. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the [Declaration of No Social Security Number Form](#). Please call the Customer Service Center at 360-236-4700 if you do not have one.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

2. Personal Data Questions:

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession. If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

3. Other License, Certification, or Registration:

List all jurisdictions in which you hold or have held a credential. Verification is required on the form provided.

4. Education:

List in date order, the name and location of each college, university, or professional school attended, the time spent in each, and the year of graduation. Official transcripts are required.

5. Supervised Experience:

In order to qualify for licensure, an applicant must demonstrate completion of 3,300 hours of supervised experience:

- 300 practicum hours
- 1,500 internship hours
- 1,500 additional hours (can be a combination of up to 1,500 preinternship hours, up to 1,500 postdoctoral hours, and/or additional internship hours beyond the minimum 1,500 hours)

Practicum [WAC 246-924-049](#):

At least nine months and 300 practicum hours of direct experience, 100 hours of which must be in supervision.

- No more than 300 practicum hours may count towards licensure requirements. Additional hours accrued following completion of the nine month practicum may count towards licensure requirements if the hours meet all preinternship requirements in [WAC 246-924-053](#).

Preinternship [WAC 246-924-053](#):

A preinternship experience occurs between the practicum required by [WAC 246-924-049](#) and internship required by [WAC 246-924-056](#). The preinternship is optional, and the hours count towards the 1,500 additional hours required for licensure.

Internship [WAC 246-924-056](#):

The internship must include at least 1,500 hours of supervised experience and be completed within 24 months. The internship program must be accredited by the American Psychological Association (APA), be a member program of the Association of Psychology Postdoctoral and Internship Centers (APPIC), or submit documentation that the requirements in [WAC 246-924-056](#) are met. Internship hours above the minimum 1,500 hours count towards the 1,500 additional hours required for licensure.

Postdoctoral [WAC 246-924-059](#):

Postdoctoral supervised experience occurs after the doctoral degree is conferred and is optional. No more than 1,500 postdoctoral experience hours can count towards the 3,300 total experience requirement. For each postdoctoral experience, submit a supervision agreement that meets the requirements in [WAC 246-924-059\(2\)](#).

6. Documentation of Non-APA or Non-CPA Approved Educational Requirements:

If you complete Non-APA or Non-CPA education, then you will need to complete this section. List your course work, course number and transcript title, year, credits, and attach syllabi for all coursework listed on application.

7. Internship:

If your internship was accredited by the American Psychology Association (APA) or a member of the Association of Psychology Postdoctoral and Internship Centers (APPIC), include a copy of your certificate of completion or letter from the internship director. If your internship was not APA accredited or an APPIC member, provide documentation that your internship meets the requirements defined in [WAC 246-924-056](#).

8. Applicant's Attestation:

You must sign and date this for us to process the application.

Other Important Information:

Important background check information: Washington State law authorize the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This would be at your own expense.

Psychologist licensing requirements can be found in the Licensing Information page on the [psychology website](#).

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
 - A copy of your marriage certificate to show proof of marriage; or
 - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

Jurisprudence Examination Information

The jurisprudence examination is available online. The examination will be sent electronically to you after you have passed the Examination of Professional Practice in Psychology (EPPP), has completed your experience hours, and have met all requirements to be licensed.

Jurisprudence Examination Topics:

You should know and understand Washington State statutes and rules not limited to, and how they relate to the practice of psychology in this state, including, but not limited to:

[RCW 18.83 Psychology Law](#)

[RCW 18.130 Uniforms Disciplinary Act](#)

[RCW 70.02 Health Care Information Act](#)

[RCW 26.44 Abuse of Children](#)

[RCW 71.05 Mental Illness Act](#)

[RCW 74.34 Abuse of Vulnerable Adults](#)

[WAC 246-15 Whistleblower Complaints](#)

[WAC 246-12 Administrative Procedures & Requirements for Credentialed Health Care Providers](#)

[WAC 246-924 Psychology Rules](#)

[WAC 246-16 Standards of Professional Conduct](#)

We appreciate your interest in obtaining a credential. You will be notified in writing if further documentation is required. If your application is incomplete, you will be mailed or emailed a letter regarding the deficiencies.

- The application is considered incomplete if requested information is left blank. Put N/A or place a line through a section instead of leaving it blank.
- You must keep your address up to date in order to receive a courtesy renewal notice. Any renewal postmarked or presented to the department after midnight on the expiration date is late.

Get important information about your credential type by [subscribing to email alerts](#).

Date
Stamp
Here

Revenue 0219010000

Psychologist License Application

Application for (check one):

- National Written Examination and State Jurisprudence Examination (Must have completed doctoral program).
 Transfer of National Written Examination and State Jurisprudence Examination (Must have already taken and passed the EPPP. For more information on this visit ASPPB Web page at: www.asppb.org).

- Select if the following applies:** Spouse or Registered Domestic Partner of Military Personnel
 Probationary License

1. Demographic Information

Social Security Number (SSN)
(If you do not have a SSN, see instructions)

National Provider Identifier Number (NPI)
(Enter 10 digit number)

- Male Female
 Prefer not to answer
 X

Name	First	Middle	Last
------	-------	--------	------

Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County
------	-------	----------	--------

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
--------------------------	------------------------	-------------------------

Email address

Mailing address if different from above address of record

City	State	Zip Code	County
------	-------	----------	--------

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? Yes No

If yes, list name(s):

Will documents be received in another name? Yes No

If yes, list name(s):

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

“Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.
1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.....

“Currently” means within the past two years.

“Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

“Currently” means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ..

Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?
 - b. Diverted controlled substances or legend drugs?.....
 - c. Violated any drug law?
 - d. Prescribed controlled substances for yourself?
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, please attach an explanation and provide copies of all judgments, decisions, and agreements?
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?

3. Other License, Certification, or Registration

List all jurisdictions, including Washington State, in which you hold or have held a credential. Verification is required on form provided.

State or Jurisdiction	License/Certification/Registration Type	Permanent or Temporary	License		Currently Active?
			Year Issued	Number	

5. Supervised Experience [WAC 246-924-043](#)

Supervised Experience

Applicants must complete 3,300 hours of experience to be eligible for licensure. Professional Reference Request forms signed by both applicant and supervisor must be submitted to verify all 3,300 hours of supervised experience. See below to review requirements for each supervision category.

Dates between supervision categories (practicum, preinternship, internship, postdoc) must occur chronologically and cannot overlap. All information below should match the information provided on the Professional Reference Request form that both the supervisor and applicant need to complete.

Director of Clinical Training

If the Director of Clinical Training (DCT) will be signing on behalf of an experience, please list their name in the corresponding experience below and use the Professional Reference Request form to provide the names of the supervisors the DCT is signing on behalf of.

Research Hours

Qualifying supervised experience in a human subject research setting is only allowed for hours providing and obtaining supervision for those clinical services defined as the "practice of psychology" under RCW [18.83.010\(1\)](#). All other research related hours do not qualify for supervised experience.

Practicum ([WAC 246-924-049](#))

A practicum is required and is the initial supervised experience. The doctoral program must include a practicum of at least nine months in length and 300 hours of direct experience, 100 hours of which must be supervision. No more than 300 hours may count towards licensure. Additional hours accrued past the completion of the nine-month practicum may be reported under the preinternship portion below if those hours meet the preinternship requirements in [WAC 246-924-053](#).

Dates of supervised experience: From _____ / _____ To _____ / _____

Supervisor Name:

Name of facility/institution/practice where applicant obtained supervised experience:

Dates of supervised experience: From _____ / _____ To _____ / _____

Supervisor Name:

Name of facility/institution/practice where applicant obtained supervised experience:

Dates of supervised experience: From _____ / _____ To _____ / _____

Supervisor Name:

Name of facility/institution/practice where applicant obtained supervised experience:

Dates of supervised experience: From _____ / _____ To _____ / _____

Supervisor Name:

Name of facility/institution/practice where applicant obtained supervised experience:

5. Supervised Experience [WAC 246-924-043 \(Cont.\)](#)

Preinternship ([WAC 246-924-053](#))

The preinternship is optional and occurs between the practicum and internship; dates cannot overlap. A maximum of 1,500 hours can account for this experience.

Dates of supervised experience: From _____ / _____ To _____ / _____

Supervisor Name:

Name of facility/institution/practice where applicant obtained supervised experience:

Dates of supervised experience: From _____ / _____ To _____ / _____

Supervisor Name:

Name of facility/institution/practice where applicant obtained supervised experience:

Dates of supervised experience: From _____ / _____ To _____ / _____

Supervisor Name:

Name of facility/institution/practice where applicant obtained supervised experience:

Dates of supervised experience: From _____ / _____ To _____ / _____

Supervisor Name:

Name of facility/institution/practice where applicant obtained supervised experience:

Dates of supervised experience: From _____ / _____ To _____ / _____

Supervisor Name:

Name of facility/institution/practice where applicant obtained supervised experience:

Dates of supervised experience: From _____ / _____ To _____ / _____

Supervisor Name:

Name of facility/institution/practice where applicant obtained supervised experience:

5. Supervised Experience [WAC 246-924-043 \(Cont.\)](#)

Internship ([WAC 246-924-056](#))—Applicants must complete an organized internship as part of the doctoral program. The internship must include 1,500 hours of supervised experience completed within 24 months.

If the internship was not accredited by APA or APPIC, applicant must submit the written agreement or brochure that describes the goals and content of the internship as required in [WAC 246-924-056\(2A\)](#).

Dates of supervised experience: From _____ / _____ To _____ / _____

Supervisor Name:

Name of facility/institution/practice where applicant obtained supervised experience:

Dates of supervised experience: From _____ / _____ To _____ / _____

Supervisor Name:

Name of facility/institution/practice where applicant obtained supervised experience:

Dates of supervised experience: From _____ / _____ To _____ / _____

Supervisor Name:

Name of facility/institution/practice where applicant obtained supervised experience:

Dates of supervised experience: From _____ / _____ To _____ / _____

Supervisor Name:

Name of facility/institution/practice where applicant obtained supervised experience:

Postdoctoral Supervised Experience ([WAC 246-924-059](#))

If 3,000 supervised experience hours (in addition to the 300 Practicum hours) have not been completed during the doctoral program, up to 1,500 hours may be acquired through qualifying postdoctoral supervised experience. If claiming hours in this category, applicant must submit the written agreement for supervision as required in [WAC 246-924-059\(2\)](#).

Dates of supervised experience: From _____ / _____ To _____ / _____

Supervisor Name:

Name of facility/institution/practice where applicant obtained supervised experience:

Dates of supervised experience: From _____ / _____ To _____ / _____

Supervisor Name:

Name of facility/institution/practice where applicant obtained supervised experience:

Dates of supervised experience: From _____ / _____ To _____ / _____

Supervisor Name:

Name of facility/institution/practice where applicant obtained supervised experience:

6. Documentation of Non-APA Approved Educational Requirements

Applicants for a psychology license must have psychological coursework as specified in [WAC 246-924-046](#).

Enter the indicated information below. This information is reviewed by the Board together with the transcript from your doctoral institution. Attach an official syllabus for each course listed in this section.

You must have completed three or more semester hours, or five or more quarter hours, of core study in each of the following content area:

Biological bases of behavior for example: Physiological psychology, comparative psychology, neural bases of behavior, sensation and perception, and biological bases of development

Course number and transcript title	Credit type	Year	# of Credits
	S=semester Q=quarter		

Cognitive-affective bases of behavior for example: Learning, thinking, motivation, emotion, and cognitive development

Course number and transcript title	Credit type	Year	# of Credits
	S=semester Q=quarter		

Social bases of behavior for example: Social psychology, organizational theory, community psychology, and social development

Course number and transcript title	Credit type	Year	# of Credits
	S=semester Q=quarter		

Individual differences for example: Personality theory and psychopathology

Course number and transcript title	Credit type	Year	# of Credits
	S=semester Q=quarter		

6. Documentation of Non-APA Approved Educational Requirements (cont.)

Scientific and professional ethics

Course number and transcript title	Credit type S=semester Q=quarter	Year	# of Credits

History and systems of psychology

Course number and transcript title	Credit type S=semester Q=quarter	Year	# of Credits

Statistics and psychometrics

Course number and transcript title	Credit type S=semester Q=quarter	Year	# of Credits

Research design and methodology

Course number and transcript title	Credit type S=semester Q=quarter	Year	# of Credits

Techniques of data analysis

Course number and transcript title	Credit type S=semester Q=quarter	Year	# of Credits

6. Documentation of Non-APA Approved Educational Requirements (cont.)**Human development (developmental psychology, child development, adult development, and aging)**

Course number and transcript title	Credit type S=semester Q=quarter	Year	# of Credits

Cultural and individual differences and diversity

Course number and transcript title	Credit type S=semester Q=quarter	Year	# of Credits

Psychopathology and dysfunctional behaviors

Course number and transcript title	Credit type S=semester Q=quarter	Year	# of Credits

Theories and methods of assessment and diagnosis-minimum of two courses

Course number and transcript title	Credit type S=semester Q=quarter	Year	# of Credits

Effective psychological intervention and evaluation of the efficacy of interventions-minimum of three courses

Course number and transcript title	Credit type S=semester Q=quarter	Year	# of Credits

6. Documentation of Non-APA Approved Educational Requirements (cont.)

Psychopharmacology

Course number and transcript title	Credit type	Year	# of Credits
	S=semester Q=quarter		

7. Internship ([WAC 246-924-056](#))

It is the applicant's responsibility to provide sufficient and clear documentation regarding the internship completed.

- A. Was your internship APA accredited or an APPIC member listed?..... Yes No

If **yes**, do not complete this form, instead, provide certificate of completion or letter from the internship director.

If **no**, please use the following as a check list to document the internship completed meets the requirements of [WAC 246-924-056](#).

- B. Did your internship provide a planned programmed sequence of training experience to assure breadth and quality of training?..... Yes No

Provide the following information for the psychologist responsible for the internship program.

- C. Was there a psychologist licensed by the appropriate state or provincial licensing authority clearly designated as responsible for the integrity and quality of the internship program?..... Yes No

Please indicate the name and license number of the director.

Name _____ License number _____ State Credentialed _____

- D. Did your internship have two or more psychologists available as supervisors, at least one of whom was licensed as a psychologist? Yes No

Please indicate the names of at least two supervisors, (and license numbers if applicable).

Name _____ License number _____

Name _____ License number _____

- E. Was your internship supervision provided by the person who was responsible for the cases being supervised?..... Yes No

Please document by brochure or letter from the director/supervisor the relationship between the supervisor and the internship program.

- F. Was at least 75 percent of your internship supervision provided by a licensed psychologist with two years post-license experience?..... Yes No

Please document in a brochure or letter from your internship director/supervisor.

- G. Was at least 25 percent of your time or internship spent in direct client contact assessment and intervention?..... Yes No

Please submit a brochure or letter from your internship director/supervisor indicating

7. Internship ([WAC 246-924-056](#)) (Cont.)

that the requirements of [WAC 246-924-056](#) were met in the internship experience.

- H. Was there a minimum of two hours for every 40 hours of internship experience of regularly scheduled, formal, face to face individual supervision that addressed the direct psychological services rendered by the intern? Yes No

Please document in a brochure or letter from your internship director/supervisor.

- I. Was there at least two hours of other learning activities for every 40 hours of internship experience, (such as case conferences, seminars on applied issues, conducting co-therapy with a staff person, including discussion of the case, and group supervision)? Yes No

Please document in a brochure or letter from your internship director/supervisor.

- J. If more than 75 percent but less than 100 percent of the internship was supervised by a licensed psychologist with two years post-license experience, was the remaining percent of your internship (up to 25 percent) supervised by one or more health professionals in the following categories? Yes No

- A psychiatrist with three years experience beyond residency;
- A licensed mental counselor with at least five years post-license experience;
- A licensed advanced social worker or licensed independent clinical social worker with five years post-license experience; or
- A doctoral level psychologist with three years postdoctoral experience who is exempt from licensing under [RCW 18.83.200\(1\), \(2\), \(3\), or \(4\)](#) if the supervision occurred in Washington State, or an equivalent exemption under state or provincial licensing laws if the supervision occurred in another state or province.

- K. Did trainees in your internship program have titles such as “intern”, “resident”, “fellow”, or other designation of trainee status? Yes No

Please document in a brochure or letter from your internship director/supervisor.

- L. Did your internship (at the time you were enrolled) have a written statement or brochure describing the goals and content of the internship, stating clear expectations regarding quality of trainee’s work and made available to prospective interns? Yes No

Please provide a copy of the brochure.

- M. Did your internship consist of at least 1500 hours completed within 24 months? Yes No

Please provide documentation in brochure or letter from supervisor.

8. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of the state of
(Name of applicant)

Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ By: _____
(mm/dd/yyyy) (Original signature of applicant)

(This page intentionally left blank.)



Board of Psychology Credentialing
 PO Box 47877
 Olympia, WA 98504-7877
 360-236-4700

Professional Reference Request

Print Clearly

Use a separate form for each supervisor verifying supervised experience. After working with the supervisor to agree on the hours claimed, applicant will complete section 1 and 7, sign the form, and forward it to the supervisor for verification

Supervisor will complete supervisor information (sections 2-6), verify the hours claimed by applicant (section 7), and date and sign to indicate they agree with the information. To submit, the form will need to come directly from the supervisor either through email at hsqaReview1@doh.wa.gov or by mail to the address above.

1. Applicant Information

First Name	Middle	Last Name
Credential #		Date of Birth

Supervisor Information

2. Supervisor: I am:

- The Original Supervisor (complete section 3 and 5 below)
- The Director of Clinical Training (DCT) (complete sections 3, 5, and 6 below)
- Signing on behalf of the supervisor who is deceased or cannot be found (complete sections 3, 4, and 5 below)

3. Supervisor Information: To be completed by the supervisor completing and signing the form.

Supervisor Name	Supervisor license number and state license held
-----------------	--

Name of facility/institution/practice where applicant obtained supervised experience

4. Deceased or Unavailable Supervisor Information: Provide the information of the deceased or not located supervisor.

Supervisor Name	Supervisor license number and state license held
-----------------	--

Name of facility/institution/practice where applicant obtained supervised experience

5. Supervisor Qualification: If you provided supervision for the applicant for his/her Practicum, Preinternship, Internship, or Postdoctoral supervised experience, identify with the category of credentialing that applied to you at the time you provided the supervision. If you select "Other", identify your credential status under the applicable laws in your state or province.

Select which category(ies) apply to you and mark the appropriate box(es):

- Psychologist with at least two years post-licensure experience
- Psychiatrist with at least three years of experience beyond residency
- Social Worker, Mental Health Counselor, or Marriage and Family Therapist with at least five years post-licensure experience
- Doctoral level psychologist with at least three years postdoctoral experience who is exempt from licensure under [RCW 18.83.200](#)
- Other

6. Signing as DCT: If signing as DCT on behalf of supervisors, please identify all supervisors you are signing on behalf of. All supervisors must still meet supervisor requirements for the experience they supervised. If more room is needed to list all supervisors, please use another copy of this page and include with form when ready to submit.

Supervisor Name	Supervisor license number and state license held
-----------------	--

Name of facility/institution/practice where applicant obtained supervised experience

Supervisor Name	Supervisor license number and state license held
-----------------	--

Name of facility/institution/practice where applicant obtained supervised experience

Supervisor Name	Supervisor license number and state license held
-----------------	--

Name of facility/institution/practice where applicant obtained supervised experience

Supervisor Name	Supervisor license number and state license held
-----------------	--

Name of facility/institution/practice where applicant obtained supervised experience

Supervised Experience

7. Supervised Experience: *Dates of the practicum, preinternship, internship, and postdoctoral experiences must be chronological and cannot overlap.*

Type of supervised hours (may be more than one):

- Practicum
 Preinternship
 Internship
 Postdoctoral

Are the supervised hours you are attesting to the:

- Original Submission
 Resubmission (explain why below)

Please provide an explanation as to why the hours are being resubmitted:

Practicum [WAC 246-924-049](#) Practicum is the initial supervised experience and must be at least nine months in length and 300 hours of direct experience, 100 hours which must be supervision. No more than 300 hours may count towards licensure. Additional hours accrued past the completion of the nine-month practicum may be reported under the preinternship portion below if they meet the preinternship requirements.

Dates of supervised experience: From ____/____/____ To ____/____/____

	Total Hours Verified
A. Direct Experience	
B. Hours of Supervision as defined in WAC 246-924-049	
C. Total Hours for this Practicum Experience $A + B = C$	

Preinternship [WAC 246-924-053](#)) Preinternship occurs between the practicum and internship, dates cannot overlap. A maximum of 1500 hours can account for this experience.

Dates of supervised experience: From ____/____/____ To ____/____/____

	Minimum Required Hours	Total Hours Verified
A. Direct client contact hours providing assessment and intervention services	At least 60% of total hours	
B. Regularly scheduled, formal face-to-face individual supervision that addresses the direct psychological services provided by the applicant	At least 2 hours out of every 20 hours of experience (at least 10% of total hours)	
C. Other learning activities or indirect experience e.g. case conferences, seminars on applied issues, conducting co-therapy with a staff person including discussion of a case, and group supervision	At least 2 hours out of every 20 hours of experience (at least 10% of total hours)	
D. Total Hours for this Preinternship Experience	$A + B + C = D$	

Internship [WAC 246-924-056](#) Internship must include 1,500 hours of supervised experience completed within 24 months.

Was the internship site APA accredited or approved by APPIC?: Yes No

If yes, provide APPIC # _____

Note to applicant: if claiming hours in this category, the internship was non-APA/APPIC, and it hasn't already been submitted, please ensure you include the written statement or brochure from the institution/practice that describes the goals and content of the internship.

Dates of supervised experience: From ____/____/____ To ____/____/____

	Minimum Required Hours	Total Hours Verified
A. Direct client contact hours providing assessment and intervention services	At least 25% of total hours	
B. Regularly scheduled, formal face-to-face individual supervision that addresses the direct psychological services provided by the applicant	At least 2 hours out of every 40 hours of experience (at least 5% of total hours)	
C. Other learning activities or indirect experience e.g. case conferences, seminars on applied issues, conducting co-therapy with a staff person including discussion of a case, and group supervision	At least 2 hours out of every 40 hours of experience (at least 5% of total hours)	
D. Total Hours for this Internship Experience	A + B + C = D	

Postdoctoral [WAC 246-924-059](#)) A maximum of 1,500 hours may account for this experience.

Note to applicant: if claiming hours in this category and it hasn't already been submitted, please ensure you include the supervision agreement for this experience.

Dates of supervised experience: From ____/____/____ To ____/____/____

	Minimum Required Hours	Total Hours Verified
A. Professional activities		
B. Individual face-to-face supervision	At least 1 hour out of every 20 hours of experience (5% of total hours)	
D. Total Hours for this Post doctoral Experience	A + B = C	

Attestations Applicant please date and sign the form after discussing with supervisor and completing section 1 and 7. Once signed forward to your supervisor.

Supervisor, please date and sign the form after completing supervisor information in sections 2-6 and verifying the hours claimed by the applicant in section 7. Once form is complete supervisor will need to submit form directly to the department either through email at hsqaReview1@doh.wa.gov or by mail to the address on top of form.

I attest that the information above is true and complete to the best of my knowledge.

Applicant Signature: _____ Date: _____

I attest that the information above is true and complete to the best of my knowledge and that I have verified and agree with the hours claimed.

Supervisor Signature: _____ Date: _____

(This page intentionally left blank.)



Board of Psychology Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Examining Board of Psychology License Verification

To Applicant:

Please complete this side of form and send it to the state(s) and/or jurisdiction(s) where you are or have held a license/registration/certification. Instruct them to return the form directly to the address listed above. Make a copy of this form if you are licensed in more than one state and/or jurisdiction. Licensing agencies normally charge a fee to verify a license. Please check in advance to help expedite this process.

If you have a license with the Department of Health, you do not need to complete a verification form.

This form is not required of those credentials issued by Washington State.

Name: _____

Mailing Address: _____

City, State & Zip Code: _____

Any other names used: _____

License Number: _____ Date Issued: _____

Have the licensing agency return this completed form to the address above.

License Verification

(To be Completed by the State Psychology Board)

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

Name of licensed psychologist: _____

Authority providing verification: _____

Applicant was licensed by:

Written Examination: _____ Date: _____ Score: _____

Name of Examination: _____

Other Examination: _____ Date: _____ Score: _____

Name of Examination: _____

Is license current? Yes No

Expiration Date: _____ Issuance Date: _____

Is this licensee considered to be in good standing in your state? Yes No

If "No," please attach explanation.

Has this license ever been:

Yes No

Denied

Suspended

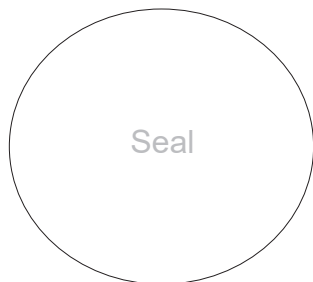
Revoked

Surrendered

Reinstated

If this licensee has been disciplined, has he/she successfully completed all requirements and is currently in good standing? Yes No

If yes, please provide a copy of the Final Order or other documentation of action taken.



Signature: _____

Title: _____

Date: _____

RCW/WAC and Online Website Links

RCW/WAC Links

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

[Psychology Laws, RCW 18.83](#)

[Psychology Rules, WAC 246-924](#)

Online

[Board of Psychology, Web Page](#)