State of Arizona Board of Psychologist Examiners

1740 West Adams Street, Ste. 3403
Phoenix, AZ 85007

PH: 602-542-8162
FX: 602-926-8095

Email: kathy.fowkes@psychboard.az.gov
Website: psychboard.az.gov

Verifier: Email the completed verification form to the Arizona Board at psysubmissions@psychboard.az.gov. Thank you!

SUPERVISED PREINTERNSHIP EXPERIENCE VERIFICATION
Educational Institution

INSTRUCTIONS

Applicant: please complete Sections A & B of this form (make as many copies of the Preinternship Site page as needed). See the tutorial regarding how to fill out Section B. Submit all pages (Sections A through E) to your training director or other school official who will be completing this verification.

Verifier: Please compare the information filled out by applicant in Section B with your training records, correct any errors, then complete Section C through E. Submit the completed form by email to psysubmissions@psychboard.az.gov. Thank you!

SECTION A:

Date: _____

Dear Dr. _____:
(Name of DCT or Other Faculty/Program Official Verifier)

I am applying for licensure in Arizona as a Psychologist. My application shows that while a student at _____, I participated in supervised preinternship psychology training experiences (see Preinternship Site pages, attached). Arizona Revised Statutes (A.R.S.) § 32-2071(D)(5) requires that verification of these experiences be sent to the Arizona Board of Psychologist Examiners (Board). Please verify the experiences I have listed on the Preinternship Site page(s), complete Section C for each Preinternship Site page, as well as Sections D & E, and email all pages of the completed and signed form to the Board at psysubmissions@psychboard.az.gov. Thank you for your assistance.

Applicant Signature: _____

Applicant Printed Name: _____

Student Identification Number: _____ Date of Birth: _____

Title of Doctoral Program or Predoctoral Specialty Area: _____

Name of Institution: _____

Dates of Enrollment: _____ Semester/Year of Graduation: _____

To Be Completed by Applicant:

Pursuant to A.R.S. §32-2071(E)(5), I have provided the Board a copy of the written training plan for each site developed by the doctoral program from the educational institution from which I graduated. (If no, please attach an explanation on a separate page)	Yes ☐	No ☐

PREINTERNSHIP SITE

SECTION B: TO BE COMPLETED BY THE APPLICANT AND VERIFIED BY THE EDUCATIONAL INSTITUTION:

List in chronological order each site of preinternship supervised professional experience (SPE) for which you are applying hours towards licensure. Download additional copies of this page as needed from the Board's Forms page. Questions? See online tutorial.

Name of Applicant:		Email:	
Name of Facility/Training Site:		Phone:	
Address:		City & State:	
Dates of SPE:	From:	To:	
Applicant's working title:			
Term/Class number/title in which you received academic credit for this experience (e.g., Fall 2009, PSY 660 Practicum)*:			

**Note: If academic credit was not received for this experience, please attach an explanation.*

See online tutorial for explanation of the following categories of hours.

_____ Total OVERALL Number of Supervised Professional Experience (SPE) Hours

_____ Total Hours of Direct Patient/Client Contact (minimum 25% of total overall SPE hours

_____ Number of Hours Worked per Week (no more than 40 hrs/week can be given credit)

_____ Total hours of Face-to-Face Supervision distributed as follows: (at least 2 hours for every 20 hours worked)

- _____ Total Hours of Individual Supervision (at least 1 hour for every 20 hours worked)
- _____ Total hours of Group Supervision (maximum 50% of total face to face supervision)

_____ Hours of Face to Face Supervision per Week distributed as follows:

- _____ Hours of Individual Supervision per week (at least 1 hour per week)
- _____ Hours of Group Supervision per week

Description of Training:

Name of Director of Clinical Training (DCT): _____

Name of Primary Supervisor: _____ Title: _____

Profession of Primary Supervisor: _____ License No. _____ State: _____

Name of Secondary/Other Supervisor: _____ Title: _____

Profession of Secondary/Other Supervisor: _____ License No. _____ State: _____

SECTION C: Verified by (To Be Completed by Doctoral Program DCT or Other Faculty/Program Official. If the school is closed, the site supervisor may complete this section):

Printed Name: _____ **Address:** _____

Signature: _____ **City & State:** _____

Title/Position: _____

Educational Institution: _____ **City & State:** _____

Email Address: _____

SECTION D: To Be Completed by Doctoral Program DCT or Faculty/Program Official: Please check Yes or No for each question. (FOR #1 – 9, EACH "NO" RESPONSE, PLEASE ATTACH AN EXPLANATION REFERENCING THE QUESTION #.)

			YES	NO
1.	Was the training experience(s) completed within 72 months?			
2.	Pursuant to A.R.S. 32-2071(2) and (5), was there a written training plan between the student and graduate training program for each supervised experience? (If YES, please attach a copy of the plan(s)			
3.	Did the preinternship supervised experience(s):			
	a.	Reflect a faculty-directed organized sequential series of supervised experiences?		
	b.	Provide increased complexity following appropriate academic coursework?		
	c.	Prepare the applicant for internship?		
4.	Did the written training plan(s):			
	a.	Designate an allotment of time for each training activity?		
	b.	Specify goals and objectives?		
	c.	Indicate methods of evaluation of the student?		
	d.	Indicate methods of evaluation of the supervisory experiences?		
5.	If any of the supervision was conducted off-site, was the licensed supervisor's approval obtained in writing?			
6.	Was at least 50% of the supervised experience spent in psychological service-related activities?			
7.	Did this applicant successfully complete this supervised training experience(s)?			
8.	Was ethics training included throughout the training experience?			
9.	Was regularly scheduled contemporaneous face-to-face individual supervision provided for at least one hour per week per twenty hours of supervised preinternship professional experience that addressed the direct psychological services provided by the student?			
10.	_____ Indicate the percent of supervision provided by a licensed psychologist. _____ Indicate the percent of supervision provided by another type of licensed mental health professional, psychology intern or postdoc under the supervision of a licensed psychologist			
11.	Were any other modifications made to the training program due to the pandemic that were not captured above? If yes, please provide a written explanation detailing the changes. If this supervised experience did not occur during the pandemic, please indicate with n/a: _____			

SECTION E: Please certify with your signature and contact information that the information provided in this primary source verification form is true and complete. Email the completed and signed form with any additional pages to psysubmissions@psychboard.az.gov.

I hereby certify that the information provided on this form and additional pages is true and complete to the best of my knowledge.

Completed By (Printed Name): _____

Signature: _____ **Date:** _____

Title/Position: _____

Name of Educational Institution: _____

Address: _____ **City, State and Zip:** _____

Email Address: _____ **Phone No. :** _____

Verifier: Please email the completed and signed form with any additional pages to psysubmissions@psychboard.az.gov. Thank you!