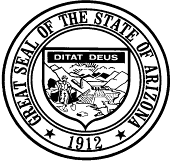

State of Arizona Board of Psychologist Examiners

1740 West Adams Street, Ste. 3403 Phoenix, AZ 85007
Phone: 602-542-8162 Fax: 602-542-8279
E-Mail: Kathy.fowkes@psychboard.az.gov
https://psychboard.az.gov

If sending by fax, please use a cover sheet with your facility's logo or letterhead.

SUPERVISED PREINTERNSHIP EXPERIENCE VERIFICATION
Educational Institution

Date: ___________________________________

Dear Dr. ____:

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 list below). 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. Please verify the experiences I have listed below, complete the subsequent questions, and send this and any other requested information directly to the Board at the above address. 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:

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

TO BE COMPLETED BY THE APPLICANT AND VERIFIED BY THE EDUCATIONAL INSTITUTION:
List in chronological order each place of supervised preinternship experience for which you are claiming hours.
Please print. Use additional copies of this page as needed.

Name of Facility/Training Site:		Phone:	
Address:		City & State:	
Dates of Supervised Experience	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 experience was not received for this experience, please attach an explanation.

_____________ Total Number of Supervised Experience Hours

_____________ Total Hours of Direct Patient/Client Contact

_____________ Number of Hours Worked per Week

_____________ Total hours of face-to-face supervision distributed as follows:

_____________ Total Hours of Individual Supervision

_____________ Total hours of Group Supervision

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

_____________ Hours of individual supervision per week

_____________ Hours of group supervision per week

Description of Training: ____

____

____

Name of Faculty Supervisor: ____

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: ________

Verified by (To Be Completed by Doctoral Program Training Director, Faculty Supervisor, or Other Institution Official):

Signature: ______________________ Address: ______________________

Printed Name: ______________________ City & State ______________________

Title/Position: ____

Institution: ______________________ City & State: ______________________

Email Address: ____

To Be Completed by Doctoral Program Training Director, Faculty Supervisor, or Other Institution Official: Please check Yes or No for each question. (FOR 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. ________ Please indicate the percent of supervision provided by a licensed psychologist.

________ Please indicate the percent of supervision provided by a licensed mental health professional.

I hereby certify that the information provided here is true and complete to the best of my knowledge.

Completed By (Printed Name): ______________________________

Signature: ______________________________ **Date:** ______________________________

Title/Position: ______________________________

Name of Educational Institution: ______________________________

Address: ______________________________ **Phone:** ______________________________

Email Address: ______________________________