State of Arizona Board of Psychologist Examiners

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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: _____