State of Arizona Board of Psychologist Examiners

1740 West Adams Street, Ste. 3403
Phoenix, AZ 85007
Psychologist Document Submissions Portal

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

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

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). Submit all pages (Sections A through E) to your training director or other school official who will be completing this verification. Please have the verifier compare any information you filled out in Section B with your training records, correct any errors and complete Section C through E. Please have the verifier upload the completed and signed form to Psychologist Document Submissions Portal.

SECTION A:

Date: _____ _____

Dear Dr. _____:
(Name of Training Director or Other 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. Please verify the experiences I have listed on the Preinternship Site page(s), complete Sections C for each Preinternship Site page, as well as Sections D & E, and upload all pages of the completed and signed form to the Psychologist Document Submissions Portal. 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)	☐	☐

PREINTERNSHIP SITE

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

List in chronological order each site of supervised preinternship experience for which you are claiming hours. Use additional copies of this page as needed. Please review the FAQ for a detailed explanation of this form.

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 (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 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: _____

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

Signature: _____ Address: _____

Printed Name: _____ City & State _____

Title/Position: _____

Institution: _____ City & State: _____

Email Address: _____

SECTION D: To Be Completed by Doctoral Program Training Director, Faculty Supervisor, or other Institution Official: Please check Yes or No for each question. (FOR #1 – 10, EACH "NO" RESPONSE, PLEASE ATTACH AN EXPLANATION REFERENCING THE QUESTION NUMBER. FOR #11, IF "YES", ATTACH AN EXPLANATION.)

			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 another type of licensed mental health professional.			
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: 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: _____ **City, State and Zip:** _____

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

Verifier: Please upload the completed and signed form to the Board's Psychologist Submissions Portal. If a firewall prevents this, please email to kathy.fowkes@psychboard.az.gov.