BOARD OF PSYCHOLOGY

ORGANIZED HEALTH SERVICE TRAINING PROGRAM CONFIRMATION

Iowa licensed psychologist /Applicant: _____

The above named psychologist has applied for Iowa certification as a Health Service Provider in Psychology (HSP). The certification requirements are found at 481—IAC 885.6(1). The requirements of the organized health service training program at found at 481—IAC 885.6(2). Please complete this form to verify the applicant's completion of the internship program. **Note:** Additional documentation is required if the internship program was not APA accredited or APPIC designated at the time the training was completed.

Name of Internship Agency: _____

Address of Internship Agency: _____

Director of Training: _____

City: _____ State: _____ Zip: _____

DATES THE ABOVE NAMED APPLICANT PARTICIPATED IN THE INTERNSHIP PROGRAM:

1. From: Month: _____ Year: _____ to: Month: _____ Year: _____

   Full-Time ☐ Part-time ☐ Total hours _____

2. Applicant's primary supervisor(s): _____

3. Supervisor's credentials (highest degree/program) _____

   State licensed/certified: Yes ☐ No ☐

   Specialty boards: Yes ☐ No ☐

   Are you listed in the National Register of Health Service Providers in Psychology? Yes ☐ No ☐

   Are you certified as a Health Service Provider in Psychology by a state licensure board? Yes ☐ No ☐

4. Applicant's title at agency: _____

5. Was the internship program approved by the American Psychological Assn. (APA)? Yes ☐ No ☐

6. If not APA approved, was the internship program APPIC designated at the time of completion? Yes ☐ No ☐

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7. Was the internship satisfactorily completed? Yes ☐ No ☐

8. Was the internship part of a university/school doctoral program requirement? Yes ☐ No ☐

If yes, name of university department / program: _____

I hereby attest that all the above information is true and correct to the best of my knowledge.

Signature: _____

Title: _____

Date: _____

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