Department of Inspections, Appeals, & Licensing

Organized Health Service Training Program Confirmation
Board of Behavioral Health Professionals

Iowa licensed psychologist or applicant: _____

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: _____

Director of training: _____

Address of internship agency: _____
City: _____State: _____Zip: _____

Dates the above-named applicant participated in the internship program:

1. Start Date (MM/DD/YYYY) _____ End Date (MM/DD/YYYY) _____
2. Applicant's primary supervisor(s): _____
3. Supervisor's credentials (highest degree/program): _____
   a. State licensed/certified: Yes ☐ No ☐
   b. Specialty board: Yes ☐ No ☐
   c. Are you listed in the National Register of Health Service Providers in Psychology? Yes ☐ No ☐
   d. 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 ☐
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, attest that I have completed this form, and all the information submitted herein is truthful and accurate. I understand my failure to answer questions contained in this form truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license.

Signature: _____ Title: _____ Date: _____

Department of Inspections, Appeals, & Licensing
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