IOWA | Department of Inspections, Appeals, & Licensing

Supervisor Confirmation Form for HSP

Board of Behavioral Health Professionals

Iowa Licensed Psychologist / Applicant _____

Note: Do not include academic teaching or research. Please complete this form and return it to the address at the bottom of this form. Thank you for your assistance.

Supervisor Credentials

Name: _____

Organization or agency: _____

Address: _____

City: _____ State: Iowa _____ Zip Code: _____

Are you listed in the National Register of Health Service Providers in Psychology or certified as a Health Service Provider in Psychology by the Iowa Board? Yes ☐ No ☐ Other States? Yes ☐ No ☐

Highest Degree Earned: _____ Degree Program: _____

State(s) Licensed/Certified: _____ License number(s): _____

Specialty Boards? Yes ☐ No ☐ Certifications _____

Dates of my supervision of the above-named applicant for certification:

1. From: _____ (month/day/year) to: _____ (month/day/year)
2. Number of hours of applicant clinical experience per week _____
3. Total number of hours of applicant clinical experience _____
4. Number of individuals, in person or remote, face to face supervision hours per week for the period listed ____
5. Total number of individuals, in person or remote, face-to-face supervision hours for the period listed _____
6. Name of agency or organization _____
7. My title at the time: _____
8. Applicant's title at the time: _____

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

Signature: _____ Date: _____

Title: _____

Department of Inspections, Appeals & Licensing
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