



BOARD OF PSYCHOLOGY

SUPERVISOR CONFIRMATION FORM FOR HSP

Iowa Licensed Psychologist / Applicant _____

The above named psychologist has applied for Iowa certification as a **Health Service Provider in Psychology (HSP)**. You are identified by the applicant as a direct supervisor for all or a portion of the required postdoctoral clinical experience in a health services setting. The requirements are found at 481—IAC 885.14. **Note:** Do not include academic teaching or research. Please complete this form and return it to the Board of Psychology. Thank you for your assistance.

SUPERVISOR CREDENTIALS

Name: _____

Organization or agency: _____

Address: _____

City: _____ State: _____ 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: _____ to: _____
(month/day/year) (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 individual, in person or remote, face to face supervision hours per week for the period listed _____

5. Total number of individual, 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: _____

Title: _____

Date: _____

Revised 02/2025