



Supervisor Confirmation Form for Health Service Provider Board of Behavioral Health Professions — Psychology

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: _____

Email Address: _____

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: _____ Lic. number(s): _____

Specialty Boards: Yes ☐ No ☐ Certifications: _____

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

1. From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____
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. 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: _____