## IOWA BOARD OF PSYCHOLOGY IOWA DEPARTMENT OF PUBLIC HEALTH LUCAS STATE OFFICE BLDG, 5<sup>TH</sup> FLOOR 321 E 12TH STREET, DES MOINES, IOWA 50319-0075

#### https://idph.iowa.gov/Licensure/Iowa-Board-of-Psychology/Licensure

## SUPERVISION REPORT

\_\_\_\_\_\_, a psychology licensure applicant, has indicated that you provided supervision of the applicant's professional work experience. In order for the Board of Psychology to verify completion of this candidate's qualifications, it is necessary for you to complete and return this form to the Board at the address above. The supervision requirements are found at 645—IAC 240.6 and 240.9.

## A. Description of Supervision

1. Duration of supervision (must be a minimum of 1500 hours completed in no less than 10 months):

- 2. Total hours of supervised professional experience accrued by the applicant: \_\_\_\_\_
- 3. Frequency and total hours of face-to-face, individual supervision
  - a. Number of hours per week: \_\_\_\_\_
  - b. Total number of face-to-face individual supervision hours (minimum of 45 hours required): \_\_\_\_\_
- 4. Description of services provided by the applicant, and approximate percentage of time for each type of service:
- 5. Mode of supervision: Please specify the type of supervisory modalities that were employed and the proportion of total supervisory time devoted to each. For example, modes of supervision might include talking with the applicant; directly observing the applicant's counseling, therapy assessment, teaching, research or consultative work; reviewing the applicant's reports and/or notes; viewing and/or listening to tapes of the applicant's professional work; conducting co-counseling; co-teaching or joint research; or consultative endeavors with the applicant.
- 6. Goals/objectives of supervision:

#### **B.** Evaluation of Applicant

- 1. Areas of proficiency and limitations:
  - a. Overall level of proficiency in area for which license is being sought:

Low				High
1	2	3	4	5

If rated 1 or 2, explain:

- b. Client population or organizational entity the applicant appears capable of adequately serving:
  - Infants & Toddlers
     Children
     Adolescents
     Adults
     Elderly
     Business or Industrial Organizations
     Schools/Education Organizations
     Other (specify)
- c. Evaluation and diagnostic techniques utilized at the time you supervised this applicant:

Cognitive/Intellectual Assessment	Behavioral/Observational	
Perceptual/Motor	†Social, Ecological	
Personality Assessment	Interests & Attitude	
Objective	Education, teaching, research evaluation	
Projective	Organizational Climate	
Neuropsychological Assessment	Other	

d. Intervention techniques utilized at the time you supervised this applicant:

Play therapy	Sex Therapy
Parent Consultation	Biofeedback
Family Therapy	Behavior Therapy
Group Therapy	Vocational & Career counseling
Individual Therapy	Marital Therapy
Special Education Program	Hypnotherapy
Short Term Counseling	Organizational Consulting
Consultation with other professionals	Teaching and Research techniques
	Other special skills and techniques
	(specify)

e. Ethics and conduct

1. Quality of applicant's use of knowledge

Low				High
1	2	3	4	5

- 2. Does the applicant appear aware of areas of professional strengths and weaknesses and willing to limit professional practice accordingly? □ Yes □ No
- 3. Does the applicant appear willing to obtain the appropriate supervision/consultation/education to strengthen skills and knowledge where needed: □ Yes □ No

# C. Recommendation/Additional Comments

1. Would you recommend this applicant for licensure? □ Yes □ No If no, please list and explain any reservations:

2. If you wish to provide additional clarification for any of the above, or other information regarding this applicant, please state:

State(s) in which you are currently licensed of	or certified to practice psychology:
License/Certification Number(s):	
Effective dates: month/year	to month/year
Are you listed in The National Register of He Health Service Provider in any state?  Yes	lealth Service Providers in Psychology or certified as a s 🗌 No
If yes, please specify:	
Were you licensed or certified to practice psy □ Yes □ No	ychology for the duration of your supervision of the applicant?
If yes, please indicate State:	Name of Licensing Organization:
Original Issue Date of License or Certificate:	:
Highest degree/program:	
Print name:	
Organization or agency:	
Signature:	
Date:	