IOWA | Department of Inspections, Appeals, & Licensing

Supervision Report

Board of Behavioral Health Professions — Psychology

_____, 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 481—IAC 885.14.

Description of Supervision

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

   From (MM/DD/YYYY): _____ **To** (MM/DD/YYYY): _____

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** (min. 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:**

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
☐ Elderly
☐ Children
☐ Business or Industrial Organizations
☐ Adolescents
☐ Schools/Education Organizations
☐ Adults
☐ Other (specify): _____

   c. **Evaluation and diagnostic techniques utilized at the time you supervised this applicant**:

☐ Cognitive/Intellectual Assessment
☐ Perceptual/Motor
☐ Personality Assessment
☐ Objective
☐ Projective
☐ Neuropsychological Assessment
☐ Behavioral/Observational
☐ Social, Ecological
☐ Interests & Attitude
☐ Education, Teaching, Research Evaluation
☐ Organizational Climate
☐ Other (specify): _____

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

☐ Play therapy
☐ Parent Consultation
☐ Family Therapy
☐ Group Therapy
☐ Individual Therapy
☐ Special Education Program
☐ Short Term Counseling
☐ Sex Therapy Biofeedback
☐ Behavior Therapy
☐ Vocational & Career counseling Marital Therapy
☐ Hypnotherapy
☐ Organizational Consulting
☐ Consultation with Other Professionals
☐ Teaching and Research Techniques
☐ Other Special Skills and Techniques

(specify): _____

   e. **Ethics and conduct**
   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 ☐

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 or certified to practice psychology: _____

_____

License/Certification Number(s): _____

Effective Dates: From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____

Are you listed in The National Register of Health Service Providers in Psychology or certified as a Health Service Provider in any state? Yes ☐ No ☐

If yes, please specify: _____

Were you licensed or certified to practice psychology for the duration of your supervision of the applicant? Yes ☐ No ☐

If yes, Provide State: _____ Name of Licensing Org.: _____

Original Issue Date of License or Certificate: _____

Highest Degree / Program: _____

Print name: _____

Organization or Agency: _____

Signature: _____ **Date**: _____

Department of Inspections, Appeals, & Licensing
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