Dear Applicant:

This application packet is for those who are applying for a Psychologist license and includes the form for those applying for Health Service Provider (HSP) designation. The requirements for application are detailed in the Board Rules (https://publications.tnsosfiles.com/rules/1180/1180.htm) and State licensure statutes (Title 63, Chapter 11 http://tn.gov/health/article/psych-statutes). Please read the instructions, statutes and rules carefully to ensure that your application is complete.

All documents submitted to the Board become part of your file and are not returnable or transferable. Your application will be reviewed for completeness and you will be notified when the review is completed. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you by mail.

Typically, application materials are in the applicant’s file within two weeks of the postmarked date. Absent any complicating factors, the average application processing time is four to six weeks. The Board’s administrative staff is dedicated to the professional management of all applicant files. If you would like to personally review your file, please call the board office and make an appointment.

Acceptability of licensure application is a Board decision, not an administrative staff decision. Please be aware that the review for completeness of your file does not indicate whether you are accepted as a candidate for licensure.

The Board meets regularly throughout the year and at these meetings the Board considers applications, written examination results, and HSP support materials for the purpose of licensure. The Division of Health Related Boards is empowered to issue licenses to those applicants deemed qualified by the Board of Examiners in Psychology. Licenses are generally issued within thirty days of the Board meeting.

Please understand that applicants and licensees have the responsibility to notify the board office whenever a change of name or mailing address occurs. Notification needs to be in writing. Please reference your profession and the board in your correspondence. A change of name request must be accompanied by the document that changed your name (i.e., marriage certificate, divorce decree, etc.).

Absent any complicating factors, the average application processing time is eight (8) weeks. Once the application is completed, your file will be reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.

Every effort will be made to keep you informed of your application’s status and to process your application in a timely manner. Inquiries regarding your file will receive a response by mail.

To ensure timely receipt of materials, all information is to be addressed as follows:

Board of Examiners in Psychology
665 Mainstream Drive
Nashville, Tennessee 37243
Directions for Application for Licensure

a) You are obligated to complete the application truthfully and completely. To ensure the accurate completion of these forms, it is recommended that you carefully read both the state law and the Board rules before completing this application. In particular, the Rules in 1180-02 provide information that might be helpful in completing your application.

b) Please provide information about the three individuals whom you have asked to provide the board with letters of recommendation. Rule 1180-02-.03(6) details the credentials that are required for those who write your recommendation letters. Please review this rule before soliciting letters of recommendation.

c) Please provide information about your graduate training in Psychology. If you attended more than one graduate program in psychology, use a separate page to provide information on other institutions.

The issue of designation or accreditation of the degree program only matters for the training program where you completed your doctoral degree or specialty retraining. Please check with the training program if you are unsure about whether your program was accredited by American Psychological Association’s (APA) Committee on Accreditation or listed by Council for the Nationally Register of Health Service Providers in Psychology/Association of State and Provincial Boards’ (NR/ASPPB) “Designated Doctoral Programs in Psychology” at the time you graduated.

d) If you are applying for the Health Service Provider (HSP) Designation, please provide information about your internship. If you are not applying for this designation, do not complete this item. Please check with your internship if you are unsure about whether the internship was accredited by APA’s Committee on Accreditation or a member Association of Psychology Postdoctoral and Internship Centers (APPIC).

e) If you are applying for the HSP Designation and you have completed at least one year of post-doctoral supervised experience (1900 hours required), you need to provide information about this experience. If you are not applying for this designation or have not yet completed the post-doctoral supervised experience, do not complete this item. If this postdoctoral year was completed at more than one setting, please use a separate page to provide information on other settings.

f) Please provide information about previous employment where you provided mental health services or any type of healthcare employment. You need not include paid or unpaid graduate training-related practicums or placements. If you had more than one mental health employment setting, please use a separate page to provide information on other settings.

g) Please provide two (2) recent signed passport type photographs. Passport photos are head-and-shoulders pictures. After signing the back of the photos, attach them to the space indicated.

h) All applicants must complete a criminal background check. The instructions can be found at: https://www.tn.gov/health/health-professionals/criminal-background-check.html

i) All applicants must complete, sign and have notarized the Declaration of Citizenship form and submit the documents required by the Declaration of Citizenship form. The Declaration is available online at https://www.tn.gov/health/health-program-areas/health-professional-boards/psychology-board/psych-board/applications.html

j) Please complete the Mandatory Practitioner Profile which can be found at: https://www.tn.gov/health/health-program-areas/health-professional-boards/psychology-board/psych-board/applications.html

k) You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §36-5-1301(a), as authorized by 42 U.S.C. §405 (c) (2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

l) You have now completed the general application for licensure. This application will need to be signed. Please be aware that depending on the type of application and your current status in another jurisdiction, you might need to complete additional forms.

m) Please request that the institution(s) of higher education submit the transcript(s) of all graduate coursework directly to the Board office. The transcript needs show the highest degree granted, coursework and credits and must carry the official seal of the institution. Unofficial transcripts are not acceptable.
If the transcript shows that you have completed the required course work but have not received your degree, you need to have the Registrar submit a letter attesting to the date upon which you will graduate, affixed with the seal of the institution. We will use the transcript and letter to complete our initial review of your application. Please remember that a final transcript showing your degree must be received before licensure can be granted.

Foreign trained applicants must send their transcripts to World Education Service, P.O. Box 745, Old Chelsea Station, New York, NY 10113-0745, (212) 966-6311 for assessment and their results must be mailed directly to the Board of Examiners in Psychology, 665 Mainstream Dr., Nashville, TN 37243. Supporting documents such as course descriptions, syllabi, and thesis or dissertation summaries must be supplied in order to determine equivalency of education training.

n) Payment of the application fee ($175), licensure fee ($200), state regulatory fee ($10), and ethics and jurisprudence exam fee ($100) must accompany your application. Other fees might also need to be paid. For example, those asking for a Temporary License must pay an additional $100 and those requesting a Provisional License must pay an additional $125. Please consult Chapter 1180-01 of the Board’s Rules in order to determine if you will need to pay any additional fee(s). A personal check or money order should be made payable to the “State of Tennessee.” The application fee is non-refundable, however the other fees may be refunded if the application is withdrawn or denied. Please contact the Board administrator if you believe that any fees should be refunded to you. Refunds will take approximately eight weeks to process. You can submit one check to pay all necessary fees.

o) The written examination, or EPPP, is a computer delivered 225-item test covering basic psychological science, professional application, ethics, and related considerations in psychology. Information concerning the exam can be obtained by writing to Association of State and Provincial Psychology Boards (ASPPB), P.O. Box 3079, Peachtree, Georgia 30269. Upon approval by the board to take the EPPP the applicant’s name will be submitted to the ASPPB. Written authorization for testing will be sent to the applicant by ASPPB with instructions to contact the chosen testing provider and information regarding the exam fee.

p) Ethics and Jurisprudence examinations will be scheduled by the Board administrator after it has been determined that you have passed the EPPP. The purpose of the exam is to test your knowledge of Tennessee law related to the practice of psychology, the code of ethics as it is represented in the Board’s Rules, and current professional standards and guidelines promulgated by the state and national organizations of psychologists. Relevant materials and references to sources will be provided. This is an open-book test.

q) Temporary License Forms. If you are eligible and need this license, separate forms need to be completed by you and the person who will be supervising while you work under the Temporary License. If you do not need a Temporary License, then do not submit this form.

When your file is administratively complete, reviewed by the Board and approved, your Temporary License will be issued. In the event an application is not approved, a refund of the Temporary License fee may be requested in writing. Allow 6-8 weeks for processing this refund.

r) Provisional License Forms. This license is required for anyone completing a post-internship, post-doctoral supervised year of experience in Tennessee. If you are eligible and need this license, separate forms need to be completed by you and the person who will be supervising you while you work under the Provisional License. Both forms need to be notarized and submitted with the Provisional License fee. If you do not need a Provisional License, then do not submit this form.

When your file is administratively complete, reviewed by the Board and approved, your Provisional License will be issued. You may begin working toward your 1900 post-doctoral supervised hours once your receive this Provisional License. In the event an application is not approved, a refund of the Provisional License fee may be requested in writing. Allow 6-8 weeks for processing this refund.

s) Licensure Endorsement Form. Please provide each person writing a letter of recommendation with a copy of this form and ask that the completed form accompany the recommendation letter. Be aware that it is essential that you request references from individuals who have personal knowledge of, and can attest to, your education, training and performance. All letters shall be current (attesting to current or recent work), original letters on professional letterhead written specifically for this licensure application and mailed directly to the Board by the person providing the information. Such letters are valid for one year from date of receipt. Make certain that the psychologists writing your letters clearly indicate that they are endorsing you as a Psychologist or Psychologist with HSP designation. They should also avoid using a letter already written for a job application. The Board may initiate inquiries if additional information is needed.

t) Please complete the Postdoctoral Supervised Experience Documentation Form. This form provides the board with verification that your post-doctoral year of supervised experience has been completed and it should not be
submitted to the board until you have finished the required 1900 hours. The form needs to be signed by you and your supervisor. If you accumulated your 1900 hours at more than one location, please provide the information on a copy of this form.

Checklist

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<tr>
<th>You send</th>
<th>You request others to send</th>
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<td>___</td>
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<td>Signed application</td>
<td>Official transcripts</td>
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<td>Certified Original or Notarized Copy of Birth Certificate</td>
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<td>Notarized Declaration of Citizenship form found at: <a href="https://www.tn.gov/health/health-program-areas/health-professional-boards/psychology-board/psych-board/applications.html">https://www.tn.gov/health/health-program-areas/health-professional-boards/psychology-board/psych-board/applications.html</a></td>
<td>3 Recommendation Letters with Licensure Endorsement Forms</td>
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<td>2 signed passport photographs</td>
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<td>Temporary License Application (if applicable)</td>
<td>Verification of Licensure, if licensed in other jurisdiction regardless of the status of the license (i.e., inactive)</td>
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<tr>
<td>Temporary License Supervisor Affidavit (if applicable)</td>
<td>Results of the EPPP sent to the board administrative office</td>
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<tr>
<td>Provisional License Application (if applicable)</td>
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<tr>
<td>Provisional License Supervisor Affidavit (if applicable)</td>
<td>Letter from Internship Director</td>
</tr>
<tr>
<td>Completed Mandatory Practitioner Profile Questionnaire (<a href="https://www.tn.gov/health/health-program-areas/health-professional-boards/psychology-board/psych-board/applications.html">mail with the application</a>)</td>
<td>Criminal Background Check <a href="https://www.tn.gov/health/health-professionals/criminal-background-check.html">https://www.tn.gov/health/health-professionals/criminal-background-check.html</a></td>
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<tr>
<td>Postdoctoral Supervised Experience Documentation Form (if applicable)</td>
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<tr>
<td>Check or money order for all applicable fees</td>
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Type of license sought (check one) _______ Psychologist _______ Psychologist with Health Service Provider Designation

Are you applying for a Temporary license? ___ Yes ___ No       Are you applying for a Provisional license? ___ Yes ___ No

NAME______________________________________________________________________________________

(Last)     (First)     (Middle/Maiden)

CURRENT HOME MAILING ADDRESS:               CURRENT PRACTICE NAME & ADDRESS:

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

*If you have no practice address, notify the Board of your practice address within 30 days of obtaining a practice address. If you have multiple practice address, please attach an additional page listing all practice addresses.

HOME PHONE ______________________________ PRACTICE PHONE ______________________________

E-MAIL ADDRESS: _________________________________________________________________________

Do you wish to receive notifications, including renewal notification, from the Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. ____ Yes       ____ No

Social Security No. _______ - _______ - _______    Birth Date: ___ / ___ / ___

Race: _______    Gender: Female _____    Male _____    U.S. Citizen: Yes_____    No_____    

All applicants must complete the Declaration of Citizenship form.

Entitled to Live and Work in the U.S. Yes ___ No___ (MUST check one)

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.)    Yes             No _____

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.)    Yes             No _____

Have you ever been known by any other names besides what is listed above?    Yes _____    No _____

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known:

__________________________________________________________________________________________

EDUCATIONAL INFORMATION
Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space. Request an official transcript be submitted directly from the APA accredited educational institution where you completed your psychology program.

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<th>From:</th>
<th>To:</th>
<th>Educational Institution</th>
<th>City, State</th>
<th>Degree Earned</th>
<th>Year Graduated</th>
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**LICENSURE INFORMATION**

Have you ever taken or registered for the Exam for Professional Practice in Psychology (EPPP)?

If yes, please have the ASPPB send a copy of your test scores directly to the board administrative office.

Are you or have you ever been licensed in this profession in another state?

Are you or have you ever been licensed in any other profession in Tennessee or another state?

List below ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED. Additional pages may be added if necessary. Request that verification of licensure be submitted directly to the Board’s Office from each state.

<table>
<thead>
<tr>
<th>STATE</th>
<th>PROFESSION</th>
<th>LICENSE NUMBER</th>
<th>CURRENT STATUS</th>
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Have you ever held a job in a healthcare profession? YES: _________ NO: __________

Please complete your entire healthcare employment history (NOT including psychology) starting with the most current position first. Use the back of this page, if you need additional space. Dates of employment must be included.

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<thead>
<tr>
<th>Company/ Employer:</th>
<th>Address: (City, and State)</th>
<th>Position:</th>
<th>Duties:</th>
<th>Dates Mo./Yr. Mo./Yr.</th>
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**PSYCHOLOGY EMPLOYMENT HISTORY:**

CURRENT EMPLOYER: ___________________________
TYPE OF FACILITY: ________________________________

CITY: ____________________ STATE: ___________ ZIP: _________

TYPE OF POSITION: ________________________________ WORK PHONE: _______________

JOB TITLE: ________________________________ TYPE OF POSITION: __________________

EMPLOYMENT DATES: FROM: ___/___ TO: ___/___

SUPERVISOR’S NAME: ________________________________ SUPERVISOR’S POSITION: _______________

SUPERVISOR’S LICENSURE STATUS: ____________________________

TYPES OF CLIENTS SERVED AND PSYCHOLOGICAL SERVICES RENDERED: ________________________________

FORMER EMPLOYER: ________________________________

TYPE OF FACILITY: ________________________________

CITY: ____________________ STATE: ___________ ZIP: _________

TYPE OF POSITION: ________________________________ WORK PHONE: _______________

JOB TITLE: ________________________________ TYPE OF POSITION: __________________

EMPLOYMENT DATES: FROM: ___/___ TO: ___/___

SUPERVISOR’S NAME: ________________________________ SUPERVISOR’S POSITION: _______________

SUPERVISOR’S LICENSURE STATUS: ____________________________

TYPES OF CLIENTS SERVED AND PSYCHOLOGICAL SERVICES RENDERED: ________________________________

FORMER EMPLOYER: ________________________________

TYPE OF FACILITY: ________________________________

CITY: ____________________ STATE: ___________ ZIP: _________

TYPE OF POSITION: ________________________________ WORK PHONE: _______________

JOB TITLE: ________________________________ TYPE OF POSITION: __________________

EMPLOYMENT DATES: FROM: ___/___ TO: ___/___

SUPERVISOR’S NAME: ________________________________ SUPERVISOR’S POSITION: _______________

SUPERVISOR’S LICENSURE STATUS: ____________________________

TYPES OF CLIENTS SERVED AND PSYCHOLOGICAL SERVICES RENDERED: ________________________________
COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer “yes” to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made. For the purposes of these questions, the following phrases or words have the following meanings:

1. “Ability to practice your profession” is to be construed to include all of the following:
   a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;
   b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
   c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. “Medical Condition” includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3. “Minor Traffic Offense” generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. “Chemical substances” is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. “Currently” does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one’s functioning as a licensee or within the past two (2) years.

6. “Illegal use of illicit or controlled substances” means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS: Please respond to ALL questions. If you answer “YES” to any question, please attach a written explanation.

YES NO

1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice? _______ _______

2. Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety? _______ _______

If so, please list:

(If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.)
3. At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?

4. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?

5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?

6. Have you ever held or applied for a license, privilege, registration or certificate to practice psychology in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?

7. Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?

8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?

9. Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?

10. Have you ever been rejected or censured by a professional association or society?

11. In relation to the performance of your professional services in any profession:
   a. Have you ever had a final judgment rendered against you;
   b. Have you ever entered into any settlement of any legal action; or
   c. Are there any legal actions pending against you or to which you are a party?

12. Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?

13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)
RECOMMENDATION INFORMATION

Recommendation letter writers:
Full name                      License #                      Licensing Jurisdiction

Graduate Training in Psychology:
Department & program name: __________________________________________________________
Program address: ________________________________________________________________
Degree received: ___________________ Major: ___________________
Dates of attendance from _____________ (month/year) to _____________ (month/year)

During the time you attended this doctoral program was it:
Yes  No
Accredited by APA’s Committee on Accreditation? ______  ______
Listed in the NR/ASPPB’s Designated Doctoral Programs in Psychology? ______  ______

Pre-doctoral Internship in Psychology:
Internship name: __________________________
Internship address: _____________________________________________________________
Internship Director’s Name: __________________________________________________________
Dates of attendance: from _____________ (month/year) to _____________ (month/year)

During the time you attended this internship program was it:
Yes  No
Accredited by APA’s Committee on Accreditation? ______  ______
A member of APPIC? ______  ______

Post-doctoral Supervised Experience:
Facility name: __________________________
Type of facility: __________________________
Facility address: _____________________________________________________________
Supervisor name: __________________________ License # ___________ Licensing Jurisdiction ___________
Dates of post-doctoral experience: _____________ (month/year) to _____________ (month/year)

Hours worked per week: __________________________
Number of face-to-face client contact hours per week: __________________________
Number of face-to-face individual supervision hours per week: __________________________
Number of group supervision hours per week: __________________________

Describe types of clients served and psychological services delivered:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
AFFIDAVIT OF APPLICANT

I, ________________________________ of _____________________________ being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board’s Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a psychologist in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a psychologist.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_________________________________________  ____________________________
SIGNATURE DATE
Temporary Psychologist License Application

The Temporary License will allow the applicant to perform the functions specified in T.C.A. § 63-11-203 only under qualified supervision. Statutory requirements for a Temporary License can be found in T.C.A. § 63-11-206 and detailed in section 1180-02-.05 of the Board Rules. Applicants for this license need to supply to the Board a completed application, a completed Supervisor Affidavit, and required fees. If granted, the Temporary License is valid for one year.

1. Name

   Last        First       Middle       Maiden

2. Type of license sought (check one)

   ______ Psychologist
   ______ Psychologist with Health Service Provider Designation

3. Social Security Number

   You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §36-5-1301(a), as authorized by 42 U.S.C. §405 (c) (2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

4. Have you ever been issued a temporary license to practice psychology in Tennessee? _____ Yes _____ No

5. Have you within the last year failed the Examination for Professional Practice in Psychology? _____ Yes _____ No

   If yes, provide date(s) __________________________________________

6. Have you within the last year failed the Ethics and Jurisprudence Exam for licensure as a psychologist or psychological examiner in Tennessee? _____ Yes _____ No

   If yes, provide date(s) __________________________________________

I, __________________________________________ certify that the statements on this temporary license application are true and correct. In signing this affidavit, I am aware that Chapter 9, Public Acts of 1947, provides that a person filing a forged affidavit of identification is subject to punishment prescribed by law for the crime of forgery.

____________________________
Signature of Applicant
Temporary Psychologist License Application
Supervisor Affidavit

The Temporary License will allow the applicant to perform the functions specified in T.C.A. § 63-11-203 only under qualified supervision. Statutory requirements for a Temporary License can be found in T.C.A. § 63-11-206 and detailed in section 1180-03-.05 of the Board Rules. Applicants for this license need to supply to the Board a completed application, a completed Supervisor Affidavit, and required fees. If granted the Temporary License is valid for one year.

________________________________________ has applied for a Temporary Psychology license. I will have the responsibility for direct supervision of psychological services delivered by the above named applicant during the tenure of his/her Temporary License in accordance with Standards of Supervision in the current Board Rules.

The applicant will provide psychological services at the following locations:

________________________________________________________________________

________________________________________________________________________

Describe the types of clients that will be seen and services that will be provided.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Signature of Supervisor

Print Name of Supervisor

Tennessee License Number

Area of Competency/Health Services Provider

NOTE: No Temporary License will be issued until this form is completed and received in the Board office. Should the applicant's Temporary License expire, both the supervisor and the applicant will be notified by the Board within ten (10) days.
Provisional Psychologist License Application

The Provisional License will allow the applicant to perform the functions specified in T.C.A. § 63-11-203 only under qualified supervision. Statutory requirements for a Provisional License can be found in T.C.A. § 63-11-206 and detailed in section 1180-02-.06 of the Board Rules. Applicants for this license need to supply to the Board a completed application, a completed Supervisor Affidavit, and required fees. If granted the Provisional License is valid for one year.

1. Name
   Last    First    Middle    Maiden

2. Social Security Number
   You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §36-5-1301(a), as authorized by 42 U.S.C. §405 (c) (2)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

The applicant will provide psychological services at the following location.

________________________________________________________________________

Describe the types of clients that will be seen and services that will be provided.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

I, ___________________________________________ certify that the statements on this Provisional License application are true and correct. In signing this affidavit, I am aware that Chapter 9, Public Acts of 1947, provides that a person filing a forged affidavit of identification is subject to punishment prescribed by law for the crime of forgery.

________________________________________________________________________

Signature of Applicant
State of Tennessee
Department of Health
Board of Examiners in Psychology

Provisional Psychologist License Application
Supervisor Affidavit

The Provisional License will allow the applicant to perform the functions specified in T.C.A. § 63-11-203 only under qualified supervision. Statutory requirements for a Provisional License can be found in T.C.A. § 63-11-206 and detailed in section 1180-02-.06 of the Board Rules. Applicants for this license need to supply to the Board a completed application, a completed Supervisor Affidavit, and required fees. If granted the Provisional License is valid for one year.

_____________________________________________ has applied for a Provisional Psychology License. I will have the responsibility for direct supervision of psychological services delivered by the above named applicant during the tenure of this Provisional License in accordance with Standards of Supervision in the current Board Rules.

The applicant will provide psychological services at the following locations.

________________________________________________________________________

________________________________________________________________________

Describe the types of clients that will be seen and services that will be provided.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Signature of Supervisor

Print Name of Supervisor

NOTE: No Provisional License will be issued until this form is completed and received in the Board office. Should the applicant's Provisional License expire, both the supervisor and the applicant will be notified by the Board within ten (10) days.

Tennessee License Number

Area of Competency/Health Services Provider
State of Tennessee
Board of Examiners in Psychology
Psychologist Application
Licensure Endorsement Form

Date ____________________________

Applicant’s Name ____________________________

Endorser’s Name ____________________________

Endorser’s License ____________________________

Endorser’s City and State ____________________________

If licensed, is license active? _____ Yes _____ No

Is endorser licensed as a Health Services Provider (HSP)? _____ Yes _____ No _____ Equivalent License

If no, does your jurisdiction designate HSP? _____ Yes _____ No

(A Health Service Provider (HSP) is a licensed psychologist who delivers direct, preventive, assessment and therapeutic intervention services to individuals whose growth, adjustment, or functioning is actually impaired or may be at risk of impairment)

Is endorser listed in the National Register? _____ Yes _____ No

Is endorser ABPP? _____ Yes _____ No

Please list specialty. __________________________________________________________

Do you recommend this applicant as a designated Health Services Provider? _____ Yes _____ No

In your accompanying letter (on your letterhead), please describe in detail the nature of your relationship with the applicant, the dates of contact with the applicant, and the basis of your knowledge of the applicant’s suitability to practice psychology such as the quality of the applicant’s performance, education and training, experience, ethics and character. As endorser, you will have direct knowledge of and attest to the applicant’s competency in the areas. Mail your letter directly to the Board of Examiners in Psychology.

Please indicate which of the following best reflects your opinion of the applicant’s application for licensure.

_____ Recommended without Reservation

_____ Recommended with Reservation

_____ Not recommended

To ensure timely receipt of materials, all information is to be addressed as follows:

Board of Examiners in Psychology
665 Mainstream Drive
Nashville, TN 37243
Board of Examiners in Psychology
Postdoctoral Supervised Experience Documentation Form

Applicant Name

TN Provisional License # ___________________________ Date Issued ________________
Other Psychology License ____________________________ State Issued __________________
Date Issued ____________________________ Current? _____ Yes _____ No

List the name and address of the facility where you provided psychological services during the postdoctoral supervised experience.

____________________________________________________________________________________
____________________________________________________________________________________

What type of facility was this? (e.g., Community Mental Health Center, Hospital, etc.).

____________________________________________________________________________________
____________________________________________________________________________________

Provide a description of the types of clients seen and services provided during the postdoctoral supervised experience.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What was your title?

____________________________________________________________________________________

Month and year experience started ________________ completed ________________

What was the average number of hours per week that you worked? ____________________________

What was the number of hours of direct, individual face-to-face supervision per week? ____________________________

Name and Degree of Supervisor ____________________________

License number ____________________________ State of License ____________________________

Supervisor’s Title ____________________________

Is Supervisor licensed as a Health Service Provider? _____ Yes _____ No

If not, what was the Supervisor’s license designation? ____________________________

What was the total number of postdoctoral supervised hours completed? ____________________________

What was the total number of hours of supervision? ____________________________

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

Signature of Supervisor ____________________________ Date ____________________________

Signature of Applicant ____________________________ Date ____________________________
VERIFICATION OF PRE-DOCTORAL INTERNSHIP

If you are applying for licensure as a psychologist with designation as a Health Service Provider, you must have successfully completed an Internship. Please complete the top portion of this form and have the director of your internship complete the verification portion and mail it directly to the Board. This form is considered part of your application; therefore, your file will not be reviewed if you are applying for licensure as a psychologist with Health Service Provider designation until this form is in your file. A notarized copy of a signed serialized certificate of completion of an APA approved pre-doctoral internship in professional psychology may be sent in lieu of the Internship Director Verification form.

I am applying for a license to practice as a psychologist in Tennessee. The Tennessee Board of Examiners in Psychology requires that I submit evidence of successful completion of an internship. Please complete the form and return it to:

Board of Examiners in Psychology
665 Mainstream Drive
Nashville, TN 37243

You are hereby authorized to release any information, favorable or otherwise, directly to the Tennessee Board of Examiners in Psychology. Your prompt attention will be appreciated.

Signature:________________________________________________________

Print or type name: __________________________________________________________________________

******************************************************************************

Credentials of Director (to be completed by director)

This is to certify that I was the training director of the internship for _____________________________________ (applicant’s name) and the following information is true and complete to the best of my knowledge.

Your name: _______________________________________________________________________________

(Signature)

Print or type name: __________________________________________________________________________

Office Address: _____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Your highest degree: _______________________________________________________________________

Are you licensed as a psychologist? Yes ______ No ______

State(s) and license number(s): ______________________________________________________________

What specialty designation if any? _____________________________________________________________

Are you in the National Register of Health Service Providers in Psychology? Yes ______ No ______

Are you a fellow/diplomat of ABPP? Yes ______ No ______

If yes, specialty: __________________________________________________________________________
What is your title within your organization? _______________________________________________________

Internship Information:

Person supervised: _________________________________________________________________________

Title and location of Internship: ___________________________________________________________________

APA approved: Yes ______ No ______

Listed in the Directory of Internships for Doctoral Students in School Psychology (until December 31, 1999). Yes ___ No ___

APPIC listed: Yes ______ No ______

Number of Internship hours: ___________________________________________________________________

Date Internship began: ______________________  Date Internship ended: _____________________

I certify that __________________________________________________________ successfully

(complete this Internship on: ______________________

(Name of Candidate)

(Date)

PLEASE SIGN:

___________________________________________________________

Signature

___________________________________________________________

Title

If the internship described was APA approved or APPIC listed STOP HERE and return this entire form to the Board of

Examiners in Psychology.  If the internship was NOT APA approved or APPIC listed, please fill out the following additional

information:

How many hours (per week) were spent in regularly scheduled, formal face-to-face individual supervision with a

psychologist, dealing with the psychological services rendered by the intern? ____________________________

What percentage of the total Internship hours does this represent? _____________________________

Was the Internship training post-clerkship and post-practicum? Yes ____________  No ___________

How many Interns were present during the trainee’s training period? _____________________________

Is there a written statement or brochure describing the goals and content of the Internship and expectations regarding the

trainee’s work available to intern applicant? Yes ____________  No ___________

If there is such a statement or brochure, please include it with this form.