NORTH CAROLINA PSYCHOLOGY BOARD

895 State Farm Road, Suite 101, Boone, NC 28607
Telephone: (828) 262-2258

DOCUMENTATION OF ORGANIZED HEALTH SERVICES TRAINING PROGRAM

(type or legibly print all information)

Applicant's Name: ____

Training Site Name and Address: ____

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TO THE APPLICANT: Fill in the above information and forward this form to the organized health services site training director for his/her completion.

TO THE TRAINING DIRECTOR: After completion, return this form directly to the Psychology Board.

In accordance with G.S. 90-270.20, any licensed psychologist who is qualified by education, who holds permanent licensure and a doctoral degree, and who provides or offers to provide health services to the public must be certified as a health services provider psychologist (HSP-P) by the Board.

Health services in psychology include the diagnosis, evaluation, treatment, remediation, and prevention of: mental, emotional, and behavioral disorder, disability, and illness; substance abuse; habit and conduct disorder; and psychological aspects of physical illness, accident, injury, and disability. Included are counseling, psychoeducational, and neuropsychological services related to the above. Health services include collateral contacts by a psychologist with families, caretakers, and other professionals for the purpose of benefiting a patient or client of that psychologist, as well as, direct services by a psychologist to individuals and groups.

The Board requests your assistance in verifying the following components of the above named applicant's training.

Was the training an internship accredited by the American Psychological Association in Clinical Psychology, Counseling Psychology, or School Psychology? Yes No
If yes, was such full-time _____ or part-time _____? Hours per week ___________

Dates of APA internship: from __________________ (mm/dd/yy) to _________________ (mm/dd/yy)
If the internship was APA accredited, complete the AFFIDAVIT on the back side and return the form to the Board.

If the training was NOT an APA accredited internship, respond to 1-11, complete the AFFIDAVIT on the back side, and return the form to the Board.

1. Was the training a planned and directed program in the provision of health services, in contrast to "on the job" training, and was the trainee provided with a planned, programmed sequence of training experience? Yes No

2. Was there a written statement or brochure describing the training program which was made available to prospective trainees? Yes No

3. Was the applicant designated as an "intern", "fellow", or "resident", or hold other designation which clearly indicated training status? Yes No
If yes, what was the applicant's title? ____

4. Was the training completed within 24 months? Yes No
   Provide dates of training: from _______________ (mm/dd/yy) to _______________ (mm/dd/yy)

5. Did the training consist of at least 1500 hours of practice? Yes No
   Provide the number of hours of practice: _________________

6. Was at least 25% of the training spent in the provision of direct health services to patients or clients seeking assessment or treatment? (see definition of health services on front) Yes No

7. What percentage of the training was spent in research activities? _________________

8. Were there a minimum of two doctorally trained licensed, certified, or license eligible psychologist at the training site as supervisors who had ongoing contact with the trainee? Yes No
   If yes, provide the names of two supervisors who met this requirement:

   1. ______________________________________ 2. ______________________________________

9. Was the training under the direction of a licensed, certified, or license eligible doctorally trained psychologist who was on staff of the training site, who approved and monitored the training, who was familiar with the training site's purposes and functions, and who had ongoing contact with the applicant, and who assumed responsibility for the quality, suitability, and implementation of the training experience. Yes No

   If yes, provide the name of that psychologist: ____

10. Did the training provide a minimum of two hours per week of individual face-to-face discussion of the applicant's practice, with the specific intent of overseeing the health services rendered by the trainee, with at least 50% of supervision being provided by licensed, certified, or license-eligible doctorally trained psychologists? Yes No

11. In addition to individual supervision, did the training site provide a minimum of two hours per week of instruction which was met by group supervision, assigned reading, seminars, and similarly constituted organized training experiences? Yes No

AFFIDAVIT

I certify that I have personal knowledge of the training program evaluated above and that all answers marked on this form and any other information attached hereto are true and correct to the best of my knowledge.

Name and title of person completing form ____

Address: ____

Telephone Number: ____

Email Address: ____

Signature: ____

Sworn to (or affirmed) and subscribed before me this _________ day of ___________________, 20_______.

____
Notary's Signature
My Commission Expires __________________________________, 20 ______.
SEAL

ORIGINAL FORM MUST BE RETURNED DIRECTLY TO THE BOARD OFFICE