North Carolina Psychology Board
895 State Farm Road, Suite 101
Boone, NC 28607
(828) 262-2258

APPLICATION FOR HEALTH SERVICES PROVIDER PSYCHOLOGIST (HSP-P)
Based on Mobility Credential
Application Fee: $50.00

Type or legibly print except for signatures. Return this form with a $50.00 check/money order(non-refundable) to the Board at the above address. Submit applicable supervision forms specified in Item 18 on the Application For Licensure Based on Mobility Credential. You will be notified if additional documentation materials are required. The $50.00 application fee must be remitted with each application or reapplication for HSP certification. A $20.00 fee will be charged for any returned bank item.

Name _____

Mailing Address _____

E-Mail Address _____

Daytime Telephone #: _____

1. Check the option under which you are making application for HSP-P Certification *(check only one)*:

☐ I am in good standing with, and currently listed in, the National Register of Health Services Providers in Psychology. **If** checking this option, **proceed to Item 4**.

☐ I am in good standing with, and currently hold a diploma from, the American Board of Professional Psychology in a health services specialty area. **If** checking this option, **proceed to Item 4**.

☐ I am in good standing with, and currently hold a Certificate of Professional Qualification from, the Association of State and Provincial Psychology Boards and meet the requirement checked below. If checking this option, **check** the applicable requirement and **complete Items 2-4**.

- ☐ I received a doctoral degree from an American Psychological Association accredited program in Clinical Psychology, Counseling Psychology, School Psychology, or Combined Professional-Scientific Psychology which included an American Psychological Association accredited internship in a health services setting, and completed an additional year of supervised experience which meets requirements in 21 NCAC 54 .2704(d).

- ☐ I received a doctoral degree from an American Psychological Association accredited program in Clinical Psychology, Counseling Psychology, School Psychology, or Combined Professional-Scientific Psychology, completed one year of supervised experience in an organized health services training program which meets the requirements in 21 NCAC 54 .2704(c), and completed an additional year of supervised experience which meets requirements in 21 NCAC 54 .2704(d).

☐ I have an academic foundation in the provision of health services, completed an internship accredited by the American Psychological Association, and completed an additional year of supervised experience which meets requirements in 21 NCAC 54 .2704(d).

☐ I have an academic foundation in the provision of health services, completed one year of supervised experience which meets the requirements in 21 NCAC 54 .2704(c) for an organized health services training program, and completed an additional year of supervised experience which meets requirements in 21 NCAC 54 .2704(d).

☐ I received a doctoral degree from an American Psychological Association accredited program in School Psychology which included an internship meeting the guidelines of the Council of Directors of School Psychology Programs, and completed an additional year of supervised experience which meets requirements in 21 NCAC 54 .2704(d). *(Enclose letters from your doctoral program head and internship site training director which verify such.)*

☐ I received a doctoral degree prior to 1979 from a program which included course work which demonstrates an academic foundation in the provision of health services and which included the equivalent of a one year supervised internship in an American Psychological Association accredited program providing health services, in a Veterans Administration setting providing health services, or at a site providing health services which was specifically acceptable to my doctoral training program, and completed an additional year of supervised experience which meets requirements in 21 NCAC 54 .2704(d). *(Enclose letters from your doctoral program head and internship site training director which verify such.)*

☐ Other. (Attach explanation, citing applicable statutes and rules.)

2. List supervised experience which meets the requirements of 21 NCAC 54 .2704(c). Each Direct Supervisor must complete and submit a HSP Form #1; or if applicable, in lieu of this form, materials banked with ASPPB which document the required supervised experience in health services provider activities may be sent directly to the Board from the ASPPB.[1] (Attach additional sheets, using the same format, if necessary.)

DATE (mm/dd/yyyy)	Hours Per Week	INSTITUTION (Name & Address)	POSITION/ TITLE	DUTIES	DIRECT SUPERVISOR (Name & Address)
From _____ To _____					
From _____ To _____					

[1]Check here ☐ if forms will be sent from ASPPB

3. List supervised experience which meets the requirements of 21 NCAC 54 .2704(d). Each Direct Supervisor listed must complete a SUPERVISOR FORM; or if applicable, in lieu of this form, materials banked with ASPPB which document the required supervised experience in health services provider activities may be sent directly to the Board from ASPPB.[1] (Attach additional sheets, using the same format, if necessary.)

DATE (mm/dd/yyyy)	Hours Per Week	INSTITUTION (Name & Address)	POSITION/ TITLE	DUTIES	DIRECT SUPERVISOR (Name & Address)
From _____ To _____					
From _____ To _____					

[1]Check here ☐ if forms will be sent from ASPPB.

4. I, the undersigned, verify that the statements and information contained herein are true, complete, and accurate to the best of my knowledge and belief, and that I have not withheld any information which might affect this application. I understand that engaging in fraud or deceit in attempting to secure health services provider certification or concealing material information in application for health services provider certification is a violation of G.S. 90-270.15 and could result in denial of my application, revocation of the HSP certificate, and other disciplinary action.

_____
Signature of Applicant

Sworn to (or affirmed) and subscribed before me this _____ day of _____, 20____

_____
Notary Public

SEAL

My Commission expires _____, 20____.