

**LICENSURE/CERTIFICATION FORM
FLORIDA BOARD OF PSYCHOLOGY**

PART I: TO BE COMPLETED BY THE APPLICANT

Complete this part and submit a copy to each state where you hold or have ever held a license to practice psychology or a related profession, making copies of this form as necessary. By doing so, you authorize release of all information to this office.

Applicant Name _____ SS# _____

Address _____

License/Certification Number _____ State of: _____

Applicant Signature _____ Date _____

PART II: TO BE COMPLETED BY AN OFFICIAL OF THE REGULATORY BOARD AND RETURNED TO THE ADDRESS BELOW

Licensee Name _____ Profession _____

License/Certification Number _____ Issue Date _____

License/Certification Status _____ Expiration Date _____

Is there any time period when the licensee's license was not active, for any reason? ___ Yes ___ No

If yes, please verify reason(s) and beginning and ending dates of non-active periods(s):

Was the License/Certification issued based on licensure in another state? ___ Yes ___ No

If yes, what state? _____

If no, license was based on: State exam _____ National exam _____

(Check all that apply) Reciprocity with _____ Endorsement _____

Education _____ Experience _____

Is License/Certification in good standing? ___ Yes ___ No

Has the License/Certification ever been revoked or suspended? ___ Yes ___ No

Do you have any disciplinary action information on file regarding the licensee? ___ Yes ___ No

If this license was ever revoked, suspended or otherwise acted against, please attach a copy of the Board's action to this form.

Verified by: _____

Board Seal

Signature of Official _____ State _____

Printed Name and Title _____

Date Signed _____

MAILING ADDRESS:
DEPARTMENT OF HEALTH
MEDICAL THERAPIES/PSYCHOLOGY
4052 BALD CYPRESS WAY ● BIN # C05
TALLAHASSEE, FL 32399-3255