SUPERVISING PSYCHOLOGIST VERIFICATION FORM

TO BE COMPLETED BY THE PRIMARY SUPERVISING PSYCHOLOGIST

Florida law requires 4,000 hours of supervised experience for licensure. By Rule 64B19-11.005, Florida Administrative Code, the Board recognizes that the applicant's internship satisfies 2,000 of those hours. This form is to be used to verify the remaining 2,000 postdoctoral hours.

*****THIS FORM IS NOT REQUIRED FOR ENDORSEMENT APPLICANTS*****

Please complete the following questions in full. Do not leave any question blank. Failing to accurately answer all questions will delay the processing of the application.

A. Supervisor's Basic Profile Information	
Supervisor's Name:	
Address:	
Supervisor's Telephone Number: ( )	
At the time you supervised the applicant, were you licensed as a psychologist in any state?	☐ Yes ☐ No
List state(s) and license number(s):	

B. Supervisor's Educational Background			
Name of School, College or University OF DOCTORAL DEGREE:	Date Graduated (mm/dd/yy):	Type of Degree: ☐ Ph.D. ☐ Psy.D. ☐ Ed.D. ☐ Other_____	Major: ☐ Clinical ☐ Counseling ☐ School ☐ Other:_____

C. Applicant's Post-Doctoral Supervised Experience Location(s)*
Facility/Office:
Street Address:
City/State/Zip:
Facility/Office:
Street Address:
City/State/Zip:
Facility/Office:
Street Address:
City/State/Zip:
Facility/Office:
Street Address:
City/State/Zip:

***IMPORTANT NOTE:** For applicants who completed the required post-doctoral supervised experience at more than one location under more than one supervisor, the Board requires the primary supervising psychologist provide a written statement describing the manner in which the training and supervision comprised a cohesive and integrated training experience. Please see Rule 64B19-11.005(2)(b)-(c), Florida Administrative Code, for additional information.

PRINT APPLICANT NAME HERE: _____

Note: Any items requiring additional explanation may be documented by adding additional pages, as needed.

D. Applicant's Post-Doctoral Experience Dates

Dates of Post-Doctoral Supervised Experience (mm/dd/yyyy) From: _____/____/____ To: ____/____/____

Please list only the date range over which the 2000 hours of post-doctoral supervised experience was completed.

E. Applicant's Post-Doctoral Experience Content

1. In your opinion, was the post-doctoral training a cohesive and integrated training experience?	☐ Yes ☐ No
2. Did the applicant's supervised experience for a total of 2,000 hours average at least twenty (20) hours a week over no more than one hundred and four (104) weeks or, alternatively, did the supervised experience average no more than forty (40) a week over no more than fifty-two (52) weeks? ***If "no", indicate the total hours of supervised experience the applicant accrued while under your supervision and the number of weeks of experience:*** • Total number of hours:_____ • Total number of weeks: _____	☐ Yes ☐ No
3. Did the supervised experience require at least 900 hours in activities related to direct client contact? ***If "no", how many hours were completed? _____***	☐ Yes ☐ No
4. Did the applicant's supervised experience include an average of at least two (2) hours of clinical supervision each week, with at least one (1) hour of such as individual face-to-face supervision? ***If "no", complete the following:*** • Total number of Clinical supervision hours/week:_____ • Total number of individual face-to-face supervision hours/week:_____	☐ Yes ☐ No
5. Was there any other relationship existing between the supervisor and the psychological applicant other than the supervisory association? ***If "yes", please explain.***	☐ Yes ☐ No
6. What was the applicant's title while under your supervision?	
7. Was the applicant supervised by more than one supervisor?	☐ Yes ☐ No
8. If you answered "yes" to item number 7, were you the primary supervisor; e.g., the supervisor who entered into the agreement with the applicant for supervision and who integrated all of the resident's supervised experiences?	☐ Yes ☐ No
9. Were there other licensed psychologists who provided supervision for the purpose of fulfilling Florida's licensure requirements? If so, please provide the name(s) and license number(s) below:	☐ Yes ☐ No
10. Did you, as the primary supervisor, enter into an agreement with the applicant which detailed the applicant's obligations and remuneration as well as your responsibilities to the applicant?	☐ Yes ☐ No
11. Did you, as the primary supervisor, determine that the applicant was capable of providing competent and safe psychological service to each client? ***If "no", please explain***	☐ Yes ☐ No
12. Did you maintain professional responsibility for the applicant's work? ***If "no", please explain.***	☐ Yes ☐ No
13. Did you have complete authority in all professional disagreements with the applicant? ***If "no", please explain.***	☐ Yes ☐ No
14. Were you kept informed of all the services performed by the applicant? ***If "no", please explain.***	☐ Yes ☐ No
15. Have you ever received any complaints about the psychological applicant or have any reason to suspect that the applicant is less than fully ethical, professional, or qualified for licensure? ***If "yes", please explain.***	☐ Yes ☐ No

F. SUPERVISOR STATEMENT

I declare that the above information is true and correct to the best of my knowledge. I also declare that I have read rule 64B19-11.005, F.A.C, and entered into an agreement with the applicant as required.

Supervisor's Signature:	**Date:**
Applicant's Signature:	**Date:**

***Please return this form to*: Florida Department of Health, Board of Psychology, 4052 Bald Cypress Way, BIN C05, Tallahassee, Florida 32399-3255**

PRINT APPLICANT NAME HERE: _____