SUPERVISING PSYCHOLOGIST VERIFICATION FORM
TO BE COMPLETED BY THE PRIMARY SUPERVISING PSYCHOLOGIST

Florida law requires 2 years or 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 1 year or 2,000 of those hours. This form is to be used to verify the remaining 1 year or 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

<table>
<thead>
<tr>
<th>Supervisor’s Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor’s Telephone Number: (   )</td>
<td></td>
</tr>
<tr>
<td>At the time you supervised the applicant, were you licensed as a psychologist in any state?</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>List state(s) and license number(s):</td>
<td></td>
</tr>
</tbody>
</table>

B. Supervisor’s Educational Background

<table>
<thead>
<tr>
<th>Name of School, College or University OF DOCTORAL DEGREE:</th>
<th>Date Graduated (mm/dd/yy):</th>
<th>Type of Degree:</th>
<th>Major:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ Ph.D.</td>
<td>☐ Clinical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Psy.D.</td>
<td>☐ Counseling</td>
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<td></td>
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<td>☐ Ed.D.</td>
<td>☐ School</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Other</td>
<td>☐ Other:</td>
</tr>
</tbody>
</table>

C. Applicant’s Post-Doctoral Supervised Experience Location(s)*

<table>
<thead>
<tr>
<th>Facility/Office:</th>
<th>Street Address:</th>
<th>City/State/Zip:</th>
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</thead>
<tbody>
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</table>

*IMPORTANT NOTE: For applicants who completed the required post-doctoral supervised experience at more than one location under more than one supervisor, each supervisor must provide supervision in a manner that comports with Rule 64B19-11.005(3), F.A.C. A separate Supervising Psychologist Verification Form must be completed and signed by the licensed psychologist supervisor and applicant for each post-doctoral experience location. Please see Rule 64B19-11.005(2)(b), Florida Administrative Code, for additional information.

PRINT APPLICANT NAME HERE: ________________________________

DH-MQA 1187 (Revised 11/18) Rule 64B19-11.012, F.A.C.
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. Did the applicant's supervised experience for a total of 1 year or 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: ____________________

2. Did the supervised experience require at least 900 hours in activities related to direct client contact?  
   □ Yes □ No

3. 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? The remaining hour of clinical supervision may have included individual supervision, group supervision or case presentation. Note that both hours of supervision may have been conducted by HIPPA compliant video.  
   If "no", complete the following:  
   - Total number of Clinical supervision hours/week: 
   - Total number of individual face-to-face supervision hours/week:

4. Was there any other relationship existing between the supervisor and the psychological applicant other than the supervisory association?  
   If “yes”, please explain.

5. What was the applicant’s title while under your supervision?

6. Was the applicant supervised by more than one supervisor?  
   □ Yes □ No

7. 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:
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

8. Did you 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

9. Did you determine that the applicant was capable of providing competent and safe psychological service to each client?  
   If “no”, please explain

10. Did you maintain professional responsibility for the applicant's work?  
    If “no”, please explain.

11. Did you have complete authority in all professional disagreements with the applicant?  
    If “no”, please explain.

12. Were you kept informed of all the services performed by the applicant?  
    If “no”, please explain.

13. 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.

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.

<table>
<thead>
<tr>
<th>Supervisor’s Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant’s Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

(*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: ________________________________

DH-MQA 1187 (Revised 11/18) Rule 64B19-11.012, F.A.C.