KENTUCKY BOARD OF EXAMINERS OF PSYCHOLOGY

P.O. Box 1360, Frankfort, KY 40602 (Regular Mail)
500 Mero St., 2 SC 32, Frankfort, KY 40601 (Courier/Special Delivery)
Phone: (502) 782-8812 ~ Fax: (502) 564-4818 ~ http://psy.ky.gov

APPLICATION FOR LICENSURE AS A PSYCHOLOGIST BY RECIPROCITY

via the Certificate of Professional Qualification in Psychology or
the National Register of Health Service Providers in Psychology

SUPPLEMENTARY INFORMATION REQUIRED

1. A check or money order made payable to the Kentucky State Treasurer for the application fee of $100;
2. Three (3) letters of reference from persons qualified to evaluate your professional ability, including two (2) persons who have received a doctorate in psychology (Ph.D., Psy.D., or Ed.D.);
3. An official transcript for all levels of education required for licensure (undergraduate and graduate);
4. A letter confirming membership in the National Register or your CPQ; and
5. Curriculum Vitae with sufficient detail to demonstrate five years of full-time practice.

Please type or print all information

APPLICANT INFORMATION

(Complete the following as you would like your name to appear on license)

First Name	Middle Name	Last Name	
Date of Birth (mm/dd/yyyy)	Gender	Social Security Number — —	
Mailing Address: Street	City	State	Zip Code
Employer			
Business Address: Street	City	State	Zip Code
Home Phone	Cell Phone	Business Phone	
Home Email	Business Email		

1. Are you a U.S. Citizen?	❑ Yes ❑ No
2. Has your license or certification in Kentucky or any other state ever been suspended or revoked? If yes, attach details.	❑ Yes ❑ No
3. Have you ever been convicted of a felony? If yes, what offense?	❑ Yes ❑ No
4. Have you been or are you now Certified or Licensed in Kentucky?	❑ Yes ❑ No
5. Are you credentialed as a psychologist in any other state or province? If yes, list title of credential: _____ and where: _____ ****Please have that jurisdiction's board provide verification that your license is in good standing.**	❑ Yes ❑ No
6. Have you ever been discharged or forced to resign for misconduct or unsatisfactory service from any position, from any professional training program, or from the program of any university? If yes, attach details.	❑ Yes ❑ No

EDUCATION					
School Name	School Location	Dates Attended From - To	Graduation Date Month/Year	Number of Hours	Degree Obtained
UNDERGRADUATE					
GRADUATE					

EMPLOYMENT HISTORY

Begin with your present or most recent job and list fully and accurately the details of each job you have held relating to your professional experience.

Name of Employer		Title or Position
Start Date	End Date	Hours Per Week
Address of Employer		
Name and Title of Supervisor		
Describe Your Duties: _____ _____ _____		

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Start Date	End Date	Hours Per Week
Address of Employer		
Name and Title of Supervisor		
Describe Your Duties: _____ _____ _____		

STATUS QUESTIONNAIRE

Please complete the following questions related to your status. These must be submitted with your application materials.

1. Have you been denied licensure/certification in any state/jurisdiction?	❑ Yes	❑ No
2. Has your license/certification been suspended or revoked in any state/jurisdiction?	❑ Yes	❑ No
3. Have you surrendered or allowed your license/certification to lapse in any state/jurisdiction due to an action pending or threatened?	❑ Yes	❑ No
4. Has your license/certification been subject to any disciplinary action by any licensure/regulatory board?	❑ Yes	❑ No
5. Have you entered into a consent or other agreement with any licensure or regulatory board in connection with disciplinary action?	❑ Yes	❑ No
6. Are you aware of any pending disciplinary action against your license or certification in any state/jurisdiction?	❑ Yes	❑ No
7. Have your clinical privileges at any hospital or other health care institution or clinic been denied, limited, suspended, revoked, or not renewed for any reason?	❑ Yes	❑ No
8. Have you been denied professional liability insurance or has your policy been canceled or restricted?	❑ Yes	❑ No
9. Have you had psychiatric hospitalization in the past five years?	❑ Yes	❑ No
10. Have you been treated for alcohol or drug abuse/dependence in the past five years?	❑ Yes	❑ No
11. Do you suffer from any illness or health condition which limits or impairs your ability to practice in your profession?	❑ Yes	❑ No
12. Have you been convicted of a felony in the past five years?	❑ Yes	❑ No
13. Has any third party payor, including Medicare and Medicaid, terminated, suspended, restricted or revoked your status as a provider for reasons related to the quality of your professional practice?	❑ Yes	❑ No
14. Have you been disciplined by a professional organization for a violation of ethical standards?	❑ Yes	❑ No
15. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?	❑ Yes	❑ No

***If you have answered "yes" to any of the above questions, please explain on a supplementary sheet.**

APPLICANT'S AFFIDAVIT

I, the applicant named in the above, do hereby certify under penalty of law that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected or my license/certification revoked by the Board.

APPLICANT'S SIGNATURE: _____ DATE: _____

(Sign your name – Do not print or type)