



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 PSYCHOLOGICAL ASSOCIATE

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.); and
3. An official transcript for all levels of education required for licensure (undergraduate and graduate) sent directly from the school or third-party clearinghouse or in a sealed envelope.

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has your license or certification in Kentucky or any other state ever been suspended or revoked? If yes, attach details.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been convicted of a felony? If yes, what offense?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been or are you now Certified or Licensed in Kentucky?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you credentialed as a psychologist in any other state or province? If yes, list title of credential: _____ and where: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
**Please have that jurisdiction's board provide verification that your license is in good standing.	
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.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name:

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:			

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

Name: _____

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has your license/certification been suspended or revoked in any state/jurisdiction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you surrendered or allowed your license/certification to lapse in any state/jurisdiction due to an action pending or threatened?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has your license/certification been subject to any disciplinary action by any licensure/regulatory board?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you entered into a consent or other agreement with any licensure or regulatory board in connection with disciplinary action?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Are you aware of any pending disciplinary action against your license or certification in any state/jurisdiction?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you been denied professional liability insurance or has your policy been canceled or restricted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you had psychiatric hospitalization in the past five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you been treated for alcohol or drug abuse/dependence in the past five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Do you suffer from any illness or health condition which limits or impairs your ability to practice in your profession?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you been convicted of a felony in the past five years?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have you been disciplined by a professional organization for a violation of ethical standards?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)

Name:

CURRICULUM GUIDELINES

- Write in below the course number, course title, university, and term taken for each course which you believe meets each of the requirements as indicated.
- If the course title is **not self-evident** as meeting a particular requirement, it is your responsibility to submit, with this form, a **catalog description or course syllabus** substantiating its meeting of the requirement.
- Applicants who have taken more than one course in any given area may choose to list additional coursework on the back of this form. However, all coursework listed must appear on the official transcript(s) submitted.
- Applicants may use an individual course to meet only one requirement. For example, a course in psychopathology may *not* be used to meet requirements for both Individual Differences and Advanced Abnormal Psychology.
- Specialty courses may *not* be used to meet foundation/distribution requirements. For example, a course in group therapy is *not* acceptable to meet the distribution requirement in Social Bases of Behavior.
- Applicants may use one upper-division, undergraduate course to meet one of the distribution requirements. For example, an applicant may use a senior-level, undergraduate physiological psychology course to meet the Biological Bases of Behavior requirement.
- **Failure to follow these instructions may result in this form being returned to you for proper submission and a delay in your application process.**

In order to sit for the licensure examination as a Psychological Associate, the applicant is required to:

1. Have a 45 semester hour (54 quarter hour) master's degree from a regionally accredited educational institution with a clearly identified psychology program (i.e., identifiable psychology faculty, identifiable body of students, and a psychologist responsible for the integrated, organized sequence of study).

DEGREE	EDUCATIONAL INSTITUTION	DATE CONFERRED

2. Have had **graduate** instruction in the following:

A. Research Methodology

COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN

B. Statistics

COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN

C. Scientific and Professional Ethics and Standards

COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN

Name:

3. Have had a core program which includes three graduate semester (five quarter) hours in the following:			
A. Biological Bases of Behavior (e.g., Physiological Psychology, Comparative Psychology, Neuropsychology, Sensation and Perception)			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN
B. Cognitive-Affective Bases of Behavior (e.g., Learning, Thinking, Motivation, Emotion)			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN
C. Social Bases of Behavior (e.g., Social Psychology, Community Psychology, Systems Theory)			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN
D. Individual Differences (e.g., Personality Theory, Human Development, Abnormal Psychology)			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN

4. Have had coursework in the following area(s) of specialty for which you are seeking certification (in addition to the core areas). All courses **must** be **GRADUATE**.

CLINICAL PSYCHOLOGY			
Have had at least three semester (five quarter) hours in each of the following:			
A. Psychopathology, Advanced Abnormal Psychology			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN
B. Theories of Psychotherapy, Systems of Psychotherapy, Specific Psychotherapeutic Intervention Strategies			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN
C. Practicum in Psychotherapy **Reminder: Submit catalog description or course syllabus if title is not self-evident			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN
D. Clinical Assessment of Individual Intellectual Functioning of the Individual			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN
E. Clinical Assessment of Emotional/Psychological Functioning of the Individual			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN

Name:

F. Practicum in Psychological Assessment **Reminder: Submit catalog description or course syllabus if title is not self-evident			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN

COUNSELING PSYCHOLOGY

Have had at least three semester (five quarter) hours in each of the following:

A. Psychopathology, Advanced Abnormal Psychology

COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN

B. Counseling Theories, Techniques, or Systems

COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN

C. Practicum in Counseling
****Reminder: Submit catalog description or course syllabus if title is not self-evident**

COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN

D. Assessment of Intellectual, Personal, Social, and Vocational Functioning of the Individual

COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN

E. Practicum in Assessment
****Reminder: Submit catalog description or course syllabus if title is not self-evident**

COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN

F. Theories of Career Counseling and Development

COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN

SCHOOL PSYCHOLOGY

Have had at least three semester (five quarter) hours in each of the following:

A. Psychopathology, Advanced Abnormal Psychology, Exceptionalities of Childhood

COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN

B. Psychological Intervention, Psychotherapy, Counseling

COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN

Name:

C. Practicum in Psychological Intervention **Reminder: Submit catalog description or course syllabus if title is not self-evident			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN
D. Psychological Assessment Techniques			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN
E. Educational of Psycho-educational Assessment Techniques			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN
F. Practicum in Psychological Assessment **Reminder: Submit catalog description or course syllabus if title is not self-evident			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN

INDUSTRIAL/ORGANIZATIONAL PSYCHOLOGY			
Have had at least three semester (five quarter) hours in each of the following:			
A. Differential, Personality, Social, Experimental			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN
B. Industrial-Personnel Psychology			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN
C. Human Factors Engineering Psychology			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN
D. Organizational-Social Psychology			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN
E. Industrial-Clinical Psychology			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN
F. Marketing and Consumer Psychology			
COURSE NUMBER	COURSE TITLE	EDUCATIONAL INSTITUTION	TERM TAKEN

Name:

REPORT OF SUPERVISED EXPERIENCE

To be eligible for licensure as a psychological associate, you must demonstrate that you have had at least 600 hours of supervised experience that was part of your master's degree training. Pursuant to 201 KAR 26:190, at least half of the supervision shall be provided by one or more psychologists with an appropriate doctorate degree and license. These educational experiences typically have titles such as practicum internship, or field training and they **MUST** be reflected on your graduate transcript. Please complete the following form listing your educationally related supervised experiences.

Total of all placements must equal or exceed 600 hours. If you had more than three educationally related supervised experiences, please duplicate this form.

FIRST PLACEMENT				
Name of Placement		Type of Placement		Supervisor's Name and Degree
Placement Address: Street		City	State	Zip Code
Dates of Placement (mo/yr)	Hours Per Week	Number of Weeks		Total Hours for Placement
Description of Duties:				
SECOND PLACEMENT				
Name of Placement		Type of Placement		Supervisor's Name and Degree
Placement Address: Street		City	State	Zip Code
Dates of Placement (mo/yr)	Hours Per Week	Number of Weeks		Total Hours for Placement
Description of Duties:				
THIRD PLACEMENT				
Name of Placement		Type of Placement		Supervisor's Name and Degree
Placement Address: Street		City	State	Zip Code
Dates of Placement (mo/yr)	Hours Per Week	Number of Weeks		Total Hours for Placement
Description of Duties:				