# 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

## SUPPLEMENTARY INFORMATION REQUIRED

1. A check or money order made payable to the Kentucky State Treasurer for the application fee of $200;
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<br>— — | |
| 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:<br>_____<br>_____<br>_____ | | |

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

## 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)

**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 Psychologist, the applicant is required to:**

1. Have a Ph.D., Ed.D., or Psy.D. 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 completed a one-year (1,800 hour) internship program, which should be documented on the Report of Internship form.

3. 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 |
|---|---|---|---|
| | | | |

4. 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 |
|---|---|---|---|
| | | | |

5. 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 |
|---|---|---|---|
| | | | |

| F. Practicum in Psychological Assessment<br>****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<br>****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<br>****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 |
| | | | |

| C. Practicum in Psychological Intervention<br>****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<br>****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 |
| | | | |

## REPORT OF INTERNSHIP

To qualify for licensure as a psychologist, the candidate must have completed a one-year internship at a program site acceptable to the Board. This experience must total 1,800 hours with at least one hundred (100) hours of supervisory sessions distributed over the year. The candidate is referred to 201 KAR 26:190 for further information regarding the requirement for supervised professional experience.

Internship Agency: _____

| SUPERVISOR'S CREDENTIALS INFORMATION | | |
|---|---|---|
| Name | State | License Number |
| | | |

| EXPERIENCE INFORMATION | |
|---|---|
| Hours Per Week | Hours for the Year |
| Starting Date | Ending Date |
| Total Hours of Individual Supervision | |
| Description of Duties/Activities<br>_____<br>_____<br>_____<br>_____ | |

| REPORT OF ADVANCED PRACTICUM |
|---|
| Complete one page for each advanced practicum site. **Do <u>not</u> include basic therapy and assessment practica listed on the Curriculum Guidelines form.** |

| PLACEMENT INFORMATION | |
|---|---|
| Name of Placement | Type of Placement |
| (Dates and course number must be reflected on transcript.) | |
| Dates of Placement (mo/yr) | Course Number on Transcript |

| Hours of Direct Service (Client Contact) | Hours of Indirect Service (Includes Supervision) | Total Hours for This Site |
|---|---|---|
| | | |

| SUPERVISOR INFORMATION | | |
|---|---|---|
| (If you had more than one supervisor, complete additional pages for each.) | | |
| Name of Supervisor | Supervisor Discipline | State and License Number |
| | | |

| Face to Face Supervision Hours | |
|---|---|
| Individual | |
| Group | |
| Total Face to Face Supervision | |
| **Non Face to Face Supervision Hours** | |
| Individual | |
| Group | |
| Total Face to Face Supervision | |
| **Total Supervision Hours** | |
| **Total Hours of Supervision** | |

## REPORT OF COMPLETED POST-DOCTORAL EXPERIENCE

The candidate is referred to 201 KAR 26:190 Section 3 for further information regarding the activities required during the post-doctoral year. Pursuant to 201 KAR 26:125, to qualify for the "Health Service Provider" designation, the candidate must have completed 1,800 hours of supervised experience within one (1) or more health care settings in which the provider delivered direct psychological health care services, **in addition to** the 3,600 supervised experience hours required for licensure as a licensed psychologist under 201 KAR 26:190. Supervision shall be provided by a licensed psychologist with the health service provider designation approved by the board and shall consist of one (1) hour of individual supervision each week.

This form can be submitted at a later date when the post-doctoral experience is complete, if necessary. Future or projected dates will not be accepted.

Post-Doctoral Site: _____

| SUPERVISOR'S CREDENTIALS INFORMATION | | |
|---|---|---|
| Name | State | License Number |
| | | |

| EXPERIENCE INFORMATION | |
|---|---|
| Hours Per Week | Total Hours Accumulated at This Site |
| Starting Date | Ending Date |
| Total Hours of Individual Supervision | |
| Description of Duties/Activities<br>_____<br>_____<br>_____<br>_____ | |

| | | |
|---|---|---|
| 1. Have you passed the EPPP at the doctoral level? | ❑ Yes | ❑ No |
| 2. Are you requesting to be scheduled for the next structured exam? | ❑ Yes | ❑ No |
| 3. Are you requesting to be considered for Health Service Provider status? | ❑ Yes | ❑ No |

Applicant Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____