



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 (CPQ), the National Register of Health Service Providers in Psychology, or the American Board of Professional Psychology (ABPP)

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) sent directly from the school or third-party clearinghouse or in a sealed envelope;
4. A letter confirming membership in the National Register, your ABPP certification, 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? | <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: _____ **Please have that jurisdiction's board provide verification that your license is in good standing. | <input type="checkbox"/> Yes <input type="checkbox"/> 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. | <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)