



APPLICATION FOR LICENSURE TO PRACTICE PSYCHOLOGY IN INDIANA

State Form 27522 (R10 / 10-07)
Approved by State Board of Accounts, 2007

**STATE PSYCHOLOGY BOARD
PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2051
E-mail: pla6@pla.IN.gov

* Your Social Security number is requested by this agency in accordance with IC 4-1-8-1, and it is mandatory that it be given.

FOR AGENCY USE ONLY

Date received (month, day, year)	Decision	Initials
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PSYCHOLOGY LICENSE	TEMPORARY PERMIT
Application fee	Application fee
Date fee paid (month, day, year)	Date fee paid (month, day, year)
Receipt number	Receipt number
License number	Permit number
License issuance date (month, day, year)	Permit issuance date (month, day, year)

APPLICANT

Attach two (2) passport type quality photographs of yourself taken within the last eight weeks.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name (last, first, middle, maiden)		Social Security number*	
Home address (number and street or rural route)		City	State ZIP code
Telephone number (daytime) ()	Date of birth (month, day, year)	Place of birth	
Are you applying for licensure by: <input type="checkbox"/> Examination <input type="checkbox"/> Endorsement		E-mail address	
Do you desire a temporary license? <input type="checkbox"/> Yes <input type="checkbox"/> No			

GRADUATE EDUCATION (Doctoral)

Name of school	Department	Title of program
Street address (number and street, city, state, and ZIP code)	Dates attended (month, day, year)	Degree earned
Number of hours required for degree (excluding dissertation hours)?	APA approved at the time of graduation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Which were the hours? <input type="checkbox"/> Semester <input type="checkbox"/> Quarter		

PREDOCTORAL INTERNSHIP

Was an Internship required for graduation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of internship program	
Address of internship program (number and street, city, state and ZIP code)	
APA approved at the time of completion? <input type="checkbox"/> Yes <input type="checkbox"/> No	APPIC approved at the time of completion? <input type="checkbox"/> Yes <input type="checkbox"/> No
Inclusive dates of internship (month, day, year)	Total hours worked
Director of internship training	

POST DOCTORAL EDUCATION

Name of school	Department	Title of program
Address (number and street, city, state, and ZIP code)		Dates attended (month, day, year)

POST DOCTORAL INTERNSHIP / FELLOWSHIP

Name of Internship/Fellowship	
Address of Internship/Fellowship (number and street, city, state and ZIP code)	
Inclusive dates of Internship/Fellowship (month, day, year)	Total hours worked
Name of Supervising Psychologist	

PROFESSIONAL IDENTITY BASED UPON DOCTORAL TRAINING

(Check only one or attach explanation)

- | | |
|--|--|
| <input type="checkbox"/> Clinical Psychology | <input type="checkbox"/> Organizational / Industrial |
| <input type="checkbox"/> Counseling Psychology | <input type="checkbox"/> School |
| <input type="checkbox"/> Experimental | <input type="checkbox"/> Social |
| <input type="checkbox"/> Developmental | <input type="checkbox"/> Other (specify) |

CLAIMED AREAS OF COMPETENCE

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Do you hold, or have you ever held, a license, certificate, registration or permit to practice any regulated health occupation?

- Yes No

List all states, including Indiana, in which you have been licensed to practice any regulated health occupation:

TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	STATE	NUMBER	DATE ISSUED	CURRENT STATUS

Have you previously taken the Examination for the Professional Practice of Psychology (EPPP)?

- Yes No

If "Yes", how many times?	Date of most recent test (month, year)	Where taken (state, country)
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Have you previously filed an application for licensure as a psychologist in the State of Indiana?

- Yes No

If "Yes", when was the application filed (month, day, year)?

Do you currently hold, or have you ever held, a Basic Certificate or Limited License to practice psychology in Indiana?

- Yes No

If "Yes", state the Certificate / License number

Describe the nature of the practice of psychology in which you intend to engage:

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WE MUST RECEIVE WRITTEN DOCUMENTATION FROM YOUR CURRENT OR MOST RECENT EMPLOYER VERIFYING THE FOLLOWING INFORMATION REGARDING YOUR CURRENT OR MOST RECENT EMPLOYMENT ONLY.

List all places of professional employment, including self employment, since obtaining your doctoral degree (past ten years only). Begin with your current position and indicate your current title.

NAME AND ADDRESS OF EMPLOYER	DATES (month, day, year)	POSITION / TITLE	RESPONSIBILITIES	HOURS / WEEK	SUPERVISOR
<i>Current Employment</i>		<i>Current</i>			
<i>Past Employment</i>		<i>Past</i>			

COURSEWORK INFORMATION

List the course number and course title of the graduate coursework you have completed in the required content areas as they appear on your transcript. If the course titles as stated on your transcript do not clearly reflect the required content areas, you may be requested to provide additional supporting documentation such as course syllabus, term papers, etc. You may use the same course for more than one content area. Also, each content area may contain more than one course.

BIOLOGICAL BASES OF BEHAVIOR

NAME OF EDUCATIONAL INSTITUTION	COURSE NUMBER	COURSE TITLE	CREDIT HOURS	Semester _____
				Quarter _____

COGNITIVE-AFFECTIVE BASES OF BEHAVIOR

NAME OF EDUCATIONAL INSTITUTION	COURSE NUMBER	COURSE TITLE	CREDIT HOURS	Semester _____
				Quarter _____

SOCIAL BASES OF BEHAVIOR

NAME OF EDUCATIONAL INSTITUTION	COURSE NUMBER	COURSE TITLE	CREDIT HOURS	Semester _____
				Quarter _____

INDIVIDUAL DIFFERENCES

NAME OF EDUCATIONAL INSTITUTION	COURSE NUMBER	COURSE TITLE	CREDIT HOURS	Semester _____
				Quarter _____

If your answer is "Yes" to any of the following, explain fully in a notarized affidavit, including all related details. Describe the event including location, date, and disposition. If malpractice, provide name of plaintiff. Falsification of any of the following is grounds for permanent revocation of a certificate or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been denied a license, certificate, registration or permit to practice psychology, or any regulated health occupation in any state or country (including Indiana)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you now, or have you ever been treated for drug or alcohol abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever been charged with a crime related to drug or alcohol use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever been convicted of, pled guilty or <i>nolo contendere</i> to: A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? B. Any offense, misdemeanor or felony in any state? (Except for minor violations of traffic laws resulting in fines.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever had a malpractice judgment against you or settled any malpractice action?	<input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties of perjury that the statements made in this application are true, complete and correct.

Name of applicant (Please print or type - first, middle initial, last)

Signature of applicant

Date (month, day, year)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request, and direct any person, firm, officer, corporation, association, organization, or institution to release to the Professional Licensing Agency, or the State Psychology Board, any files, documents, records or other information pertaining to the undersigned requested by the Agency, or the Board, or any of their authorized representatives, in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, corporations, associations, organizations, persons and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency, or the State Psychology Board, to disclose to the aforementioned organizations, persons and institutions any information which is material to my application, and I hereby specifically release the Agency, and the Board, from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear and affirm that I have read the above statements and agree to same.

Signature of applicant

Date (month, day, year)