APPLICATION FOR ENDORSEMENT AS A HEALTH SERVICE PROVIDER IN PSYCHOLOGY (HSPP) *(continued)*

State Form 20231 (R19 / 11-21)

VERIFICATION OF PRACTICUM EXPERIENCE
FORM B

INSTRUCTIONS – ALL APPLICANTS:

1. *Complete the top section.*
2. *Make copies and send this form to the Doctoral Training Director (or his / her designee).*
3. *Direct the individual(s) to send this form directly to the Professional Licensing Agency.*
4. *If the Doctoral Training Director is not available, another psychologist associated with the training program may complete the form.*

1. Name *(last, first, middle, maiden)*			
2. Home address *(number and street or rural route)*	City	State	ZIP code
3. License number	Date of issuance *(month, day, year)*	Date of birth *(month, day, year)*	
I authorize _____ to furnish the Indiana State Psychology Board / Professional Licensing Agency with the following information.			
Signature of applicant		Date of signed *(month, day, year)*	

TO:	
NOTE: Applicant MUST have completed a minimum of 400 hours of master's level, basic practicum training prior to beginning doctoral level, advanced practicum. Each semester of doctoral practicum experience MUST correspond with a practicum course listed on the applicant's transcript for that semester.	
Please verify that _____ has received acceptable, supervised experience in a doctoral level practicum by providing the following information.	
1. Name and address of the agency providing the training program	
2. Your name and current address	
3. Your title at the agency at the time the applicant was in the program	
4. Date of completion of master's degree *(month, day, year)* or forty-eight (48) semesters / seventy-two (72) quarter hours	
5. Number of hours of practicum / internship completed during Master's training *(If less than 400 hours were completed during the Master's training, please indicate the term in which 400 hours of training was completed.)*	
6. When did the applicant receive training in the practicum *(please provide exact beginning and ending dates)*	
FROM:	TO:
a. Number of hours per week applicant worked in this setting	
b. Number of hours per week applicant received direct face-to-face supervision	
c. Duration of the supervision *(number of weeks or months)*	
d. Total number of hours of direct patient contact in this practicum setting	
e. Total number of hours of supervised experience completed in this setting	

See Reverse Side.

7. NAME AND DEGREES OF SUPERVISING PSYCHOLOGISTS		
Name	**Degree *(at the time the applicant was in the program)***	**State Where Certified / Licensed**

8. Please give a description of the training program's oversight of the setting

9. Was the practicum satisfactorily completed? Yes ☐ No

If No, please attach an explanation.

VERIFICATION FORM AFFIRMATION	
I swear or affirm, under penalties for perjury, that the statements made in this verification are true, complete and correct.	
Signature of Director of Training	Date signed *(month, day, year)*
Printed name of Director of Training	

Please respond as soon as possible so that the application may be completed without delay.
Please send all responses to:

INDIANA STATE PSYCHOLOGY BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204

Thank you for your assistance in this matter.