IOWA BOARD OF PSYCHOLOGY
IOWA DEPARTMENT OF PUBLIC HEALTH
LUCAS STATE OFFICE BLDG, 5TH FLOOR
DES MOINES, IOWA 50319-0075

ORGANIZED HEALTH SERVICE TRAINING PROGRAM CONFIRMATION FORM

Applicant name: _____

The above named person has applied for Iowa certification as a **Health Service Provider in Psychology (HSP)**. One of the criteria for the HSP is a minimum of two years of supervised experience in health services in psychology, including a minimum of one year of internship. Please complete this form to verify your supervision of the applicant's internship. Mail this to the Board office at the above address.

Name of Internship Agency:
_____

Address of Internship Agency:
_____

Director of Training:
_____

City: _____ State: _____ Zip: _____

DATES THE ABOVE NAMED APPLICANT PARTICIPATED IN THE INTERNSHIP PROGRAM:

1. From: Month: _____Year: _____ to: Month: _____Year:_____

   Full-Time ☐ Part-time ☐ hrs/wk: _____

   Number of face-to-face, individual supervision hours per week for the period listed:
_____

2. Applicant's primary supervisor:
_____

3. Supervisor's credentials (highest degree/program) _____

   State licensed/certified: Yes ☐ No ☐
   Specialty boards: Yes ☐ No ☐
   Are you listed in the National Register of Health Service Providers in Psychology? Yes ☐ No ☐
   Are you certified as a Health Service Provider in Psychology by a state licensure board? Yes ☐ No ☐

4. Applicant's title at agency: _____

5. Was the internship program accredited by the American Psychological Assn. (APA) or a member of APPIC at that time? Yes ☐ No ☐
6. Was the internship satisfactorily completed? Yes ☐ No ☐
7. Was the internship part of a university/school doctoral program requirement? Yes ☐ No ☐

   If yes, name of university: _____ department: _____

I hereby attest that all the above information is true and correct to the best of my knowledge.

Signature: _____

Title: _____ MUST BE NOTARIZED

Date: _____

Thank you for your assistance with this application.