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

SUPERVISOR 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. You are identified by the applicant as a direct supervisor for all or a portion of the required postdoctoral clinical experience. Please complete this form (print or type all information), and mail it to the Board of Psychology at the above address. The application cannot be processed until this form is received.

SUPERVISOR CREDENTIALS:

Name: _____ Profession: _____

Organization or agency: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Are you listed in the National Register of Health Service Providers in Psychology or certified as a Health Service Provider in Psychology by the Iowa Board? Yes ☐ No ☐ Other States? Yes ☐ No ☐

Highest Degree Earned: _____ Degree Program: _____

State(s) Licensed/Certified: _____ License number(s): _____

Specialty Boards Yes ☐ No ☐ Certifications: _____

Dates of my supervision of the above-named applicant for certification:

1. From: _____ to: _____
   (month/day/year) *(month/day/year)*
2. This was full-time (Hrs per Wk): _____, Part-time (Hrs per Wk): _____ experience for the applicant.
3. Number of individual, face-to-face supervision hours per week for the period listed:_____
4. Total number of individual, face-to-face supervision hours for the period listed:_____
5. Name of facility: _____
6. My title at the time: _____
7. Applicant's title at the time: _____

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.