

IOWA BOARD OF PSYCHOLOGY
IOWA DEPARTMENT OF PUBLIC HEALTH
LUCAS STATE OFFICE BLDG, 5TH FLOOR
DES MOINES, IOWA 50319-0075
<http://idph.iowa.gov/Licensure/Iowa-Board-of-Psychology>

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)**. The certification requirements are found at 645—IAC 240.7. The requirements of the organized health service training program are found at 645—IAC 240.7(2). Please complete this form to verify the applicant's completion of the internship program. Additional documentation is required if the internship program was not APA accredited or APPIC designated at the time the training was completed.

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

Total hours _____

2. Applicant's primary supervisor(s): _____

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 approved by the American Psychological Assn. (APA)? Yes No

6. If not APA approved, was the internship program APPIC designated at the time of completion? Yes No

7. Was the internship satisfactorily completed? Yes No

8. Was the internship part of a university/school doctoral program requirement? Yes No

If yes, name of university department / program: _____

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

Signature: _____

Title: _____

MUST BE NOTARIZED

Date: _____