ORGANIZED HEALTH SERVICE TRAINING PROGRAM CONFIRMATION FORM

Iowa licensed psychologist /Applicant: ________________________________________________

The above named psychologist 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 at found at 645—IAC 240.7(2). Please complete this form to verify the applicant’s completion of the internship program. Note: 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: __________________________________

Date: ________________________________ Revised 11/11/20