

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>

SUPERVISOR CONFIRMATION FORM

Applicant Name: _____

The above named person has applied for Iowa certification as a **Health Service Provider in Psychology (HSP)**. You are identified by the applicant as a direct supervisor for all or a portion of the required postdoctoral experience in a health services setting. The requirements are found at 645—IAC 240.7. Please complete this form and return it to the Board of Psychology. 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: _____