

**STATE OF UTAH**  
**DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING**  
**APPLICATION FOR LICENSURE**

**PSYCHOLOGIST or CERTIFIED PSYCHOLOGY RESIDENT**

**APPLICATION INSTRUCTIONS AND INFORMATION**

**General Statement:** The Utah Division of Occupational and Professional Licensing (DOPL) desires to provide courteous and timely service to all applicants for licensure. To facilitate the application process, **submit a complete application form including all applicable supporting documents and fees.** Failure to submit a complete application and supply all necessary information will delay processing and may result in denial of licensure. The fees are for processing your application and will not be refunded. **Please read all instructions carefully.**

**Address of Record:** The address you provide on this application will be your address of record. All correspondence from DOPL will be sent to that address. You are responsible to directly notify DOPL of any change to your address of record. Do not rely on a forwarding order.

**Social Security Number:** Your social security number is classified as a private record under the Utah Government Records Access and Management Act. It is used by DOPL as an individual identifier. It is also used for child support enforcement pursuant to Subsection 78-32-17(3) and is mandatory pursuant to Subsection 58-1-301(1), Utah Code Ann., which implements 42 U.S.C. 666(a)(13). If a SSN is not provided, the application is incomplete and may be denied.

**SUPPORTING DOCUMENTS AND FEES:**

**If you are applying for licensure as a Certified Psychology Resident, complete the following in addition to submitting a completed application:**

1. Submit official college transcript(s) documenting completion of a doctoral program in psychology.  
**NOTE:** Have the school send the transcript directly to DOPL. You may also have the school send the transcript to you for inclusion with your application so long as it is in a sealed envelope, bearing the school's stamp/seal on the envelope flap.
2. In addition to completing the "Educational Course Listing" section of the application, attach course descriptions, syllabi, and other pertinent information for any course that is not adequately described by the title shown on your transcript(s).  
**NOTE:** You must completely fill out this section of the application. You may not simply state, "refer to attached transcripts." Failure to complete this section will constitute an incomplete application and will delay approval of your license.
3. Submit an **\$85.00** non-refundable application-processing fee, made payable to "DOPL."

**If you are applying for licensure as a Psychologist, complete the following in addition to submitting a completed application:**

**NOTE:** If you are using this application to reinstate a Utah psychologist license that has been expired for more than two years, you must contact DOPL directly to determine the fees and requirements required in addition to those listed below.

1. Unless you are currently licensed as a Utah Certified Psychology Resident, submit official college transcript(s) documenting that you have a doctoral degree in psychology from an institution that meets the requirements of statute and rules, as well as any other official transcripts that are necessary to document completion of specific course work.  
**NOTE:** Have the school send the transcript directly to DOPL. You may also have the school send the transcript to you for inclusion with your application so long as it is in a sealed envelope, bearing the school's stamp/seal on the envelope flap.
2. Unless you are currently licensed as a Utah Certified Psychology Resident, complete the "Educational Course Listing" section of the application and attach a course description and other pertinent information for any course that is not adequately described by the title shown on your transcript(s).  
**NOTE:** You must completely fill out this section of the application. You may not simply state, "refer to attached transcripts." Failure to complete this section will constitute an incomplete application and will delay approval of your license.
3. Submit a completed "Verification of Supervised Experience" form (attached to this application) for each supervised experience. Forms must be **completed in their entirety by each supervisor**. Forms completed in part by the applicant or another party will not be accepted. The original form must be submitted. A fax or photocopy will not be accepted.  
All 4,000 hours of supervised experience must be documented. Please include documentation of not less than 1,000 hours of supervised training in mental health therapy with one hour of supervision for each 40 hours of supervised training.  
If any or all of your supervised experience was obtained in a state other than Utah, you must submit a resume from your supervisor and a copy of the supervisor's professional license, verifying that the supervisor meets Utah's supervisory requirements.
4. If you passed the Examination for the Professional Practice of Psychology (EPPP) in another state, use the "EPPP Score Transfer" form (attached to this application) to obtain official verification of your passing score.  
**NOTE:** If you plan to take the EPPP in Utah, see "EPPP & Utah Law Examination" in the "Additional Important Information" section of this application below.
5. If you are currently licensed as a psychologist in another state, use the "Request for Verification of License" form (attached to this application) to obtain verification of licensure from that state. Request that the verifying state complete the form and mail it directly to DOPL or return it to you for submission with your application.
6. Submit a **\$200.00** non-refundable application-processing fee, made payable to "DOPL."  
**NOTE:** You will also be required to submit the original letter from PSI documenting a passing score on the Utah Psychology Law Examination, see "EPPP & Utah Law and Rule Examination" in the "Additional Important Information" section of this application.

#### **ADDITIONAL IMPORTANT INFORMATION:**

1. **EPPP & Utah Law Examinations:** To register to take the EPPP or the Utah Psychology Law Examination in Utah, you must first submit a complete application for licensure with all supporting documentation, as outlined above. After submitting your application for licensure, DOPL will determine if you meet the eligibility requirements for taking the EPPP or Psychology Law Examinations in Utah.

If you are approved to sit for the EPPP Examination, DOPL will send you an approval letter and an examination registration form. At that time you may register with PES using the contact information found in the registration form.

If you are approved for the Utah Psychologist Law Examination, PSI will send you an approval letter and then you may register with PSI to take the examination. At that time you may register with PSI Examination Services at [www.psiexams.com](http://www.psiexams.com) or 1-800-733-9267.

The following applicable laws and rules are available on the Internet at [www.dopl.utah.gov](http://www.dopl.utah.gov).

- Division of Occupational & Professional Licensing Act
- General Rules of the Division of Occupational & Professional Licensing
- Psychologist Licensing Act
- Psychologist Licensing Act Rules

2. **Current Documents:** Applications, statutes, rules, and forms are occasionally changed. Go to [www.dopl.utah.gov](http://www.dopl.utah.gov) to ensure you have the most recent version of these documents.
3. **Examination Fees:** There are separate fees for all examinations. It is the responsibility of the applicant to submit the fees directly to the testing agency.
4. **“Practice of Mental Health Therapy”** means treatment or prevention of mental illness including:
  - conducting a professional evaluation of an individual’s condition of mental health, mental illness, or emotional disorder;
  - establishing a diagnosis in accordance with established written standards generally recognized in the professions of mental health therapy;
  - prescribing a plan for the prevention or treatment of a condition of mental illness or emotional disorder; and
  - engaging in the conduct of professional intervention, including psychotherapy by the application of established methods and procedures generally recognized in the professions of mental health therapy.
5. **Supervised Experience:** The 4,000 hours of supervised experience must be at a ratio of one hour of supervision for every 40 hours of practice. To be qualified to practice mental health therapy, a minimum of 1,000 hours of the 4,000 hours of supervised experience must be in mental health therapy. The mental health therapy hours must be at a ratio of one hour of supervision for every 40 hours of service provided for a total of 25 hours of face-to-face supervision. An individual completing any supervised experience during a post-doctoral residency program must be licensed as a certified psychology resident.
6. **Code of Ethics:** Licensees are required to abide by the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Society: [www.apa.org](http://www.apa.org)
7. **Endorsement (Licensure in another State):** The state of Utah does not have any reciprocal agreements with any other states; therefore, if you are licensed in another state, you may apply for licensure by endorsement. To qualify for licensure by endorsement, an applicant must submit one of the following:
  - A. a verification of licensure from a state in which the applicant is currently licensed and documentation of active practice as a licensed psychologist in that jurisdiction for not less than 2,000 hours or one year, whichever is greater
  - B.

- C. documentation of being a current holder of the Diplomate status in good standing from the American Board of Professional Psychology
- D. currently credentialed as a Health Service Provider by the National Register of Health Service Providers in Psychology
- E. current Certificate of Professional Qualification granted by the Association of State and Provincial Psychology Boards (CPQ)

Upon receiving a complete application, application fee, and all supporting documentation, DOPL will approve you to take the Utah Psychology Law Examination. To complete the licensure process, you must submit the original letter from PSI documenting a passing score on the Utah Psychology Law Examination.

8. **Knowledge of Other Statutes:** In addition to the licensing statute and rules listed above, mental health professionals may be subject to a number of other Utah statutes—including, but not limited to—those listed below. These statutes may affect your practice and you are obligated to understand and follow them. The following statutes may be reviewed on the Utah Legislature web site at [www.le.state.ut.us](http://www.le.state.ut.us):

A. Utah Health Code, Title 26, particularly:

- Section 26-6. Duty to report individual suspected of having communicable disease.
- Chapter 25. Confidential Information Release

B. The Utah Human Services Code, Title 62A, particularly:

- Section 62A-3. Reporting requirements -- Investigation -- Immunity -- Violation -- Penalty -- Physician-patient privilege – Non-medical healing.
- Section 62A-4a. Reporting requirements regarding incest, molestation, sexual exploitation, sexual abuse, physical abuse, or neglect of a child.
- Section 62A-15. Utah State Hospital and other State Facilities.

C. The Utah Judicial Code, Title 78, particularly:

- Chapter 03c. Confidential Communications for Sexual Assault Act
- Chapter 3e. Reporting School-Related Controlled Substance Abuse
- Chapter 14. Utah Health Care Malpractice Act
- Chapter 14a. Limitation of Therapist's Duty to Warn
- Section 78-25-25. Patients' records -- Inspection and copying by attorneys.

D. Utah Rules of Evidence Rule 506 - Physician and mental health therapist-patient, which can be viewed on the Utah Courts web site at [www.utcourts.gov](http://www.utcourts.gov).

9. **License Renewal:** All psychology licenses expire on September 30 of each even-numbered year.

Unlike many other states, Utah's license renewal schedule **is not** based on the licensee's date of initial licensure. Under Utah's renewal system, all licenses in each profession expire as a group on the same day every two years. Therefore, the length of a licensee's first renewal cycle depends on how far into the current renewal cycle initial licensure was obtained. Each renewal cycle thereafter is for a full two years. Additionally, the fee paid with this application for licensure is an application-processing fee only. It does not include a renewal fee. Each licensee is responsible to renew licensure **PRIOR** to the expiration date shown on the current license. Approximately two months prior to the expiration date shown on the license, renewal information is disseminated to each licensee's last address of record, as provided to DOPL.

10. **Continuing Education:** Forty-eight (48) hours of continuing education is required for each two-year period commencing October 1 of each even-numbered year. This requirement is pro rated for new licensees. For complete information on continuing education, refer to the Psychology Licensing Act Rules (R156-61-302h).
11. **Updating Address Information:** It is your responsibility to maintain a current address with DOPL. If your address is incorrect, you will not receive renewal notices or other correspondence. Address changes can be made online at [www.dopl.utah.gov](http://www.dopl.utah.gov).
12. **Name Change:** If you have been licensed by DOPL under any other name, please submit documentation of your name change (*i.e. copy of a marriage license or divorce decree*).
13. **Ceremonial Certificate of Licensure:** After obtaining your license from DOPL, you can order a Ceremonial Certificate of Licensure, printed on parchment paper with original signatures and an embossed gold seal. Order forms can be obtained at [www.dopl.utah.gov](http://www.dopl.utah.gov).
14. **Submit Completed Application to:**

<b>By U.S. Mail</b>	Division of Occupational & Professional Licensing P.O. Box 146741 Salt Lake City UT 84114-6741
<b>By Express Mail or In Person</b>	Division of Occupational & Professional Licensing 1 <sup>st</sup> Floor Lobby 160 E 300 S Salt Lake City UT 84111-2305

15. **Telephone Numbers:** (801) 530-6628  
(866) 275-3675 – toll-free in Utah
16. **Fax Number:** (801) 530-6511

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**AFFIDAVIT and RELEASE AUTHORIZATION**

1. I certify under penalty of perjury that I am a United States citizen, a qualified alien as defined in 8 U.S.C. Sec. 1641, or I am lawfully present in the United States.
2. I certify that I am qualified in all respects for the license for which I am applying in this application.
3. I certify that to the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, forgery, misrepresentation, omission of material fact; is truthful, correct, and complete; discloses all material facts regarding the applicant; and that I will update or correct the application as necessary, prior to any action on my application.
4. I authorize all persons, institutions, organizations, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division of Occupational and Professional Licensing to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
5. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

Signature of Applicant: \_\_\_\_\_ Date of Signature: \_\_\_ / \_\_\_ / \_\_\_\_\_

**EDUCATION REQUIREMENT:** *(Use additional sheets if necessary.)*

University Name: \_\_\_\_\_ Dates Attended: \_\_\_\_\_ to \_\_\_\_\_

Address: \_\_\_\_\_

Degree Received: \_\_\_\_\_ Date of Graduation: \_\_\_ / \_\_\_ / \_\_\_

University Name: \_\_\_\_\_ Dates Attended: \_\_\_\_\_ to \_\_\_\_\_

Address: \_\_\_\_\_

Degree Received: \_\_\_\_\_ Date of Graduation: \_\_\_ / \_\_\_ / \_\_\_

Is your Doctoral Degree "APA approved"?  Yes  No

If "Yes" in what area: *(please check only one)*

Clinical  School  Counseling  Combined

If "No" is your Doctoral Degree recognized by the ASPPB/National Register Joint

Designation Committee?  Yes  No

**ENDORSEMENT APPLICANTS:** (Answer “yes” or “no.”)

\_\_\_\_\_ I am verifying licensure from a state in which I am currently licensed and submitting documentation of active practice as a licensed psychologist in that jurisdiction for not less than 2,000 hours or one year, whichever is greater.

\_\_\_\_\_ I am a Diplomate of the American Board of Professional Psychology.

If yes, which specialty? \_\_\_\_\_

\_\_\_\_\_ I am currently credentialed as a Health Service Provider by the National Register of Health Service Providers in Psychology.

\_\_\_\_\_ I currently hold a Certificate of Professional Qualification (CPQ) granted by the Association of State and Provincial Psychology Boards.

**EDUCATIONAL COURSE LISTING:**

**NOTE: If you are currently licensed as a Utah Certified Psychology Resident making application for licensure as a Utah Psychologist or if you are applying for licensure by endorsement, or if you graduated from an “APA approved” program, you do not need to complete this section.**

If you did not graduate from an APA accredited program, state law requires that your program be recognized by the ASPPB /National Register Joint Designation Committee as meeting “designation” criteria. To confirm whether your program is recognized by the ASPPB /National Register Joint Designation Committee, go to [www.asppb.net](http://www.asppb.net).

Applicants must document completion of 2 graduate semester hours or 3 graduate quarter hours in the four core areas of psychological study (*scientific and professional ethics and standards, research design and methodology, statistics, and psychometrics*). Applicants must also document completion of 2 graduate semester hours or 3 graduate quarter hours in each of four substantive content areas with theoretical (*as opposed to applied*) emphasis (*biological bases of behavior, cognitive-affective bases of behavior, social bases of behavior, and individual differences*).

In the space below, document your graduate courses in each of the areas. List each course title **as it appears on your transcript**. A single course cannot be used to satisfy multiple categories. You can expedite the review process by providing a copy of the graduate catalog course description and/or syllabus of any identified courses. You must completely fill out this section of the application. You may not simply state, “refer to attached transcripts.” Failure to complete this section will constitute an incomplete application and will delay approval of your license.

**HIGHLIGHT ON YOUR TRANSCRIPTS THE COURSES YOU LIST BELOW.**

**Scientific and Professional Ethics and Standards: Total Credits: \_\_\_\_\_**

1. Course Title: \_\_\_\_\_ Course No.: \_\_\_\_\_ University: \_\_\_\_\_

Year: \_\_\_\_\_ Credits (S/Q): \_\_\_\_\_ Credits Received: \_\_\_\_\_

2. Course Title: \_\_\_\_\_ Course No.: \_\_\_\_\_ University: \_\_\_\_\_

Year: \_\_\_\_\_ Credits (S/Q): \_\_\_\_\_ Credits Received: \_\_\_\_\_

**Research Design and Methodology: Total Credits: \_\_\_\_\_**

1. Course Title: \_\_\_\_\_ Course No.: \_\_\_\_\_ University: \_\_\_\_\_  
Year: \_\_\_\_\_ Credits (S/Q): \_\_\_\_\_ Credits Received: \_\_\_\_\_
2. Course Title: \_\_\_\_\_ Course No.: \_\_\_\_\_ University: \_\_\_\_\_  
Year: \_\_\_\_\_ Credits (S/Q): \_\_\_\_\_ Credits Received: \_\_\_\_\_

**Statistics: Total Credits: \_\_\_\_\_**

1. Course Title: \_\_\_\_\_ Course No.: \_\_\_\_\_ University: \_\_\_\_\_  
Year: \_\_\_\_\_ Credits (S/Q): \_\_\_\_\_ Credits Received: \_\_\_\_\_
2. Course Title: \_\_\_\_\_ Course No.: \_\_\_\_\_ University: \_\_\_\_\_  
Year: \_\_\_\_\_ Credits (S/Q): \_\_\_\_\_ Credits Received: \_\_\_\_\_

**Psychometrics (including test construction and measurements): Total Credits: \_\_\_\_\_**

1. Course Title: \_\_\_\_\_ Course No.: \_\_\_\_\_ University: \_\_\_\_\_  
Year: \_\_\_\_\_ Credits (S/Q): \_\_\_\_\_ Credits Received: \_\_\_\_\_
2. Course Title: \_\_\_\_\_ Course No.: \_\_\_\_\_ University: \_\_\_\_\_  
Year: \_\_\_\_\_ Credits (S/Q): \_\_\_\_\_ Credits Received: \_\_\_\_\_

**Biological Bases of Behavior: Total Credits: \_\_\_\_\_**

1. Course Title: \_\_\_\_\_ Course No.: \_\_\_\_\_ University: \_\_\_\_\_  
Year: \_\_\_\_\_ Credits (S/Q): \_\_\_\_\_ Credits Received: \_\_\_\_\_
2. Course Title: \_\_\_\_\_ Course No.: \_\_\_\_\_ University: \_\_\_\_\_  
Year: \_\_\_\_\_ Credits (S/Q): \_\_\_\_\_ Credits Received: \_\_\_\_\_

**Cognitive-Affective Bases of Behavior: Total Credits: \_\_\_\_\_**

1. Course Title: \_\_\_\_\_ Course No.: \_\_\_\_\_ University: \_\_\_\_\_  
Year: \_\_\_\_\_ Credits (S/Q): \_\_\_\_\_ Credits Received: \_\_\_\_\_
2. Course Title: \_\_\_\_\_ Course No.: \_\_\_\_\_ University: \_\_\_\_\_  
Year: \_\_\_\_\_ Credits (S/Q): \_\_\_\_\_ Credits Received: \_\_\_\_\_

**Social Bases of Behavior: Total Credits: \_\_\_\_\_**

1. Course Title: \_\_\_\_\_ Course No.: \_\_\_\_\_ University: \_\_\_\_\_  
Year: \_\_\_\_\_ Credits (S/Q): \_\_\_\_\_ Credits Received: \_\_\_\_\_
2. Course Title: \_\_\_\_\_ Course No.: \_\_\_\_\_ University: \_\_\_\_\_  
Year: \_\_\_\_\_ Credits (S/Q): \_\_\_\_\_ Credits Received: \_\_\_\_\_

**Individual Differences: Total Credits: \_\_\_\_\_**

1. Course Title: \_\_\_\_\_ Course No.: \_\_\_\_\_ University: \_\_\_\_\_  
Year: \_\_\_\_\_ Credits (S/Q): \_\_\_\_\_ Credits Received: \_\_\_\_\_
2. Course Title: \_\_\_\_\_ Course No.: \_\_\_\_\_ University: \_\_\_\_\_  
Year: \_\_\_\_\_ Credits (S/Q): \_\_\_\_\_ Credits Received: \_\_\_\_\_

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# PSYCHOLOGIST QUALIFYING QUESTIONNAIRE

Answer “yes” or “no” for each question. Do not leave any question blank.

1. \_\_\_\_\_ Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?
2. \_\_\_\_\_ Have you ever been denied the right to sit for a licensure examination?
3. \_\_\_\_\_ Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
4. \_\_\_\_\_ Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any health care professional licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
5. \_\_\_\_\_ Are you currently under investigation or is any disciplinary action pending against you now by any licensing or governmental agency?
6. \_\_\_\_\_ Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
7. \_\_\_\_\_ Have you ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending against you by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
8. \_\_\_\_\_ Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?
9. \_\_\_\_\_ Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
10. \_\_\_\_\_ Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?
11. \_\_\_\_\_ Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?

*(Continued on the next page.)*

12. \_\_\_\_\_ Have you been named as a defendant in a malpractice suit?
13. \_\_\_\_\_ Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions, or conditions imposed by any malpractice carrier?
14. \_\_\_\_\_ Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?
15. \_\_\_\_\_ If you are licensed in the occupation/profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?
16. \_\_\_\_\_ Have you ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?
17. \_\_\_\_\_ Have you been terminated from a position because of drug use or abuse within the past five (5) years?
18. \_\_\_\_\_ Are you currently using or have you recently (*within 90 days*) used any drugs (*including recreational drugs*) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?
19. \_\_\_\_\_ Have you ever used any drugs without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law, for which you have not successfully completed or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?
20. \_\_\_\_\_ Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?
21. \_\_\_\_\_ Do you currently have any criminal action pending?
22. \_\_\_\_\_ Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.
23. \_\_\_\_\_ Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?
24. \_\_\_\_\_ Have you, in the past ten (10) years, been allowed to plea guilty or no contest to any criminal charge that was later dismissed (*i.e. plea in abeyance or deferred sentence*)?

(Continued on the next page.)

25. \_\_\_\_\_ Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction or on probation/parole in any jurisdiction?



**If you answered “yes” to questions 21, 22, 23, 24, or 25 above, you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).**

**If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.**

**If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.**



**If you answered “yes” to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.**

**A “yes” answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.**

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**PREDOCTORAL SUPERVISED EXPERIENCE IN PSYCHOLOGY:**

***(Do not complete this section if you are applying for licensure as a Certified Psychology Resident.)***

List in chronological order each place of supervised experience prior to receiving your doctoral degree for which you are claiming experience hours. PLEASE SHOW MONTH AND YEAR FOR EACH. (Use additional sheets if needed.)

1. Name of Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Dates of Supervised Experience: from \_\_\_/\_\_\_ to \_\_\_/\_\_\_ Working Title: \_\_\_\_\_

Hours Worked Per Week: \_\_\_\_\_ Hours of Face-to-Face Supervision Per Week: \_\_\_\_\_

Total Supervised Hrs. Worked: \_\_\_\_\_ Total Hrs. of Face-to-Face Supervision: \_\_\_\_\_

Total Hours of Mental Health Therapy: \_\_\_\_\_

Description of Training: \_\_\_\_\_

\_\_\_\_\_

Name and Title of Director of Training: \_\_\_\_\_

Name and Title of Direct Supervisor: \_\_\_\_\_

2. Name of Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Dates of Supervised Experience: from \_\_\_/\_\_\_ to \_\_\_/\_\_\_ Working Title: \_\_\_\_\_

Hours Worked Per Week: \_\_\_\_\_ Hours of Face-to-Face Supervision Per Week: \_\_\_\_\_

Total Supervised Hrs. Worked: \_\_\_\_\_ Total Hrs. of Face-to-Face Supervision: \_\_\_\_\_

Total Hours of Mental Health Therapy: \_\_\_\_\_

Description of Training: \_\_\_\_\_

\_\_\_\_\_

Name and Title of Director of Training: \_\_\_\_\_

Name and Title of Direct Supervisor: \_\_\_\_\_

**POSTDOCTORAL SUPERVISED EXPERIENCE IN PSYCHOLOGY:**

***(Do not complete this section if you are applying for licensure as a Certified Psychology Resident.)***

List in chronological order each place of supervised experience after receiving your doctoral degree. PLEASE SHOW MONTH AND YEAR FOR EACH. (Use additional sheets if needed.)

1. Name of Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Dates of Supervised Experience: from \_\_\_/\_\_\_ to \_\_\_/\_\_\_ Working Title: \_\_\_\_\_

Hours Worked Per Week: \_\_\_\_\_ Hours of Face-to-Face Supervision Per Week: \_\_\_\_\_

Total Supervised Hrs. Worked: \_\_\_\_\_ Total Hrs. of Face-to-Face Supervision: \_\_\_\_\_

Total Hours of Mental Health Therapy: \_\_\_\_\_

Description of Training: \_\_\_\_\_

\_\_\_\_\_

Name and Title of Director of Training: \_\_\_\_\_

Name and Title of Direct Supervisor: \_\_\_\_\_

2. Name of Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Dates of Supervised Experience: from \_\_\_/\_\_\_ to \_\_\_/\_\_\_ Working Title: \_\_\_\_\_

Hours Worked Per Week: \_\_\_\_\_ Hours of Face-to-Face Supervision Per Week: \_\_\_\_\_

Total Supervised Hrs. Worked: \_\_\_\_\_ Total Hrs. of Face-to-Face Supervision: \_\_\_\_\_

Total Hours of Mental Health Therapy: \_\_\_\_\_

Description of Training: \_\_\_\_\_

\_\_\_\_\_

Name and Title of Director of Training: \_\_\_\_\_

Name and Title of Direct Supervisor: \_\_\_\_\_

**PROFESSIONAL EMPLOYMENT EXPERIENCE: (For Endorsement Applicants Only)**

List in chronological order all places of professional employment experience. PLEASE SHOW MONTH AND YEAR FOR EACH. (Use additional sheets if necessary.)

1. Position: \_\_\_\_\_ Phone: \_\_\_\_\_  
Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
Dates of Employment: from \_\_\_/\_\_\_ to \_\_\_/\_\_\_ Contact Person: \_\_\_\_\_  
Primary Responsibilities/Activities: \_\_\_\_\_  
\_\_\_\_\_

2. Position: \_\_\_\_\_ Phone: \_\_\_\_\_  
Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
Dates of Employment: from \_\_\_/\_\_\_ to \_\_\_/\_\_\_ Contact Person: \_\_\_\_\_  
Primary Responsibilities/Activities: \_\_\_\_\_  
\_\_\_\_\_

3. Position: \_\_\_\_\_ Phone: \_\_\_\_\_  
Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
Dates of Employment: from \_\_\_/\_\_\_ to \_\_\_/\_\_\_ Contact Person: \_\_\_\_\_  
Primary Responsibilities/Activities: \_\_\_\_\_  
\_\_\_\_\_

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*(FOR TWO-SIDED PRINTING)*

## VERIFICATION OF SUPERVISED EXPERIENCE

**TO BE COMPLETED BY EACH DIRECT SUPERVISOR OF THE REQUIRED SUPERVISED EXPERIENCE HOURS:** If the hours supervised include both predoctoral and postdoctoral work, indicate clearly how many hours apply to each category. Indicate inclusive dates for each category. Only hours completed may be verified in this form. Do not include projected hours.

Applicant's Name: \_\_\_\_\_

Direct Supervisor's Name: \_\_\_\_\_

Direct Supervisor's Current Phone Number: \_\_\_\_\_

Direct Supervisors License Number: \_\_\_\_\_

State Issued : \_\_\_\_\_ Profession: \_\_\_\_\_ Year: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Inclusive Dates of **Predoctoral** Supervised Training: from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>Predoctoral Area</b>	<b>Hours</b>
Hours of Supervised Experience in Mental Health Therapy	
Hours of Face-to-Face Individual Supervision for Mental Health Therapy	
Hours of Other Supervised Experience	
<b>Total Hours of Supervised Experience</b>	

Inclusive Dates of **Postdoctoral** Supervised Training: from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>Postdoctoral Area</b>	<b>Hours</b>
Hours of Supervised Experience in Mental Health Therapy	
Hours of Face-to-Face Individual Supervision for Mental Health Therapy	
Hours of Other Supervised Experience	
<b>Total Hours of Supervised Experience</b>	

*(Continued on the next page.)*

Hours of Face-to-Face Individual Supervision Per Week: \_\_\_\_\_ Hours Worked Per Week: \_\_\_\_\_

The hours worked and supervised are reported on the basis of:

- Direct Supervisor's appointment calendars or records
- Direct Supervisor's best recollection

Nature of Applicant's Duties: \_\_\_\_\_

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(Answer "yes" or "no.")

Yes  No I certify that the applicant for licensure as a psychologist has satisfactorily completed the reported supervised experience.

If the applicant has not satisfactorily completed the supervised experience, please explain the nature of the problem and recommendations for remediation. (Use additional sheets if necessary.)

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I certify that I am a licensed psychologist in good standing and I am a qualified supervisor in accordance with statute and rules. I further certify that I am professionally responsible for the acts and practices of the applicant that are a part of the required supervised training.

Signature of Supervisor: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## REQUEST FOR VERIFICATION OF LICENSE

*(Use this form to verify licensure from another state, if applicable.)*

### PART 1 - TO BE COMPLETED BY THE APPLICANT:

Complete the first section of the form. Request that the verifying state complete the form and mail it directly to the DOPL or return it to you for submission with your application.

Applicant's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I am requesting licensure in the state of Utah as a: \_\_\_\_\_

I am/have been licensed in your state under the name: \_\_\_\_\_

My Social Security Number is: \_\_\_\_\_

My Date of Birth is: \_\_\_\_/\_\_\_\_/\_\_\_\_

My license number in your state is/was: \_\_\_\_\_

I have enclosed the necessary license verification fee in the amount of: \_\_\_\_\_

Signature of Qualifier: \_\_\_\_\_

Date of Signature: \_\_\_\_/\_\_\_\_/\_\_\_\_

*(Continued on the next page.)*

**PART 2 - TO BE COMPLETED BY THE VERIFYING AGENCY:**

Please furnish the information requested, sign and verify the document, and place the completed form in an envelope, seal the envelope and provide it to the applicant in person or by mail. The qualifier will include the verification of licensure with his/her Utah application. Thank you.

Name of Verifying State: \_\_\_\_\_

Name of Licensee (*as it appears in verifying state's records*): \_\_\_\_\_

Name of Qualifying Person: \_\_\_\_\_

Classification of License Issued: \_\_\_\_\_

License Number: \_\_\_\_\_ Current Status: \_\_\_\_\_

Original Date of Licensure: \_\_\_\_/\_\_\_\_/\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Continuously Licensed:

Yes  No, please explain: \_\_\_\_\_

Licensed By:

Exam, Type: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Endorsement, from what state? \_\_\_\_\_

Disciplinary Action or Pending Disciplinary Action:

No  Yes, please provide certified copies of all Petitions, Orders, etc.

Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Agency: \_\_\_\_\_

Date of Signature: \_\_\_\_/\_\_\_\_/\_\_\_\_

(SEAL)

## VERIFICATION OF ACTIVE PRACTICE AS A LICENSED PSYCHOLOGIST *(For Endorsement Only)*

**TO BE COMPLETED BY THE EMPLOYER, HUMAN RESOURCE PERSONNEL, OR IF IN PRIVATE CLINICAL PRACTICE, OTHER VERIFYING PARTY:**

Name of Applicant: \_\_\_\_\_

License Number: \_\_\_\_\_ State of Licensure: \_\_\_\_\_

Name of Person Verifying Employment: \_\_\_\_\_

Phone #: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone Number: \_\_\_\_\_

Describe the applicant's employment setting: *(private practice, governmental entity, nonprofit and charitable corporation, school, college, university, licensed health facility or other)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dates applicant was employed with this agency or conducted private practice:

from \_\_\_ / \_\_\_ / \_\_\_ to \_\_\_ / \_\_\_ / \_\_\_

Number of hours applicant worked per week: \_\_\_\_\_

What was the applicant's schedule?  full-time  part-time

Was the applicant contracted labor?  Yes  No

*(Continued on the next page.)*

Did the applicant and individual verifying employment work within the same employment setting where the experience hours were obtained?  Yes  No If No, please explain:

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If not in private clinical practice, is the applicant still employed with agency?  Yes  No

If no, is the applicant re-hirable?  Yes  No

I certify that the applicant has been actively engaged in legal practice as a licensed Psychologist and has completed (*check only one*)

Not less than 2,000 hours of experience or one year of full-time employment or active clinical practice, whichever is more: or

\_\_\_\_\_ Hours of experience towards the 2,000 hour minimum. (enter amount)

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_