APPLICATION FOR ENDORSEMENT AS A HEALTH SERVICE PROVIDER IN PSYCHOLOGY (HSPP) *(continued)*

State Form 20231 (R19 / 11-21)

VERIFICATION OF INTERNSHIP EXPERIENCE
FORM A

INSTRUCTIONS – ALL APPLICANTS:

1. *Complete the top section.*
2. *Make copies and send this form to the Director of Training of your experience (internship).*
3. *Direct the individual(s) to send this form directly to the Professional Licensing Agency.*
4. *If the Director of Training is not available, another psychologist associated with the internship may complete the form.*
5. *If a psychologist is not available, you must provide a written explanation to the Board.*

1. Name *(last, first, middle, maiden)*			
2. Home address *(number and street or rural route)*	City	State	ZIP code
3. License number	Date of issuance *(month, day, year)*	Date of birth *(month, day, year)*	

I authorize ______________________________ to furnish the Indiana State Psychology Board / Professional Licensing Agency with the following information.

Signature of applicant	Date of signed *(month, day, year)*

TO:	

Please verify that ______________________________ has received acceptable, supervised experience *(internship)* by providing the following information.

1. Name and address of the agency providing the training program

2. Your name and current address

3. Your title at the agency at the time the applicant was in the program

4. What role did you play in the internship?

5. Did you directly supervise the applicant? ☐ Yes ☐ No | *If No, what was your relationship to the applicant?*

6. Type of patient / client population

7. When did the applicant receive training in your program / internship? *(please provide exact beginning and ending dates)*

FROM: TO:

a. Was the internship APA approved at the time of completion? ☐ Yes ☐ No

b. Was the internship APPIC approved at the time of completion? ☐ Yes ☐ No

c. Number of hours per week applicant worked in this setting

d. Number of hours per week applicant received individual, not group, supervision

e. Duration of the supervision *(number of weeks or months)*

f. Total number of hours the applicant worked in this setting

8. Number of interns in the program when the applicant was in the program

9. NAME AND DEGREES OF SUPERVISING PSYCHOLOGISTS		
Name	**Degree *(at the time the applicant was in the program)***	**State Where Certified / Licensed**

10. Please give a description of the applicant's internship experience

11. Was the internship satisfactorily completed? ☐ Yes ☐ No

If No, please attach an explanation.

12. At the time of supervision

A. Were you licensed or certified in Indiana? ☐ Yes ☐ No

B. If you were licensed or certified in Indiana, were you endorsed as a health service provider in psychology? ☐ Yes ☐ No

If you were not licensed or certified in Indiana and HSPP, or were not listed in the National Register, has your resume been attached? ☐ Yes ☐ No

VERIFICATION FORM AFFIRMATION

I swear or affirm, under penalties for perjury, that the statements made in this verification are true, complete and correct.

Signature of applicant	Date signed *(month, day, year)*

Please respond as soon as possible so that the application may be completed without delay.
Please send all responses to:

INDIANA STATE PSYCHOLOGY BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204

Thank you for your assistance in this matter.