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

State Form 20231 (R19 / 11-21)

VERIFICATION OF POST-INTERNSHIP EXPERIENCE
FORM C

INSTRUCTIONS – ALL APPLICANTS:

1. *Complete the top section.*
2. *Make copies and send this form to each individual who supervised your experience in a health service setting (post-internship).*
3. *Direct the individual(s) to send this form directly to the Professional Licensing Agency.*

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 post-internship by providing the following information.

1. Name and address of the facility in which the experience was obtained

2. Your name and current address

3. Your title in the health service setting during the time you supervised the applicant

4. Type of patient / client population

5. INCLUSIVE DATES AND NUMBER OF HOURS PER WEEK THE APPLICANT WORKED IN THIS SETTING

Dates *(month, day, year)*	Hours

a. Number of hours per week you directly supervised applicant *(individual, not group, supervision)*

b. When did you supervise the applicant? *(Provide exact beginning and ending dates.)*

c. Number of hours of experience completed by the applicant while under your supervision

d. Number of hours of direct patient contact by the applicant while under your supervision

See Reverse Side.

6. Briefly describe the nature of the applicant's work

7. Was the supervised experience satisfactorily completed by the applicant? ☐ Yes ☐ No

If No, please attach an explanation.

8. 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 Director of Training	Date signed *(month, day, year)*
Printed name of supervisor	

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.