The Commonwealth of Massachusetts
Division of Professional Licensure
Board of Registration of Allied Mental Health
and Human Service Professions
1000 Washington Street, Suite 710
Boston, MA 02118-6100

EDUCATIONAL PSYCHOLOGIST LICENSURE APPLICATION

Important information for Applicants and Supervisors:

The information provided below may help you determine if you are eligible for licensure as an Educational Psychologist. If you have further questions, please contact the Board Staff at (617) 701-8683or via e-mail at amh.board@state.ma.us.

All Applicants:

- The NON-REFUNDABLE application fee of **$117.00** must accompany the submitted application. Check or money order payable to "Comm. of MA" is acceptable.
- The Checklist provided at the end of this application must be completed and included.
- Submit completed, notarized applications to the address above.

Please be aware that if you submit an application and it is determined by the Board that it is incomplete, or that you have failed to meet the regulatory requirements for licensure, the Board will provide you six months to complete your application or submit the information needed to demonstrate that you meet the regulatory requirements, which will be communicated to you in a written letter from the Board. After six months, if your application is still incomplete, or if you have still failed to demonstrate that you meet the regulatory requirements for licensure, you will be issued a letter from the Board indicating that your application has been closed or denied. If your application is closed or denied, you would need to re-apply for licensure by submitting a complete application to the Board and by paying a new application fee.

Education and Practicum/Internship: Official transcripts demonstrating the conferral of a **Master's Degree, CAGS, or Doctoral Degree in School Psychology from an educational institution licensed or accredited by the State in which it is located is required**. Such programs must consist of a minimum of 60 graduate credit hours of coursework and include a minimum of 1200 clock hours of supervised practicum or internship experience, at least 600 hours of which must be in a school setting. **Verification of supervised practicum must be submitted from Academic Program Director in the form of a written statement.**

Supervised Experience: Two (2) years supervised experience and employment as a school psychologist is required. Employment in private practice is not acceptable.
AN APPROVED SUPERVISOR is a person licensed or eligible for licensure as an Educational Psychologist by the Massachusetts Board of Allied Mental Health and Human Services Professions and has a minimum of five full-time academic years, or equivalent part-time experience as a school psychologist licensed or certified by a state department of education.

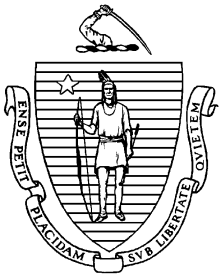
SCHOOL PSYCHOLOGICAL SERVICES is the rendering of professional services to individual groups, organizations, or the public for compensation, monetary or otherwise.

Such professional services include: applying psychological principles, methods, and procedures in the delivery of services to individuals, groups, families, educational institutions and staff and community agencies for the purpose of promoting mental health and facilitating learning. Such services may be preventative, developmental, or remedial and include psychological and psychoeducational assessment, therapeutic intervention, program planning and evaluation, research, teaching in the field of educational psychology, consultation and referral to other psychiatric, psychological, medical and educational resources when necessary.

Examination: All applicants must take and pass the National School Psychology Examination (ETS/NTE Test #0401). For more information regarding the examination, contact Educational Testing Service, PO Box 6051, Princeton, NJ 08541 (609) 771-7395. The Reporting Code for the Board is R7417.

Return completed, application, along with all required supplemental documentation and fee to the Board office at:
Board of Registration of Allied Mental Health and Human Service Professions
1000 Washington Street, Suite 710
Boston, MA 02118-6100

ALL APPLICANTS MUST SUBMIT THE CHECKLIST PROVIDED AT THE END OF THIS APPLICATION



The Commonwealth of Massachusetts
Division of Professional Licensure
Board of Registration of Allied Mental Health
and Human Service Professions
1000 Washington Street,
Suite 710 Boston, MA 02118-6100

Please attach recent passport type

EDUCATIONAL PSYCHOLOGIST

LICENSURE APPLICATION

2" X 2"

head and shoulder photograph

NON-REFUNDABLE APPLICATION FEE: $117.00

1. Name:_____
Last First Middle Maiden

2. Mailing Address: _____
No. Street Apt. No.

_____
City/Town State Zip Code

***NOTE**: The mailing address above will be a **matter of public record**. It will appear on your license and will be used for all board correspondence. The mailing address and the business address provided below may be the same.*

3. Date of Birth:_____ Place of Birth: _____

4. Telephone Number: (Day)_____(Evening) _____

5. Email Address:_____
Do you consent to receiving information about your application from the Board via email (e.g., incomplete documents): Yes_____No_____

6. Graduate School Attended:_____ Degree:_____# of Credits: ____

Major:_____ Date Degree Conferred:_____

NOTE: Official, sealed, graduate level transcripts must be included with application, along with verification of Practicum from Academic Program Director. Applicant must request written statement from Academic Program Director verifying completion of the required practicum/ internship.

7. DISCIPLINARY HISTORY

If you answer "YES" to any of the following questions (A - F), please attach a complete explanation.

A. Has any disciplinary action been taken against you by a licensing/certification board located in the United States or any country or foreign jurisdiction? YES_____ NO _____

B. Are you the subject of pending disciplinary action by a licensing/certification board located in the United States or any country or foreign jurisdiction? YES_____ NO _____

C. Have you ever voluntarily surrendered or resigned a professional license to a licensing /certification board in the United States or any country or foreign jurisdiction? YES_____NO _____

D. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction? YES_____NO _____

E. Have you ever been convicted of a felony or misdemeanor in the United States or any country or foreign jurisdiction, other than a traffic violation for which a fine of less than $100.00 was assessed? YES_____NO_____

F. Have you taken a Board-approved training in Domestic and Sexual Violence? YES_____NO____

The Board is registered under the provisions of M.G.L c.6 §172 to receive Criminal Offender Record Information (CORI) for the purpose of screening current licensees and otherwise qualified prospective license applicants. CORI must be checked as part of your licensing process. No convictions contained in a CORI are automatic disqualifiers. In order to complete the CORI check process, please fill out the Criminal Offender Record Information Acknowledgment Form on Page 11 & 12.

8. PROFESSIONAL LICENSES/REGISTRATION

List any professional licenses/registration you hold or held in the United States or any country or foreign jurisdiction and the state/jurisdiction from which the license/registration was issued along with the license number. **Official letter of standing from each state listed must accompany this application (copy of your license is NOT acceptable).**

_____

_____

CERTIFICATION STATUS
Complete applicable certification information below. **Attach copies of current certification(s) with application.**

A. Nationally Certified School Psychologist (NCSP) by the National Association of School Psychologists? ____Yes ____No If Yes, Certification No. _____

B. (1) Certification as School Psychologist by the Massachusetts Dept. of Education?_____Yes_____No
If Yes, Certificate No._____ or,

(2) Certification as School Psychologist by another state?_____Yes_____No
If Yes, State_____Certificate No. _____

9. EXAMINATION

National School Psychologist Examination Date Taken _____

NOTE: Official examination scores must be sent to the Board by Educational Testing Services (ETS).

10. POST-MASTER'S DEGREE EXPERIENCE

Applicants must document two (2) years full-time, or equivalent part-time, post-master's degree experience in school psychological services supervised by an approved supervisor. Provide attached Statement of Supervised Experience Form to approved supervisor to document required experience.

Name and Address of Employer:_____

Your Job Title: _____

Your Duties: _____

_____

Dates of Experience in School Psychological Services: From_____To _____

FULL TIME: From_____To_____PART TIME: From_____To _____
No. of Days per Week:_____Total No. of Days: _____

NOTE: Attach additional information in this format as necessary to document required hours.

11. Pursuant to M.G.L., Chapter 62C, S. 49A, I have filed all state tax returns and paid all state taxes required under law._____Yes ____No. If No, please explain. _

AFFIDAVIT

Pursuant to G.L. c. 119 s. 51A and G.L. c. 112, s. 1A, my signature on this application is my certification that I understand my obligation to report the abuse or neglect of children and that failure to do so may result in criminal punishment including fines and/or imprisonment.

The applicant named on this application agrees to abide by the rules and regulations for Licensed Educational Psychologists and attests that all statements are truthful and are made under the pains and penalties of perjury.

_____ _____

Applicant's Signature Date

The Commonwealth of Massachusetts
Division of Professional Licensure
Board of Allied Mental Health and
Human Services Professions
1000 Washington Street,
Suite 710 Boston, MA 02118-6100

STATEMENT OF SUPERVISED CLINICAL EXPERIENCE
(To be completed by Approved Supervisor)

Applicant: Duplicate this form as necessary to document two years of POST MASTER'S DEGREE experience in School Psychological Services under APPROVED SUPERVISION for submission with your application.

See following page for the definition of Approved Supervisor.
PLEASE PRINT CLEARLY OR TYPE AND SUBMIT ORIGINAL OF THIS FORM.

1(a). Name of Applicant: _____

(b). Name of Approved Supervisor: _____

2(a) Name/Address of Employing Facility/System: _____

(b) Name/Address of Facility where Applicant Completed Experience: _____

_____

3. Applicant's Post-Master's Degree Experience in School Psychological Services
(a) FULL-TIME Employment From _____ To _____

Total Number of Years of Applicant's Full-Time Employment _____
(Minimum 2 years required)

(b) PART-TIME Employment From _____ To _____

# of Days per Week _____ # of Weeks _____ Total # of Days _____

(Combined total days from all part-time employment must meet the minimum of 360 days.)

4. Total Number of Supervision Hours

_____
(30 Supervision Contact Hours required per year/ Total of 60 contact hours required)

5. Applicant's Title and Description of Applicant's Duties

_____

_____

Approved Supervisor Qualification: Licensure as an Educational Psychologist or demonstrated eligibility for said license is required to be an "approved supervisor". Please provide all information below applicable to your qualifications and experience.

6(a) Are you licensed as an Educational Psychologist by the Massachusetts Board of Allied Mental Health and Human Services Professions or any other State's Board?

_____Yes _____No License Number _____ License Status _____

(b) If not currently licensed are you eligible to be licensed as an Educational Psychologist?_____Yes _____No

(c) Are you a Nationally Certified School Psychologist?_____No_____Yes

If Yes, NCSP Certificate Number _____

If you are not licensed, please provide transcript of graduate training and Praxis II School Psychology Examination score OR verification of your NCSP status (copy of certification card) to demonstrate eligibility for licensure/ approved supervisor qualifications.

(d) Do you hold a Dept. of Education License or Certification as a School Psychologist?

_____Yes _____No If Yes, Certification Number _____

(e) Provide dates of your Post Master's Degree Experience in School Psychological Services.

From_____To_____Total # of Years Experience _____

(Minimum 5 years experience required)

I, the undersigned state, under the pains and penalties of perjury, that the above statements are true.

Signature of Approved Supervisor _____

Date _____

Print Name _____

Title/Position _____

Address _____

The Commonwealth of Massachusetts
Division of Professional Licensure
Board of Registration of Allied Mental Health and
Human Services Professions
1000 Washington Street, Suite 710
Boston, MA 02118-6100

PROFESSIONAL REFERENCE FORM

INSTRUCTIONS: All applicants must submit a minimum of TWO professional references. Please duplicate this form as necessary and provide it to your post-master's supervisor, as well as, your most recent supervisor (if this is also your post-master's supervisor, then provide it to your next most recent supervisor). *PLEASE PRINT CLEARLY OR TYPE AND SUBMIT ORIGINAL SIGNED DOCUMENT.*

Waiver of Liability: (Must be completed by licensure applicant)

I,_____, hereby authorize _____
(applicant's name) (reference's name)
(hereinafter "the reference") to provide the Board of Registration of Allied Mental Health and Human Service Professionals with all information of any kind that the reference may, in his or her absolute discretion, deem relevant to my qualifications as an applicant. I hereby release and discharge the professional reference from all claims arising out of the provision of such information.

Applicant's signature:_____Date: _____

Remainder of Form to be completed by Approved Supervisor

General information for references completing this form:

- **The Board assumes that you, in recommending this applicant, will be willing to interpret or to substantiate to the Board your recommendation, should the Board desire to contact you. The Board will keep all information confidential to the maximum extent permitted by law.**
- **Complete this reference form only if the applicant has signed the above waiver of liability.**

Reference's name:_____Title: _____

Reference's license type:_____License number/Jurisdiction: _____

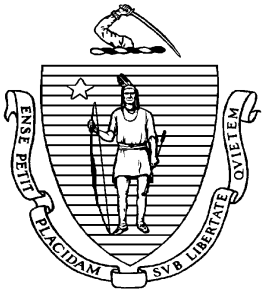
Length of time the reference has known the applicant: from_____to _____

Extent of knowledge of applicant's professional and ethical behavior:
☐Thorough ☐Moderate ☐Limited

Based on my experience, to the best of my knowledge, the applicant is an individual of good moral character:
☐Yes ☐No ***(if no, please explain on a separate sheet)***

Quality and extent of endorsement: ☐Without reservation ☐With reservation ☐No recommendation
(if "with reservation" or "no recommendation", please explain on a separate sheet)

Signature of Reference **Date**



The Commonwealth of Massachusetts
Division of Professional Licensure
Board of Registration of Allied Mental Health and
Human Services Professions
1000 Washington Street, Suite 710
Boston, MA 02118-6100

PROFESSIONAL REFERENCE FORM

INSTRUCTIONS: All applicants must submit a minimum of TWO professional references. Please duplicate this form as necessary and provide it to your post-master's supervisor, as well as, your most recent supervisor (if this is also your post-master's supervisor, then provide it to your next most recent supervisor). *PLEASE PRINT CLEARLY OR TYPE AND SUBMIT ORIGINAL SIGNED DOCUMENT.*

Waiver of Liability: (Must be completed by licensure applicant)

I,_____, hereby authorize _____
(applicant's name) (reference's name)
(hereinafter "the reference") to provide the Board of Registration of Allied Mental Health and Human Service Professionals with all information of any kind that the reference may, in his or her absolute discretion, deem relevant to my qualifications as an applicant. I hereby release and discharge the professional reference from all claims arising out of the provision of such information.

Applicant's signature:_____Date: _____

Remainder of Form to be completed by Approved Supervisor

General information for references completing this form:

- **The Board assumes that you, in recommending this applicant, will be willing to interpret or to substantiate to the Board your recommendation, should the Board desire to contact you. The Board will keep all information confidential to the maximum extent permitted by law.**
- **Complete this reference form only if the applicant has signed the above waiver of liability.**

Reference's name:_____Title: _____

Reference's license type:_____License number/Jurisdiction: _____

Length of time the reference has known the applicant: from_____to _____

Extent of knowledge of applicant's professional and ethical behavior:
☐Thorough ☐Moderate ☐Limited

Based on my experience, to the best of my knowledge, the applicant is an individual of good moral character:
☐Yes ☐No ***(if no, please explain on a separate sheet)***

Quality and extent of endorsement: ☐Without reservation ☐With reservation ☐No recommendation
(if "with reservation" or "no recommendation", please explain on a separate sheet)

Signature of Reference **Date**

Educational Psychologist Application Check list:

PLEASE BE SURE TO SUBMIT THIS WITH YOUR APPLICATION

MANDATORY

My social security number is: ☐☐☐-☐☐-☐☐☐☐

Pursuant to G.L. c. 62C, § 47A, the Division of Professional Licensure is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you are in compliance with the tax laws of the Commonwealth.

Please be sure you have provided:

____Completed application w/ photo.

_____Check/Money Order payable to "Comm. of MA" for non-refundable application fee of $117.00.
Please note that an initial licensure fee of $155.00 will be due when all requirements have been met and is separate from the application fee.

_____Official, sealed Transcript(s) (Non-Baccalaureate degrees only).

_____Verification of supervised practicum/ internship from Academic Program Director (must request written statement from Academic Program Director).

___Copy of current certification from Department of Education or other acceptable entity.

_____If currently or previously licensed in another State, official letter of verification from that State in sealed envelope.

____Two professional reference forms completed by two most recent supervisors.

___Complete Criminal Offender Record Information Request Form, including notarization.

COMMONWEALTH OF MASSACHUSETTS
1000 Washington Street, Suite 710
Boston, MA 02118-6100

CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT FORM

The Division of Professional Licensure by itself and on behalf of boards of registration pursuant to M.G.L. c. 13, §9 [hereinafter, "Division of Professional Licensure"] is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective license applicants and current licensees.

As a license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Services ("DCJIS"). I hereby acknowledge and provide permission to the Division of Professional Licensure to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing the Division of Professional Licensure written notice of my intent to withdraw consent to a CORI check.

FOR LICENSING PURPOSES ONLY:

I understand that the Division of Professional Licensure may conduct a subsequent CORI check within one year of the date this Form was signed by me.

By signing below, I provide my consent to an initial CORI check and a subsequent CORI check, both within one year of the date of this Form, and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

_____ _____

Signature Date

Please provide the name of the board of registration and license type for which you are applying or currently hold:

_____ _____

Board of Registration License Type

NOTE: DPL CANNOT ACCEPT THIS TWO-PAGE CORI ACKNOWLEDGMENT FORM UNLESS IT IS EITHER (1) SIGNED IN PERSON AT THE BOARD'S OFFICES IN THE PRESENCE OF A DPL EMPLOYEE WHO HAS VERIFIED THE APPLICANT'S IDENTITY THROUGH ACCEPTABLE IDENTIFICATION, OR (2) SIGNED IN THE PRESENCE OF A NOTARY PUBLIC WHO HAS LIKEWISE VERIFIED IDENTITY AND THEN MAILED OR OTHERWISE DELIVERED TO THE BOARD'S OFFICES AT THE ADDRESS SET FORTH ABOVE.

SUBJECT INFORMATION: (A red asterisk (*) denotes a required field)

_____

*Last Name *First Name Middle Name Suffix

_____

*Maiden Name (or other name(s) by which you have been known)

_____ _____

*Date of Birth Place of Birth

* Social Security Number: _____-_____-_____

Sex: _____ Height: ____ ft. ____ in. Eye Color: _____

Driver's License or ID Number: _____ State of Issue: _____

Current and Former Addresses:

_____

Street Number & Name City/Town State Zip

_____

Street Number & Name City/Town State Zip

_____

IDENTITY VERIFICATION SECTION: If this form is submitted by hand at DPL Offices, Section A must be completed. Otherwise, Section B must be completed.

SECTION A: VERIFICATION BY DPL EMPLOYEE: I hereby certify that I verified the identity of the above-referenced subject by reviewing the following form(s) of government-issued identification:[1]

☐ Passport ☐ State-issued driver's license ☐ Military identification ☐ State-issued identification card

VERIFIED BY: _____

Name of Verifying DPL Employee (Please Print)

_____

Signature of Verifying DPL Employee Date

SECTION B: VERIFICATION BY NOTARY:

On this _____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____ (name of document signer), and proved to me through satisfactory evidence of identification, which was the following:[1]

☐ Passport ☐ State-issued driver's license ☐ Military identification ☐ State-issued identification card

to be the person whose name is signed on the preceding or attached document, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose.

_____

Notary Public: Notary Commission Expires On

[1] If a subject does not have an acceptable government-issued identification, his or her identity shall be verified by other forms of documentation as determined by DCJIS. 803 CMR 2.09(2).