The Commonwealth of Massachusetts
Division of Professional Licensure
Board of Psychologists
1000 Washington Street, Suite 710
Boston, MA 02118-6100
(617) 701-8782
pyboard@mass.gov

Psychologist Application Checklist

I. How to Apply: You Must Apply Online

Applications are only accepted through the ePlace portal. To apply, create an account, log in, click on "Manage Licenses, Permits and Certificates," "File an Online Application," accept the terms, scroll down to "Board of Psychologists," click the arrow next to it, then select "Psychologist Application," click "Continue" at the bottom of the page, and follow the instructions.

Please review the Board's regulations before you apply.

II. Application Materials

All forms except the Criminal Offender Record Information (CORI) Acknowledgement Form are appended to this checklist.

A. Documents Required from All Applicants

1. All applicants must have the following information or documents to upload. These documents should be uploaded by the applicant and not emailed or mailed to the Board by you or the person who completed the form.

   - ❑ Academic Program Director Form
     - This form must be completed by the Chair of the department or training director for your doctoral program.
   - ❑ A notarized CORI Acknowledgement Form
   - ❑ You must use a credit card or checking account to pay the non-refundable application fee of $150.

2. All applicants must arrange for the following to be emailed (to pyboard@mass.gov) or mailed (to the address above) to the Board:

   - ❑ Your doctoral program must send an official transcript.
   - ❑ Professional and Ethical Reference Form
     - Each applicant must have three references submit this form directly to the Board. Each reference must be a licensed psychologist, licensed board-certified psychiatrist, or licensed independent clinical social worker. At least two references must have "thorough" knowledge of your professional and ethical behavior, and one may have "moderate" knowledge. At least

one reference must be a licensed psychologist, and one reference must have directly supervised you.

3. All applicants must, before applying:

   - ❑ Complete a board-approved training in domestic and sexual violence. Please see chapter260training.org to take the free online training.

   - ❑ Regardless of where you plan to practice, apply to be a fully participating or non-billing provider with MassHealth. Contact the MassHealth Customer Service Center for Providers at (800) 841-2900 (Main), (800) 497-4648 (TTY), or providersupport@mahealth.net.

B. Documents Required for Some Applicants

1. If you have already taken the EPPP and passed, you must arrange for the following to be emailed (to pyboard@mass.gov) or mailed (to the address above) to the Board from the Association of State and Provincial Psychology Boards (ASPPB) (https://www.asppb.net):

   - ❑ EPPP Score Report

2. If you currently hold or have previously held a professional license in another jurisdiction, regardless of its status, please arrange for the following to be emailed (to pyboard@mass.gov) or mailed (at the address above) to the Board by the issuing entity:

   - ❑ Official License Verification

     - Please contact the Board for further directions in the event the entity that licensed you does not issue verifications and only offers an online license lookup. A copy of your license is not an acceptable alternative.

3. If you are applying for your first license in any jurisdiction, or you do not qualify as a licensed psychologist listed in the National Register of Health Service Psychologists (see below), you must also upload the following documents:

   - ❑ Internship Program Director Form

   - ❑ Post-Internship Supervisor Form

     - This form must be completed by each supervisor – submit as many forms as necessary to capture enough qualifying experience – **or**, if your program had a training director, the director can complete the Internship Program Director Form.

4. If you are applying for your first license in any jurisdiction, or you are not listed in the National Register of Health Service Psychologists (see below), you **may** also upload the following document, but it is not required:

   - ❑ Advanced Practicum Supervised Experience Form

- Applicants may combine practicum and post-doctoral hours for the non-internship hours required. This form must be completed by the training director of your doctoral program.

5. If any setting in which you accrued experience hours is not clearly a health service setting, you must also upload the following document:

   ❑ "Is This a Health Service Setting?" Form

   - This form must be completed by the training director or supervisor at the site in question.

C. Licensed for at Least Five Years and Listed in National Register of Health Service Psychologists

1. If you are licensed in good standing as a psychologist in another state and have been for at least five years, and you are currently listed in the National Register of Health Service Psychologists (https://www.nationalregister.org), you also must arrange for the following to be emailed (to pyboard@mass.gov) or mailed (at the address above) to the Board:

   ❑ Official Verification of Registration with National Register of Health Service Psychologists

2. If you qualify in (1) above, you do not have to submit the Internship Program Director Form, the Post-Internship Supervisor Form, or the Advanced Practicum Supervised Experience Form.

D. Foreign Graduates or Graduates from Non-Qualifying Doctoral Programs:

1. If you received your doctorate from a foreign institution, please contact the Board before applying for information about a foreign credentials evaluation.

2. If your doctoral program was not accredited by the American Psychological Association (APA) or the Canadian Psychological Association (CPA) at the time you graduated or within three years thereafter, your degree does not qualify for licensure in Massachusetts. Please contact the Board before applying for information about respecialization programs.

E. Application Review and Approval

After your application is reviewed, you will be notified by email of any deficiencies in your application or with instructions on how to take the EPPP or Massachusetts Jurisprudence Examination. All applicants must take the Massachusetts Jurisprudence Examination as the last step before being licensed.

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ACADEMIC PROGRAM DIRECTOR FORM

(To be filled out by Academic Director of Doctoral Program in Psychology)

Name of Applicant _____

Name of Program Director _____

Institution _____

Department _____

Title of Program _____

Address _____

Applicants for licensure as psychologists must attend doctoral programs in Psychology which meet program requirements outlined in 251 CMR 3.03. Please indicate with a check mark whether the academic program the applicant completed at your institution met these requirements.

YES	NO	
_____	_____	Program was accredited by the Commission on Accreditation (COA) of the American Psychological Association, or designated as a doctoral program in psychology by the Association of State and Provincial Psychology Boards or the National Register of Health Service Psychologists, at the time the degree was granted or within three years thereafter
_____	_____	Training is at the doctoral level and offered in a regionally accredited institution of higher education
_____	_____	Stands as a coherent, recognizable entity in your institution
_____	_____	There is clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines

YES	NO	
_____	_____	Is an organized sequence of study
_____	_____	Has an identifiable psychology faculty, and a psychologist responsible for the program
_____	_____	Has an identifiable body of students who have matriculated in that program for a degree
_____	_____	Includes supervised practica, internship, or laboratory training appropriate to the practice of psychology
_____	_____	The curriculum includes a minimum of three academic years of full-time graduate study, of which a minimum of one academic year of full-time academic graduate study in Psychology is completed in residence at the institution granting the doctoral degree
_____	_____	Dissertation or equivalent is psychological in method and content

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This form must be signed.

I, the undersigned do state under the penalties of perjury that the answers given above are true and correct.

Date: _____ _____

Academic Program Director's Signature

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PROFESSIONAL AND ETHICAL REFERENCE FORM

Name of Applicant_____

1. Name of endorser_____ 2. Title_____

3. Address_____

4. Telephone number_____ 5. Email Address_____

5. Relationship of endorser to applicant (e.g. supervisor, consultant, collaborator, colleague, teacher, or other)

_____

6. Length of time applicant known: From _____ to _____
month/year month/year

7. Indicate the setting(s) in which you have known applicant, description of applicant's duties, and extent of your contact with applicant.

_____

_____

_____

8. Extent of knowledge of applicant's professional and ethical behavior:

Limited _____ Moderate _____ Thorough _____

9. Do you certify that the applicant is an individual of good moral character? Yes _____ No _____

10. Quality and extent of endorsement:

Without reservation _____ With reservation _____ No endorsement _____

If you checked "With reservation" or "No endorsement", please specify reasons:

_____

11. Do you feel that the applicant conducts his/her activities as a psychologist in conformance with the Code of Ethics of the American Psychological Association?

Yes _____ No _____ If no, please explain:

_____

_____

_____

12. Are you licensed or certified as a psychologist?

Yes _____ No _____ License number_____ State _____

13. Are you a psychiatrist certified or eligible for Board certification by the American Board of Psychiatry?

Yes _____ No _____ License number_____ State_____

14. Are you a Licensed Independent Clinical Social Worker?

Yes _____ No _____ License number_____ State _____

I, the undersigned, do state under the penalties of perjury that the answers given above are true and correct.

DATE: _____ _____

ENDORSER'S SIGNATURE

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INTERNSHIP PROGRAM DIRECTOR FORM

INTERNSHIP DIRECTOR TO COMPLETE THIS FORM

1. Name of Applicant _____

2. Name of Internship Director _____

3. Licensure information of Internship Director _____
License type State License Number

4. Facility where applicant trained (name and address)

_____

_____

5. Department _____

6. Title of Training Program _____

Part A.

1. Applicant's title while working in this facility _____

2. What percentage of time did the applicant have direct client/patient contact? _____%

3. Did the internship provide at least four hours (total) in structured learning activities on issues related to racial/ethnic bases of behavior with a focus on people of color? Yes _____ No _____

4. Was this internship APA-approved (pre- or post-doctorally)? Yes _____ No _____

(If you answered "yes" to question 4, please skip Section B and GO TO SECTION C .

Part B. Internship Director to complete Part B ONLY if program is not APA-approved.

YES	NO	
_____	_____	Is the site an organized training program, not a supervised experience or on-the-job training?
_____	_____	A licensed psychologist is responsible for the integrity and quality of the program
_____	_____	There are two or more licensed psychologists on the staff as supervisors. If the site has 5 or fewer mental health professionals on staff, there is one full-time psychologist and a board certified or board eligible psychiatrist or licensed independent psychiatric social worker.
_____	_____	Training was at post-clerkship, post-practicum, and post-externship level
_____	_____	Supervision was conducted by a licensed professional who carried full legal and clinical responsibility for cases being supervised.
_____	_____	At least half of the hours of supervision were delivered by one or more psychologists
_____	_____	Program provided training in a range of approaches to assessment and intervention
_____	_____	At least 25% of the trainee's time was in direct contact with clients seeking assessment or treatment (minimum 400 hours for full-time internship)
_____	_____	Training included supervision at a minimum ratio of one hour of acceptable supervision per sixteen hours of work (1:16), regardless of whether the training was completed in one year or two.
_____	_____	Program offered at least four hours per week of structured activities such as case conferences, seminars on clinical issues, group supervision, and additional individual supervision (prorated for half-time internship)
_____	_____	There were at least two psychology interns at the internship training level during the applicant's period
_____	_____	Trainee had the title "intern", "resident", "fellow", or other designation which clearly indicated his/her training status
_____	_____	The training program had a written statement describing goals and content of the program, and expectations for quantity and quality of trainee's work. This statement was available prior to onset of program

Part C.

Exact dates of Internship Experience:

From _____ to _____= (A)_____
(month/day/year) (month/day/year) (total number of weeks)

Number of weeks vacation/leave time = (B)_____

Total number of weeks worked excluding vacation/leave time (A minus B) =_____(actual)

Total hours per week applicant worked in setting (no more than 50) =_____

Name and Degree of Supervisor	**State of Licensure**	**License #**	**Hours <u>per week</u> of supervision**	**Total # of weeks of supervision**	**Group or Individual**	**If group, group size?**

_____YES _____NO Was a qualifying supervisor (licensed psychologist, board-certified psychiatrist, or licensed independent clinical social worker) on the premises at all times in which the trainee delivered health services? (Please note that cell phone availability does not meet this requirement).

_____YES _____NO Did the supervisor(s) have full legal, professional, and ethical responsibility for the applicant's work? If "no", please attach an explanation.

Please provide detailed description of applicant's duties and activities:

_____

_____

_____

_____

PLEASE COMPLETE THE ADDITIONAL FORM "IS THIS A HEALTH SERVICE SETTING?" IF THE INTERNSHIP SETTING IS NOT CLEARLY A "HEALTH SERVICE SETTING"

This form must be signed.

I, the undersigned, do state under the penalties of perjury that the answers given above are true and correct.

Date: _____ _____

Internship Director's Signature

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POST-INTERNSHIP SUPERVISOR FORM

INSTRUCTIONS

1. To enable the Board to evaluate effectively the applicant's experience, ACCURATE and SPECIFIC information is required. Please fill out this form carefully.

2. A separate form for each continuous period of experience and supervisor is required.

3. Please note that Massachusetts regulations require that the applicant must receive AT LEAST ONE HOUR OF QUALIFYING SUPERVISION FOR EVERY SIXTEEN HOURS OF WORK.

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1. Name of Applicant_____

2. Name of facility where applicant worked_____

   Address of facility: _____

   _____

   Address where you supervised applicant (if different from above):

   _____

3. Applicant's title while working in this facility: _____

4. **If the site is not clearly a health service setting, submit the "Is This a Health Service Setting" form.**

5. Was a qualifying supervisor on the premises at all times in which the trainee delivered health services? (Please note that cell phone availability does not meet this requirement.)

   _____YES _____NO

SUPERVISOR INFORMATION

6. Name and degree of Supervisor_____

7. Address of Supervisor_____

   _____

8. Telephone number _____ Email address: _____

9. Licensure information of Supervisor _____
   License type State License Number

10. If you are licensed psychologist in Massachusetts, are you certified as a Health Service Provider?

    YES_____ NO_____

11. If you are a psychiatrist, are you Board-certified in Psychiatry?

    YES_____ NO_____

12. If you are a Social Worker, are you licensed at the Independent Practice level in your state of Licensure?

    YES _____ NO_____

13. Applicant level was ( ) Pre-doctoral ( ) Post-doctoral

14. Applicant worked in (check one only):

    a. Paid professional position ( )

    b. Post-doctoral fellowship ( )

    d. Other (explain) ( )

    _____

15. Exact dates of Supervision:

    From _____ to _____= (A)_____
    (month/day/year) (month/day/year) (total number of weeks)

    Number of weeks vacation/leave time = (B)_____

    Total number of weeks excluding vacation/leave time (A minus B) =_____(actual)

16. Total **hours per week** applicant worked in setting (no more than 50) =_____

17. Exact number of **hours per week** <u>you</u> supervised applicant _____

How many hours per week were in individual supervision? _____

How many hours per week were in group supervision? _____

How many supervisees/trainees were in the group? _____

18. Give detailed description of applicant's duties and activities: _____

_____

_____

19. What percentage of time did the applicant have direct client/patient contact: _____%

20. For what areas or fields of competency does this experience qualify applicant?

_____

_____

21. During the time of your supervision with applicant, what was your formal/legal relationship with the facility in which the training occurred?

_____

_____

22. Did you have full legal, professional, and ethical responsibility for the applicant's work?

Yes _____ No _____ (**If "No", please attach an explanation**)

This form must be signed.

I, the undersigned, do state under the penalties of perjury that the answers given above are true and correct.

Date: _____ _____

Supervisor Signature

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ADVANCED PRACTICUM SUPERVISED EXPERIENCE FORM

INSTRUCTIONS

1. To enable the Board to effectively evaluate the applicant's experience, ACCURATE and SPECIFIC information is required. Please complete this form carefully.

2. A separate form for each continuous period of experience is required.

3. **This form must be completed in its entirety by the individual named in Question 3. The applicant is prohibited from completing this form. Failure to follow this instruction will render the form invalid.**

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1. **Name of Applicant** _____

2. **Name of Doctoral Program** _____

3. **Name of Individual Completing this Form**_____

4. **Licensure information of individual completing this form** _____
   License type State License Number

5. **Title of Individual Completing this Form**

   ___ Academic Director ___Primary Advisor of Applicant ___Practicum Director

   ___ Other (please explain)_____

6. **Name of Training Facility where applicant worked**: _____

   Address of facility: _____

   _____

7. **Applicant's title while working in this facility** _____

8. **Written Training Plan requirement**: Please attach to this form a copy of the written training plan among the student, the advanced practicum training site, and the graduate training program. This plan must describe how the trainee's time was allotted and how the plan assured the quality, breadth, and depth of the training experience through specification of goals and objectives, and methods of evaluation of the trainee's performance.

9. **What percentage of time did the applicant have direct client/patient contact? _____%**

10. **If the training facility is not clearly a health service setting, please submit "Is This A Health Service Setting" Form.**

11. **Please answer all questions below.**

_____YES _____NO Was a qualifying supervisor (licensed psychologist, board-certified psychiatrist, or licensed independent clinical social worker) on the premises at all times in which the trainee delivered health services? (Please note that cell phone availability does not meet this requirement.)

_____YES _____NO Was this supervised experience completed AFTER a minimum of two full-time post-bachelor's academic years of graduate education in psychology, at least one year of which was completed in the degree-granting doctoral program?

_____YES _____NO Did the student provide services that are within the scope of the education received in the doctoral program?

_____YES _____NO Were at least 50% of the total hours of supervised experience in this advanced practicum in "service-related" activities, defined as "treatment/intervention, assessment, interviews, report writing, case presentations, and consultations"?

_____YES _____NO Did the applicant receive a minimum of TWO hours of **INDIVIDUAL** face-to-face supervision with a qualifying licensed supervisor **per week**?

_____YES _____NO Was at least half of the supervision provided by a licensed psychologist?

_____YES _____NO Did the applicant receive a minimum of one hour of individual or group supervision (group size no larger than 3 trainees) for each 16 hours of work?

_____YES _____NO Did the supervisor(s) have full legal, professional, and ethical responsibility for the applicant's work? If "no", please attach an explanation.

Exact dates of Advanced Practicum Experience:

From _____ to _____= (A)_____
(month/day/year) (month/day/year) (total number of weeks)

Number of weeks vacation/leave time = (B)_____

Total number of weeks worked excluding vacation/leave time (A minus B) =_____(actual)

Total hours per week applicant worked in setting (no more than 50) =_____

Name and Degree of Supervisor	State of Licensure	License #	Hours per week of supervision	Total # of weeks of supervision	Group or Individual	If group, group size?

Please provide or attach detailed description of applicant's duties and activities:

_____

_____

_____

This form must be signed.

I, the undersigned, do state under the penalties of perjury that the answers given above are true and correct.

Date: _____ _____

Signature of Individual Completing this Form

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"IS THIS A HEALTH SERVICE SETTING?" FORM

Name of Individual Completing this Form **Position/Title**

Name of Applicant **Name of Facility where Applicant Worked**

_____YES _____NO Is this facility a defined entity with programmatic coherence (e.g., clinic, hospital, school counseling center, department, division)? Please explain below.

_____YES _____NO Does this facility have a secure place for confidential records?

_____YES _____NO Does this facility teach and comply with HIPAA regulations (in addition to FERPA, where relevant)?

_____YES _____NO Does this facility provide clinical supervision by qualifying licensed professionals who are on the premises? The supervisors should have the competencies described below.

_____YES _____NO Does this facility have a protocol covering emergencies, after-hours coverage, vacation periods, and extended breaks? Please explain below or attach additional information.

_____YES _____NO Does the facility have a referral network for services that are not provided by the health service setting (e.g., medication)? Please explain below.

_____YES _____NO If research is a major component of the mission of this setting, does the setting have (i) clients/patients who are not participating in research protocols, (ii) other clinical services not part of the research protocols that are available to all clients/patients, (iii) a protocol for ensuring continuity of care for clients who withdraw from research projects?

Are each of the following competencies taught? Please feel free to attach additional information.

_____YES _____NO ***Psychological evaluation skills*****.** May include intakes, diagnostics, psychosocial history, case formulation, or psychological testing.

_____YES _____NO ***Psychological intervention skills***. Conducting psychotherapy based on knowledge of theory and research. Includes a range of psychotherapeutic intervention (e.g., family therapy, group therapy, cognitive behavior therapy, applied behavior analysis, psychoeducation). Includes case formulation, development of treatment plans, implementation of treatment plans. In child settings, the trainee should have contact with family members involved in the child's care.

_____YES _____NO ***Consultation skills***. Includes knowledge of the roles of other professionals, including other health service professionals, and the ability to relate to them in a collegial fashion. Knowledge of the formal and informal organizational structure and the ability to apply that knowledge so that consultations can have maximal impact. Trainees should have significant exposure to other health care professionals.

_____YES _____NO ***Evidence-based practice***. Integration of the best available research with clinical skill in all areas of functioning (i.e., psychological assessment, psychotherapeutic intervention, consultation). Application of knowledge from the classroom to clinical situations and problems.

_____YES _____NO ***Relationship/Interpersonal skills***. Ability to form and maintain productive relationships with others. Productive relationships are respectful, supportive, professional, and ethical. Ability to understand the role of psychologists in the setting and to maintain appropriate professional boundaries. Ability to work collegially with other professionals and to form positive therapeutic alliances with clients/patients. Ability to work collaboratively with one's supervisor.

_____YES _____NO Does the training involve providing services to a clientele of sufficient number and clinical diversity?

_____YES _____NO Is the trainee exposed to clients with psychopathology and a significant level of impairment?

_____YES _____NO Does the trainee have the opportunity to work with a variety of clinical problems?

I, the undersigned, do state under the penalties of perjury that the answers given above are true and correct.

Date: _____ _____

Signature of Training Site Supervisor or Training Director at Doctoral Program