The Commonwealth of Massachusetts
Board of Registration of Psychologists
Division of Professional Licensure
1000 Washington Street, Suite 710
Boston MA 02118-6100
(617) 727-9925

APPLICATION PACKET CHECKLIST

This page **must be** included in a complete application. Please note that not all of the items in this list are required in each application.

Name: _____

Social Security Number (mandatory): _____

Pursuant to G.L. c. 62C, s. 47A, the Division of Registration 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.

_____ Completed Application Form, signed by applicant and notarized **REQUIRED**

_____ Official transcript from doctoral program (in sealed envelope) **REQUIRED**

_____ Academic Program Director Form (in signed, sealed envelope) **REQUIRED**

_____ Three Professional/Ethical Forms (in signed, sealed envelopes) **REQUIRED**

_____ Internship Program Director Form(s) IF APPLYING FOR HSP (in signed, sealed envelope(s))

_____ Advanced Practicum Supervised Experience Form(s) (in signed, sealed envelope(s))

_____ Post-Internship Supervisor Form(s) (in signed, sealed envelopes)

_____"Is This A Health Service Setting?" Form

_____ Supervised Experience Form **REQUIRED**

_____ Academic Coursework Form (if required)

_____ $150 check made payable to "Commonwealth of Massachusetts-PY" **REQUIRED**

_____ Official EPPP score report from ASPPB (if you have already taken and passed this exam) (mailed directly to the Board by ASPPB)

_____ Letters of good standing from any state in which you have held a license (in sealed envelope)

_____ Certification letter from National Register of Health Service Psychologists (mailed directly to the Board by the National Register)

_____ Completed Criminal Offender Record Information Request Form, including notarization. **REQUIRED**

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INSTRUCTIONS FOR LICENSING APPLICATION FOR LICENSE TO PRACTICE PSYCHOLOGY IN MASSACHUSETTS

General Information

1. **New Applicants**: A "new" applicant is an individual who has never been licensed or certified as a psychologist in any other state or jurisdiction. New applicants must submit the complete licensure application and supporting materials to the Board when their required supervised hours are complete. Candidates should expect notification of their eligibility within 60 days of receipt. Upon approval from the Board, candidates must take and pass both the EPPP and Jurisprudence examinations within 3 years. Once approved, you will receive by mail and/or email the appropriate registration form and instructions for scheduling both the EPPP and jurisprudence exams. If you have already taken and passed the EPPP in another jurisdiction, you must contact ASPPB to arrange for them to send Massachusetts the Official ASPPB Score report for the EPPP exam. If you take and do not pass the EPPP exam or Jurisprudence exam, Board regulations require that you must wait three months between each test administration.

   Applicants from doctoral programs outside the USA: You must first have your doctoral degree evaluated by an educational credentials evaluation service acceptable to the Board, to determine if your degree is the equivalent of a doctoral degree in Psychology as defined by Board regulations. Please call the Board office for further instructions.

2. **Applicants licensed in another state**: Massachusetts does not have formal reciprocity with any other state or jurisdiction. However, if you have been licensed in another jurisdiction for five or more years, have a doctoral degree from an APA-approved or ASBBP/National Register designated doctoral program in psychology, AND you are listed in the National Register of Health Service Psychologists, you do not need to submit the following forms: Internship Director Form, Supervisor Form for Post-Internship Supervised Experience. All other forms must be submitted.
   In addition, you **do** need to submit:
   1) Verification letters from all states/jurisdictions in which you have held licensure
   2) Official ASPPB Score report for the EPPP exam
   3) Certification letter from the National Register

   Please contact the Board office if you have further questions. Once your application has been approved by the Board, candidates will receive the appropriate registration form for scheduling the Jurisprudence exam. If you do not achieve a passing score, you must wait three months between each Jurisprudence exam administration.

3. The applicant must submit all application materials**, including forms which are filled out by other individuals and transcripts**, at the same time in a large envelope. The following will describe the procedures to follow in order to do this correctly:
   Provide a self-addressed envelope to your endorsers for your Professional and Ethical Reference forms, all Supervisor forms, Academic Program Director Form, and Internship Program Director Form. After the individual has completed the form (or placed an official

seal on your transcript), he/she must seal it in the envelope you provided, sign his/her name across the envelope seal, and return it to you. **Envelopes which are not signed and sealed in this manner or have been opened after being sealed will not be accepted**. It is your responsibility to provide these instructions to each endorser/program explaining the procedure to be followed. If you need additional forms, please print additional copies from the application forms.

4. Send application and application fee ($150.00) to the Board at the address listed above. Checks should be made payable to "Commonwealth of Massachusetts-PY".

5. The Board does not accept photocopies or fax copies of completed forms or Verifications of licensure from other states. All signatures must be originals, and the Board does not accept "E-signatures".

6. The regulations which govern the licensing and practice of psychologists are set forth in 251 CMR (Code of Mass. Regulations). The laws which govern the licensing and practice of psychologists are set forth in M.G.L. c.112, sections 118-129B. Applicants should read the laws and regulations thoroughly to understand whether they qualify for licensure. These are available at the Board's web-site.

7. The Board recommends that you keep a copy of your application prior to mailing it to the Board. Endorsers and supervisors may also be willing to provide you with a copy of the document(s) each has completed.

8. Pursuant to 251 CMR 3.02(3), your application will be considered DENIED by the Board if you do not submit additional documentation requested by the Board within six months of the date of the Board's written notice to you. Applicants whose application has been denied by the Board must re-apply.

Specific item by item instructions for the Application

1. Type or print your full legal name as it should appear on your license. The name you provide must match the photo ID required for your admission to the examination(s).

2. Provide an address at which you can reliably receive mail, and which you understand to be a PUBLIC RECORD. Massachusetts law requires the Division of Professional Licensure to provide an address for each licensee upon request by any other agency or member of the public. Massachusetts residency is not required for licensure in Massachusetts. If at any time during the licensure process (or once you become licensed) your address should change, you are required to complete an address change form (available at the Board's web-site) or otherwise notify the Board in writing.

3. Provide your telephone number(s), and indicate which is the preferred number at which you can be reached.

4. Please provide an email address. The Board typically communicates via email with applicants if there are issues in the application forms which the applicant must address.

5-6. Please answer these questions.

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7. If you are active duty military, a veteran, or a relocated spouse, please download the Valor Act Form from the Board's web-site. If you qualify, the Division of Professional Licensure will waive the initial licensure fee.

8. Please answer the question.

9. Please provide information about any professional licenses you currently hold or have held in the past in any other state or jurisdiction. You are required to submit verification letters from all of these entities.

10-17. Please answer all questions asked, attaching any additional documentation as requested. Your application cannot be processed without this information.

18-19.Please provide information as requested.

20. If your doctoral degree is in psychology but is not from a qualifying doctoral program in psychology which meets the regulatory requirements for licensure and certification as a health service provider, you must document completion of an APA-approved re-specialization program.

21. Please provide information if you are licensed 5 or more years in another jurisdiction AND listed in the National Register of Health Service Providers in Psychology. You must arrange for the National Register to submit a certification letter to the Board.

22. All applicants must have three Professional and Ethical references from qualifying licensees, at least two of whom feel that his/her knowledge of you is "thorough". One may be "moderate". Qualifying licensees are Licensed psychologists, Board-certified psychiatrists, or Licensed Independent Clinical Social Workers. At least one form must be from a licensed psychologist, and at least one must have directly supervised you. Please refer to instructions on the form. **Remember that these forms must be returned to you in an envelope signed across the seal by the endorser, and also note that you are prohibited from completing any of the information on this form below your signature line. Do not answer ANY questions below the signature line.**

23. You must sign this application in the presence of a notary public, and have the notary sign and affix a seal. Your signature certifies that you have read all the information in a, b, c, and d., and that it is truthful and accurate.

Other Forms

1. Academic Program Director Form
   This form can be completed by the Chair of your department at your doctoral program, or your training director at the doctoral program.

2. Professional-ethical Forms
   Please note that eligible endorsers are those who hold one of the following licenses: Licensed Psychologist, Board-certified Psychiatrist, or Licensed Independent Clinical Social Worker. Non-licensees are not eligible. Please note that it is perfectly acceptable for an individual to complete this form as well as one of the other required forms, e.g., Supervisor form, Internship Director Form, etc.

3. Advanced Practicum Supervised Experience Form
   The requirements for advanced practicum hours are described in 251 CMR 3.04(7). Please review these carefully. This form must be completed by the Training Director at your doctoral program.

4. Internship Program Director Form
   Internship is also referred to in the regulations as a "health service training program". Internship criteria are described in 251 CMR 3.04(8) AND 3.06. Please read both of these sections carefully. To qualify for Health Service Provider certification, you must meet the regulatory requirements of a health service training program (one year internship: minimum of 1600 hours, minimum of 10 months/43 weeks of work, at least 100 hours of qualifying supervision), and have a total of two years of qualifying supervised experience in a health service setting, which includes the internship year. A year is defined as no fewer than 10 months/43 weeks.

5. Post-Internship Supervised Experience Form
   The supervisor(s) for your post-doctoral or post-internship supervised experience must each complete this form. If you completed a formal post-doc with a training director, your training director may complete the Internship Program Director Form instead of having each supervisor complete the Post-Internship Supervised Experience Form.

6. "Is This A Health Service Setting?" Form
   This form must be completed by the Training Director or Supervisor at any setting in which you accrued supervised experience if this setting is not clearly a health service setting.

7. Supervised Experience Form
   This form is completed by the applicant. Please fill it out completely and accurately. This form will be compared with the Supervisor forms which you submit. Any discrepancies may result in denial or delay of your licensing application.

8. Documentation of Academic Coursework Form
   This form is required ONLY for re-specialization candidates or those applicants who completed a doctoral degree in psychology outside the USA.

9. Application Packet Checklist: This is the only form on which your Social Security number should appear. This form will be shredded once the information is entered into the licensure database.

QUESTIONS?

- If you have any questions, please call the Board of Registration of Psychologists at (617) 727-9925.

The Commonwealth of Massachusetts

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1. **Applicant Name** _____

Last Name First Name Middle Name

2. **Address** (please note: this address is a **public record** as required by state law, and is the address to which all mail from the Board will be sent). If you move, you must submit an address change to the Board.

_____

No. Street Apt. #

_____

Address Line 2

_____

City State Zip code

3. **Telephone numbers**:(office) _____ Preferred? _____

(mobile)_____ Preferred? _____

(other)_____ Preferred? _____

4. **Email address:** _____

5. **Date of Birth** _____

6. **Previous/other name(s)** _____

7**. Military status**: _____Veteran _____Spouse _____Active Duty _____N/A

8. **This application is for (check as many as apply)**

_____ Licensure as Psychologist by examination

_____ Certification as Health Service Provider

9. List any professional licenses/certifications you hold or have held in the United States or any country or foreign jurisdiction and the state/jurisdiction from which the license/certification was originally issued. Please include in your application a licensure verification letter from each state or jurisdiction in which you have been licensed/certified (in a sealed envelope), indicating the status of your license and any relevant disciplinary information:

_____

_____

_____

_____

10. 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: ☐
If yes, please state the details (use a separate sheet if necessary): _____

11. Are you the subject of pending disciplinary actions by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐
If yes, please state the details (use a separate sheet if necessary):_____

12. 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: ☐
If yes, please state the details (use a separate sheet if necessary):_____

13. Have you ever been denied a professional license in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐ If yes, please state the details (use a separate sheet if necessary):
_____

14. 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 $250.00 was assessed?
Yes: ☐ No: ☐ If yes, please state the details (use a separate sheet if necessary):_____

15. Have there been any malpractice suits filed against you? Yes: ☐ No: ☐ If yes, please state the details (use a separate sheet if necessary):_____

16. Have you ever been rejected for membership in a professional organization? Yes: ☐ No: ☐
If yes, please state the details (use a separate sheet if necessary): _____

17. Have you ever been censured, revoked, suspended, or put on probation by a professional organization?
Yes: ☐ No: ☐ If yes, please state the details (use a separate sheet if necessary):

18. **Graduate Education**

Doctoral

University_____ Dates attended _____

Doctoral degree and date _____ Field _____

Date of completion of all doctoral degree requirements _____

Major Advisor _____
Name and Title

Title of Thesis/Dissertation_____

Master's or other doctoral degrees

University_____ Dates attended _____

Degree and date _____ Field _____

Major Advisor _____
Name and Title

Title of Thesis _____

Master's or other doctoral degrees

University_____ Dates attended _____

Degree and date _____ Field _____

Major Advisor _____
Name and Title

Title of Thesis _____

19. **Undergraduate Education**

If you attended more than one college or university, specify the institution which awarded your degree.

College or University _____

Dates attended_____ Degree and date _____
month/year - month/year

Major_____

20. If you are declaring training/experience in a field other than that for which you obtained your doctorate, have you completed an APA-approved re-specialization program? Yes_____ No_____

If yes, where? _____ Dates of attendance _____

21. Are you licensed 5 or more years in another jurisdiction **and** listed in the National Register of Health Service Psychologists?

Yes_____No_____ If yes, what is your National Register certificate number? _____

(You must arrange for the National Register to mail a certification letter to the Board)

22. Provide names and addresses of three references who will be completing the Professional/Ethical forms.

A. Name _____ Title or position _____

Address_____

_____ Telephone _____

B. Name _____ Title or position _____

Address_____

_____ Telephone _____

C. Name _____ Title or position _____

Address_____

_____ Telephone _____

23.

a. I agree to conform my professional activities to the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association and to 251 CMR. I certify that I possess and have completely read the most recent version of said documents;

b. Pursuant to G.L. c. 119, s. 51A and c. 112, s. 1A, I understand my obligation to report the abuse or neglect of children;

c. Pursuant to G.L. c. 62C, s. 49A, to the best of my knowledge and belief, I have complied with all laws of the Commonwealth relating to taxes, reporting of employees and contractors, and withholding and remitting of child support.

d. I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I further certify that I have had the opportunity to review and correct the information provided in this application. I understand that any misrepresentation or omission of information contained in this application may be grounds for the Board to deny the application or to suspend or revoke a license issued to me.

Signature of Applicant **Date**

Notary Name (Print)_____

Notary Signature _____

My Commission expires: _____

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PROFESSIONAL AND ETHICAL REFERENCE FORM

WAIVER OF LIABILITY

I, _____, hereby authorize _____,
(applicant) (endorser)
hereinafter "the endorser", to provide the Board of Registration of Psychologists with all information of any kind which the endorser may, in his or her absolute discretion, deem relevant to my qualifications as an applicant. I hereby release and discharge the endorser from all claims arising out of the provision of such information.

DATE: _____ APPLICANT'S SIGNATURE_____

-The remainder of this form is to be completed BY THE ENDORSER. Failure to do so will render this document invalid.
-Do not complete unless above waiver is signed. You must sign the affidavit on the reverse side in the presence of a notary.

1. Name of endorser_____ 2. Title_____
3. Address_____
4. Telephone number_____
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 _____

15. AFFIDAVIT

I, the undersigned, being duly sworn do state under the penalties of perjury that the answers given above are true and correct. I agree to provide any additional information requested by the Board.

ERASURES OR CHANGES ARE NOT ACCEPTABLE.

DATE: _____ _____

ENDORSER'S SIGNATURE

Signed in the presence of a notary public.

Notary Name (print) _____

Notary Signature: _____

My commission expires: _____

DOCUMENTATION OF ACADEMIC COURSES

(To be completed by applicant)

THIS FORM IS REQUIRED ONLY FOR CANDIDATES FROM DOCTORAL PROGRAMS OUTSIDE THE USA, AND FROM RE-SPECIALIZATION CANDIDATES

Name of Applicant _____

Name of Doctoral Program _____

This form provides information to the Board as to whether you have satisfied the coursework requirements for licensure as described in 251 CMR 3.03. Please complete this form carefully and accurately. **If the title of any course does not adequately describe its content, YOU MUST submit additional documentation in the form of a syllabus, university catalog description, notarized letter from the instructor, etc.**

Ethics

Course #	Title of Course	Semester	Credits	Additional documentation?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

History of Psychology

Course #	Title of Course	Semester	Credits	Additional documentation?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Research Design and Methods

Course #	Title of Course	Semester	Credits	Additional documentation?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Statistics and Psychometrics

Course #	Title of Course	Semester	Credits	Additional documentation?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

"Competence in these substantive content areas will typically be met by including a minimum of three graduate semester hours (five or more graduate quarter hours) in each of the substantive content areas" (251 CMR 3.03)

Biological Bases of Behavior- e.g., physiological psychology, comparative psychology, neuropsychology, sensation and perception, psychopharmacology.
NOTE: Neuropsychological assessment does not meet this requirement

Course #	Title of Course	Semester	Credits	Additional documentation?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Cognitive-Affective Bases of Behavior- e.g., learning, cognition, thinking, motivation, emotion. **NOTE: Assessment and therapy-oriented courses do not meet this requirement**

Course #	Title of Course	Semester	Credits	Additional documentation?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Social Bases of Behavior- e.g., social psychology, group processes, organizational and systems theory.
NOTE: Courses oriented primarily towards therapy do not meet this requirement.

Course #	Title of Course	Semester	Credits	Additional documentation?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Individual Differences-e.g., personality theory, human development, abnormal psychology.

Course #	Title of Course	Semester	Credits	Additional documentation?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Racial/ethnic bases of behavior with a focus on people of color- e.g., cross-cultural psychology, psychology and social oppression, racism and psychology, human diversity

Course #	Title of Course	Semester	Credits	Additional documentation?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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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 is invalid unless signed and notarized.

AFFIDAVIT

I, the undersigned, being duly sworn, do state under the penalties of perjury that the answers given above are true and correct. I agree to provide any additional information requested by the Board.

Date: _____

_____
Academic Program Director's Signature
Signed in the presence of a Notary Public

Notary Name (print) _____

Notary Signature: _____

My commission expires: _____

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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.**

---

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 provide)_____
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 is invalid unless signed and notarized.

AFFIDAVIT

I, the undersigned, being duly sworn, do state under the penalties of perjury that the answers given above are true and correct. I agree to provide any additional information requested by the Board.
ERASURES OR CHANGES ARE NOT ACCEPTABLE.

Date: _____

_____
Signature of Individual Completing this Form

Signed in the presence of a Notary Public
Notary Name (print) _____
Notary Signature: _____
My commission expires: _____

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INTERNSHIP PROGRAM DIRECTOR FORM

THIS FORM IS REQUIRED FOR APPLICANTS SEEKING HEALTH SERVICE PROVIDER CERTIFICATION

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?

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?

_____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 is invalid unless signed and notarized.

AFFIDAVIT

I, the undersigned, being duly sworn, do state under the penalties of perjury that the answers given above are true and correct. I agree to provide any additional information requested by the Board.

Date: _____

_____

Internship Director's Signature

Signed in the presence of a Notary Public

Notary Name (print) _____

Notary Signature: _____

My commission expires: _____

The Commonwealth of Massachusetts
Division of Professional Licensure
1000 Washington Street, Suite 710
Boston MA 02118-6100
Board of Registration of Psychologists
(617) 727-9925

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.

---

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, please submit form "Is This a Health Service Setting".**

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** you 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 is invalid unless signed and notarized.

AFFIDAVIT

I, the undersigned, being duly sworn, do state under the penalties of perjury that the answers given above are true and correct. I agree to provide any additional information requested by the Board.

ERASURES OR CHANGES ARE NOT ACCEPTABLE.

Date: _____ _____

Supervisor Signature
Signed in the presence of a Notary Public

Notary Name (print) _____

Notary Signature: _____

My commission expires: _____

The Commonwealth of Massachusetts
Division of Professional Licensure
1000 Washington Street, Suite 710
Boston MA 02118-6100
Board of Registration of Psychologists
(617) 727-9925

"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 if you feel it would help the Board's determination.

_____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?

This form is invalid unless signed and notarized.

AFFIDAVIT

I, the undersigned, being duly sworn, do state under the penalties of perjury that the answers given above are true and correct. I agree to provide any additional information requested by the Board.

Date: _____ _____

Signature of Supervisor at Training Site or
Director of Training at Doctoral Program

Signed in the presence of a Notary Public
Notary Name (print) _____
Notary Signature: _____
My commission expires: _____

SUPERVISED EXPERIENCE FORM (completed by applicant)

Name of Applicant: _____

Advanced Practicum Experience: Please list **advanced**-practicum pre-doctoral experience only if it meets all the requirements of 251 CMR 3.04(7), in chronological order. If you do not have any qualifying advanced-practicum experience, or do not need these hours to meet licensure requirements, you do not need to complete this page.

*****NOTE: You cannot receive credit for hours of experience which are not supported and documented by a minimum of two hours of qualifying individual supervision per week, with a minimum of one hour of individual or group supervision for each 16 hours of work, with a group size not larger than 3. (251 CMR 3.04)**

Name and address of Facility	**Dates of attendance** From _____ to _____	**APA** approved?	**# of Weeks** (minus vacation)	**# of Hours per week**	**Names of Supervisors** **Name** **Hours/week**	**Total hours of experience**
1.		Yes_____ No _____	(A)	(B)		(A x B)
2.		Yes_____ No _____				

NATURE OF EXPERIENCE AND PERCENTAGE OF TIME IN VARIOUS ACTIVITIES (e.g. psych. testing 20%):

1. _____

_____

_____

2. _____

_____

_____

You may add additional pages in this format as needed. Please label any additional pages clearly.

Name of Applicant: _____

Internship Experience: Please list all Internship experience in chronological order.

*****NOTE: You cannot receive credit for hours of experience which are not supported and documented by a minimum of one hour of individual or small group (<4) supervision for every 16 hours of work per week.**

Name and address of Facility	**Dates of attendance** From _____ to _____	**APA** approved?	**# of Weeks** (minus vacation)	**# of Hours per week**	**Names of Supervisors** **Name** **Hours/week**	**Total hours of experience**
1.		Yes_____ No _____	(A)	(B)		(A x B)
2.		Yes_____ No _____				

NATURE OF EXPERIENCE AND PERCENTAGE OF TIME IN VARIOUS ACTIVITIES (e.g. family therapy 10%):

1. _____

_____

_____

2. _____

_____

_____

You may add additional pages in this format as needed. Please label any additional pages clearly.

Name of Applicant: _____

Post Internship Experience: Please list all post-internship or post-doctoral experience in chronological order.

*****NOTE: You cannot receive credit for hours of experience which are not supported and documented by a minimum of one hour of individual or small group (<4) supervision for every 16 hours of work per week.**

Name and address of Facility	**Dates of attendance** From _____ to _____	**APA** approved?	**# of Weeks** (minus vacation)	**# of Hours per week**	**Names of Supervisors** **Name** **Hours/week**	**Total hours of experience**
1.		Yes_____ No _____	(A)	(B)		(A x B)
2.		Yes_____ No _____				

NATURE OF EXPERIENCE AND PERCENTAGE OF TIME IN VARIOUS ACTIVITIES (e.g. family therapy 10%):

1. _____

_____

_____

2. _____

_____

_____

You may add additional pages in this format as needed. Please label any additional pages clearly.

NOTICE OF JURISPRUDENCE EXAMINATION

ALL MASSACHUSETTS PSYCHOLOGY LICENSING CANDIDATES

Pursuant to Massachusetts General Laws ch. 112, s. 120, and 251 CMR 3.00, you are required to take a jurisprudence examination, in conjunction with the EPPP licensing exam. This exam will require approximately one hour and will be composed of 20 multiple choice questions drawn from the following content domain.

1. **251 CMR** (regulations promulgated by the Board of Registration of Psychologists)

2. **Massachusetts General Laws, c. 112, sections 118-129B and 12CC** (registration of licensing of psychologists, confidentiality of psychologist-patient communications, duty to provide records)

3. **Massachusetts General Laws**, **c. 19A, sections 14-26** (elder abuse)

4. **Massachusetts General Laws**, **c. 19C, sections 1-13** (protection of disabled persons)

5. **Massachusetts General Laws**, **c. 119, sections 1-84** (protection and care of children, including child abuse reporting [51A], foster care, placement of children who have committed offenses, commitment of children, visitation rights of grandparents, child in need of services [CHINS], delinquent children, commitment of delinquent children, youthful offender)

6. **Massachusetts General Laws**, **c. 123, sections 1-36B** (statutes dealing with mentally ill, mentally retarded, commitment and discharge, treatment of commitment persons with anti-psychotic medication, emergency restraint, application for hospitalization, competence, commitment of alcoholics and substance abusers, duty to warn)

7. **Massachusetts General Laws, c. 123A, sections 1-16** (care, treatment, and custody of sexually dangerous persons)

8. **Massachusetts General Laws, c. 190B** (guardians and conservators)

9. **Massachusetts General Laws, c. 233, section 20B** (privileged communications)

10. **Massachusetts General Laws, c. 208** (selected sections on divorce law)

10. **104 CMR 33.01 and 33.05** (DMH regulations regarding qualified, designated, and designated forensic psychologists)

Study materials (the Psychology Jurisprudence book containing all of the above regulations and statutes) will be mailed to candidates by PCS once your application is approved by the Board.

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:

The Division of Professional Licensure may conduct subsequent CORI checks within one year of the date this Form was signed by me. If subsequent CORI checks are necessary, the Division of Professional Licensure will provide me with written notice of the subsequent CORI checks.

By signing below, I provide my consent to a CORI check 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

*Last Six Digits of Your 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).