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| <i>Official Use Only</i>    |
| Number: _____               |
| Date Approved/Denied: _____ |
| Approved/Denied By: _____   |

## Psychologist

### APPLICANT INFORMATION

Full Legal Name: \_\_\_\_\_  
*First Middle Last*

All Previous Legal Names: \_\_\_\_\_

Other DOPL Licenses Held: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_  
*Street Address (including Apt/Unit/Ste #) and/or PO Box*

\_\_\_\_\_  
*City State ZIP Code*

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Please Select ONE:**

- I am a United States citizen OR a non-citizen of the United States who is lawfully present.
- I am a foreign national not physically present in the United States.
- None of the above, please explain: \_\_\_\_\_

**Drivers License**

**or State ID Card:** \_\_\_\_\_  
*State of Issue License Number Expiration Date*

**NOTE:** If you do not hold a US Drivers License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of authorization to work in the United States.

### AFFIDAVIT AND RELEASE

1. I certify that I am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
5. I certify that I do not currently pose a direct threat to myself, to my clients, or to the public health, safety or welfare because of any circumstance or condition.
6. I understand that I am responsible to update the Division of any changes relating to my license/certification/registration.

Signature of Applicant: \_\_\_\_\_ Date \_\_\_\_\_

## QUALIFYING QUESTIONNAIRE

**Read thoroughly, and answer each question. Do not leave any question blank.**

A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

|  |   |
|--|---|
| 1. <input type="checkbox"/> Yes <input type="checkbox"/> No  | Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?   |
| 2. <input type="checkbox"/> Yes <input type="checkbox"/> No  | Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any professional licensing agency or criminal or administrative jurisdiction? |
| 3. <input type="checkbox"/> Yes <input type="checkbox"/> No  | Are you currently under investigation or is any disciplinary action pending against you now by any <i>local, state or federal licensing, enforcement or regulatory agency</i> ?   |
| 4. <input type="checkbox"/> Yes <input type="checkbox"/> No  | Have you ever been declared by any court to be incompetent by reason of mental defect or disease and not restored?  |
| 5. <input type="checkbox"/> Yes <input type="checkbox"/> No  | Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?  |
| 6. <input type="checkbox"/> Yes <input type="checkbox"/> No  | Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug or alcohol use or abuse within the past five (5) years?   |
| 7. <input type="checkbox"/> Yes <input type="checkbox"/> No  | Are you currently using or have you recently ( <i>within 90 days</i> ) used any drugs ( <i>including recreational drugs</i> ) without a valid prescription, the possession or distribution of which is unlawful under applicable state or federal laws?   |
| 8. <input type="checkbox"/> Yes <input type="checkbox"/> No  | Have you ever unlawfully used any drugs for which you have not successfully completed, or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?   |
| 9. <input type="checkbox"/> Yes <input type="checkbox"/> No  | Do you currently have any criminal action pending?*   |
| 10. <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? *  |
| 11. <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?*  |
| 12. <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever been incarcerated for any reason in any correctional facility ( <i>domestic or foreign</i> ) in any jurisdiction or on probation/parole in any jurisdiction?*   |

**\*NOTE: Charges that were later dismissed and motor vehicle offenses such as driving while impaired or intoxicated must be disclosed; however, minor traffic offenses such as parking or speeding violations need not be listed.**

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

If you answered "Yes" to Questions 9,10,11 or 12 you must submit the following for **EACH** and **EVERY** incident:

- Personal account of the incident
- police report(s)
- court record(s)
- probation/parole officer report(s)

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

## PROFESSIONAL LICENSES

List all other licenses, registrations or certification issued by any state which you now hold or have ever held in any profession. (Use additional sheets if necessary.)

Profession: \_\_\_\_\_ License Number: \_\_\_\_\_

Issuing State: \_\_\_\_\_ License Status: \_\_\_\_\_ Issue Date: \_\_\_\_\_

Profession: \_\_\_\_\_ License Number: \_\_\_\_\_

Issuing State: \_\_\_\_\_ License Status: \_\_\_\_\_ Issue Date: \_\_\_\_\_

## MEDICAL QUALIFYING QUESTIONNAIRE

**Read thoroughly, and answer each question. Do not leave any question blank.**

*A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.*

1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:

- Yes  No a hospital or health care facility  
 Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program  
 Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency  
 Yes  No malpractice insurance coverage  
 Yes  No other entity: \_\_\_\_\_

2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:

- Yes  No a hospital or health care facility  
 Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program  
 Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency  
 Yes  No malpractice insurance coverage  
 Yes  No other entity: \_\_\_\_\_

3. Is any action pending against you now by:

- Yes  No a hospital or health care facility  
 Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program  
 Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency  
 Yes  No malpractice insurance coverage  
 Yes  No other entity: \_\_\_\_\_

4.  Yes  No Have you been named as a defendant in a malpractice suit?

5.  Yes  No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered "Yes" to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. NPDB website: <http://www.npdb.hrsa.gov>.

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

## ENDORSEMENT APPLICANTS

*To be completed by endorsement applicants only. See the instructions at the end of this application for additional instructions.*

If you are currently licensed in good standing in another state, and have practiced for a minimum of 2,000 hours or one year (whichever is greater), you may apply for **Licensure by Endorsement**.

Please select one and provide supporting documentation\*.

- I am a Diplomate of the American Board of Professional Psychology. Specialty: \_\_\_\_\_  
 I am currently credentialed as a Health Service Provider by the National Register of Health Service Providers in Psychology.  
 I currently hold a Certificate of Professional Qualifications (CPQ) granted by the Association of State and Provincial Psychology Boards.  
 I have enclosed evidence that the education, supervised experience, examination and all other requirements for licensure at the time my license was issued was substantially equivalent to the requirements in Utah.

\*Supporting documentation can be a copy of your certification, diploma, credentials, etc. Please do not send originals.

# Verification of Supervised Experience

Each supervisor must complete a separate form. Endorsement applicants do not need to complete this form.

## APPLICANT INFORMATION

To be completed by the applicant.

**Full Legal Name:** \_\_\_\_\_  
*First Middle Last*

**Mailing Address:** \_\_\_\_\_  
*Street/PO Box City State/Zip*

## EXPERIENCE INFORMATION

To be completed by the supervisor.

**Name of Establishment:** \_\_\_\_\_

**Name of Supervisor:** \_\_\_\_\_ **License Number:** \_\_\_\_\_

**Establishment Address:** \_\_\_\_\_  
*Street/PO Box City State/Zip*

**Telephone Number:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Inclusive Dates of Predoctoral Supervision:** \_\_\_\_\_ to \_\_\_\_\_  
*MM/DD/YYYY MM/DD/YYYY*

Hours of supervised experience in mental health therapy: \_\_\_\_\_

Hours of direct supervision for mental health therapy: \_\_\_\_\_

Hours of other supervised experience: \_\_\_\_\_

**Total of all predoctoral supervised experience:** \_\_\_\_\_

**Inclusive Dates of Postdoctoral Supervision:** \_\_\_\_\_ to \_\_\_\_\_  
*MM/DD/YYYY MM/DD/YYYY*

Hours of supervised experience in mental health therapy: \_\_\_\_\_

Hours of direct supervision for mental health therapy: \_\_\_\_\_

Hours of other supervised experience: \_\_\_\_\_

**Total of all postdoctoral supervised experience:** \_\_\_\_\_

**Describe the applicant's duties:** \_\_\_\_\_

Hours of direct supervision per week: \_\_\_\_\_ Hours worked per week: \_\_\_\_\_

I do hereby certify that the applicant for licensure as a psychologist has successfully completed the above hours of supervised experience. I certify that the experience supervised meets the requirements outlined in R156-61-302b.

I further certify that the applicant is qualified and competent to practice as a licensed psychologist.

**Signature of Supervisor:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Verification of Active Practice as a Psychologist in Another State

*For endorsement applicants only.  
Each employer must complete a separate form.*

## APPLICANT INFORMATION

To be completed by the applicant.

**Full Legal Name:** \_\_\_\_\_  
*First Middle Last*

**Mailing Address:** \_\_\_\_\_  
*Street/PO Box City State/Zip*

**License Number:** \_\_\_\_\_ **State of Issue:** \_\_\_\_\_

## EMPLOYMENT INFORMATION

To be completed by the employer, human resources, supervisor or colleague within the profession.

**Name of Establishment:** \_\_\_\_\_

**Establishment Address:** \_\_\_\_\_  
*Street/PO Box City State/Zip*

**Telephone Number** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Applicant's Dates of Employment:** \_\_\_\_\_ to \_\_\_\_\_  
*MM/DD/YYYY MM/DD/YYYY*

**How many hours did the applicant work per week?** \_\_\_\_\_

**Total number of hours worked:** \_\_\_\_\_

**Describe the applicant's duties:** \_\_\_\_\_

**Is the applicant still employed?**  Yes  No

**If no, is the applicant re-hirable?**  Yes  No: **Please explain:** \_\_\_\_\_

I do hereby certify that the applicant for licensure as a licensed psychologist was actively engaged in the lawful practice as a psychologist at the above named establishment for the time frame listed.

I further certify that the applicant is qualified and competent to practice as a licensed psychologist.

**Signature of Supervisor:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Applicant:** \_\_\_\_\_

## APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience, you do not need to include it with your application.

**NOTE:** Incomplete applications will be denied.

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

**Note to all applicants:** This application is used to evaluate your eligibility to take the required exams for licensure. After submitting your application for licensure, DOPL will determine if you meet the eligibility requirements for taking the EPPP or Psychology Law Examinations in Utah, and once met, you will receive additional instructions on how to register and take the exams. Your license will not be approved until DOPL is notified of your passing the required exams.

### LICENSURE BY APPLICATION

The following items are required to complete your application:

- \$200.00 non-refundable application-processing fee, made payable to "DOPL".
- Supporting documentation for any "yes" answers provided on either of the qualifying questionnaires. See pages 2 and 3 of the application for more information.
- Official transcripts documenting completion of a doctorate degree from an APA accredited program.  
**Note:** Transcripts are considered "official" when they are sent directly from the school to DOPL or sealed in an envelope bearing the school's stamp/seal on the envelope flap.  
**\*If you currently hold a Utah Certified Psychology Resident license, you do not need to submit these items again.**
- Verification of Supervised Experience. See page 4 of this application. **NOTE:** You must have each supervisor complete a separate form, and the hours from all forms must total 4,000.
- If you took the EPPP in another state, request an EPPP Score Transfer (*form available on our website*).

### LICENSURE BY ENDORSEMENT

If you are currently licensed in good standing in another state, and have practiced for a minimum of 2,000 hours or one year (whichever is greater), you may apply for **Licensure by Endorsement**. The following items are required to complete your application:

- \$200.00 non-refundable application-processing fee, made payable to "DOPL".
- Supporting documentation for any "yes" answers provided on either of the qualifying questionnaires. See pages 2 and 3 of the application for more information.
- Official verification of license from one or more states in which you are currently licensed. Verifications must cover the time period used to qualify for endorsement outlined above.
- Verification of Active Practice as a Psychologist. See page 5 of this application. **NOTE:** You must have each employer complete a separate form.
- Documentation showing you meet the educational equivalency option selected on page 3 of this application in the section titled "Endorsement Applicants".

Submit the above items with your completed application to:

**In person or via express delivery:**

Division of Occupational and Professional Licensing  
Heber M Wells Building, 1<sup>st</sup> Floor Lobby  
160 E 300 S  
Salt Lake City, UT 84111

**US Postal Service:**

Division of Occupational and Professional Licensing  
PO BOX 146741  
Salt Lake City, UT 84114-6741

If you have questions, please contact the Division via our direct email address, [dopl.bureau3@utah.gov](mailto:dopl.bureau3@utah.gov), or via the phone or fax listed below.