



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
POST-DEGREE SUPERVISED PROFESSIONAL EXPERIENCE

**MUST BE TYPED OR
 PRINTED LEGIBLY**

INSTRUCTIONS USE BLACK INK

- This form **MUST BE TYPED**.
- Provide complete information. Incomplete information will delay your review.
- Sign and date the form.

Return form to:

 State Committee of Psychologists
 3605 Missouri Boulevard
 Post Office Box 1335
 Jefferson City, MO 65102-1335
 Telephone (573) 751-0099
 TDD 1-800-735-2966
 e-mail: scop@pr.mo.gov

SECTION I – APPLICANT DATA – TO BE COMPLETED BY APPLICANT – MUST BE TYPED

1. NAME (FIRST, MIDDLE, MAIDEN, LAST)	SOCIAL SECURITY NUMBER
2. NAME (PROFESSIONAL NAME IF DIFFERENT FROM ABOVE)	
3. ADDRESS (STREET, CITY, STATE, ZIP)	
4. OFFICE PHONE	
5. PSYCHOLOGY DEGREE RECEIVED FROM:	
	YEAR:

SECTION II – SUPERVISOR DATA – TO BE COMPLETED BY PRIMARY SUPERVISOR – MUST BE TYPED

6. NAME (FIRST, MIDDLE, MAIDEN, LAST)	7. E-MAIL
8. CURRENT OFFICE ADDRESS (STREET, CITY STATE, ZIP CODE)	9. TELEPHONE NUMBER
10. MAJOR AREA OF YOUR PROFESSIONAL WORK	
<input type="checkbox"/> CLINICAL PSYCHOLOGY	<input type="checkbox"/> SCHOOL PSYCHOLOGY
<input type="checkbox"/> COUNSELING PSYCHOLOGY	<input type="checkbox"/> INDUSTRIAL/ORGANIZATIONAL PSYCH.
	<input type="checkbox"/> EVALUATIVE/APPLIED PSYCHOLOGY
	<input type="checkbox"/> OTHER ▶
10. PLEASE CHECK ALL THAT APPLY	
<input type="checkbox"/> ABPP DIPLOMATE	<input type="checkbox"/> APA MEMBER
<input type="checkbox"/> APA FELLOW	<input type="checkbox"/> MO PSYCHOLOGICAL ASSN. FELLOW
	<input type="checkbox"/> MO PSYCHOLOGICAL ASSN. MEMBER
	<input type="checkbox"/> NATIONAL REGISTER PROVIDER
	<input type="checkbox"/> OTHER ▶
	<input type="checkbox"/> NONE APPLY

11. ARE YOU A LICENSED PSYCHOLOGIST? YES NO

12. LIST ALL THE STATES IN WHICH YOU NOW HOLD OR HAVE EVER HELD A LICENSE/CERTIFICATE TO PRACTICE PSYCHOLOGY, IN ORDER OF ATTAINMENT. **IF NOT LICENSED IN MISSOURI, PLEASE ATTACH A PHOTOCOPY OF ALL CURRENT PSYCHOLOGY LICENSE(S) OR CERTIFICATE(S) WHICH CONTAIN AN EXPIRATION DATE.**

STATE	LICENSE/CERTIFICATE NUMBER	DATE OF ISSUANCE	CURRENT STATUS
A.			<input type="checkbox"/> ACTIVE <input type="checkbox"/> INACTIVE <input type="checkbox"/> OTHER
B.			<input type="checkbox"/> ACTIVE <input type="checkbox"/> INACTIVE <input type="checkbox"/> OTHER
C.			<input type="checkbox"/> ACTIVE <input type="checkbox"/> INACTIVE <input type="checkbox"/> OTHER
D.			<input type="checkbox"/> ACTIVE <input type="checkbox"/> INACTIVE <input type="checkbox"/> OTHER

13. LIST TITLES AND DEGREES YOU HELD DURING SUPERVISION OF THE APPLICANT.

TITLE	DEGREE	DATE REC'D	UNIVERSITY

14. ARE YOU A RELATIVE OF THE APPLICANT? <input type="checkbox"/> YES <input type="checkbox"/> NO	15. AT LEAST ONE HOUR PER WEEK IN INDIVIDUAL, FACE-TO-FACE SUPERVISION? <input type="checkbox"/> YES <input type="checkbox"/> NO
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16. WILL OR DID SUPERVISION OCCUR AT THE TRAINING SETTING? IF NO, EXPLAIN.
 YES NO

17. WILL YOU OR DID YOU PERSONALLY ASSUME RESPONSIBILITY FOR CLIENT ASSIGNMENT, CLIENT PROGRESS MONITORING, AND CLIENT CARE?
 YES NO

18. WILL YOU OR DID YOU REVIEW AND APPROVE TREATMENT NOTES AND CO-SIGN REPORTS? IF NO, EXPLAIN.
 YES NO

19. WILL YOU OR DID YOU REVIEW THE APPLICANT'S EDUCATIONAL TRANSCRIPT AND EXPERIENCE?
 YES NO

20. APPLICANT'S DUTIES APPROPRIATE TO HIS/HER GRADUATE EDUCATION AND TRAINING?
 YES NO

SECTION III – PROFESSIONAL SETTING – TO BE COMPLETED BY PRIMARY SUPERVISOR

21. NAME OF SETTING (WHERE SUPERVISED EXPERIENCE WILL OR DID OCCUR)

22. ADDRESS OF SETTING (STREET, CITY, STATE, ZIP)	23. TELEPHONE
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24. THE ABOVE SETTING WOULD BE BEST DESCRIBED AS (CHECK ONE BOX):

<input type="checkbox"/> EDUCATIONAL COUNSELING CENTER	<input type="checkbox"/> MENTAL HEALTH CENTER	<input type="checkbox"/> EDUCATIONAL SETTING
<input type="checkbox"/> PRIVATE PRACTICE	<input type="checkbox"/> IN-PATIENT HOSPITAL	<input type="checkbox"/> RESIDENTIAL CENTER
<input type="checkbox"/> OUT-PATIENT OR DAY HOSPITAL	<input type="checkbox"/> OTHER _____	

25. NUMBER OF EACH OF THE FOLLOWING LICENSED PROFESSIONALS EMPLOYED IN THIS SETTING:

____ PSYCHOLOGISTS	____ PROFESSIONAL COUNSELORS	____ OTHER
____ PSYCHIATRISTS	____ SOCIAL WORKERS	_____
____ PHYSICIANS (NON PSYCHIATRISTS)		

26. WILL OR DID APPLICANT CONSULT AND MEET WITH THE ABOVE PROFESSIONALS?
 YES NO

SECTION IV – SECONDARY SUPERVISOR DATA – TO BE COMPLETED BY SECONDARY SUPERVISOR – MUST BE TYPED

27. NAME (FIRST, MIDDLE, MAIDEN, LAST)	E-MAIL
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28. CURRENT OFFICE ADDRESS (STREET, CITY STATE, ZIP CODE)	29. TELEPHONE NUMBER
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30. MAJOR AREA OF YOUR PROFESSIONAL WORK

<input type="checkbox"/> CLINICAL PSYCHOLOGY	<input type="checkbox"/> SCHOOL PSYCHOLOGY	<input type="checkbox"/> EVALUATIVE/APPLIED PSYCHOLOGY
<input type="checkbox"/> COUNSELING PSYCHOLOGY	<input type="checkbox"/> INDUSTRIAL/ORGANIZATIONAL PSYCH.	<input type="checkbox"/> OTHER ▶

31. PLEASE CHECK ALL THAT APPLY

<input type="checkbox"/> ABPP DIPLOMATE	<input type="checkbox"/> APA MEMBER	<input type="checkbox"/> NATIONAL REGISTER PROVIDER
<input type="checkbox"/> APA FELLOW	<input type="checkbox"/> MO PSYCHOLOGICAL ASSN. FELLOW	<input type="checkbox"/> OTHER ▶
	<input type="checkbox"/> MO PSYCHOLOGICAL ASSN. MEMBER	<input type="checkbox"/> NONE APPLY

32. ARE YOU A LICENSED PSYCHOLOGIST? YES NO

33. LIST ALL THE STATES IN WHICH YOU NOW HOLD OR HAVE EVER HELD A LICENSE/CERTIFICATE TO PRACTICE PSYCHOLOGY, IN ORDER OF ATTAINMENT. **IF NOT LICENSED IN MISSOURI, PLEASE ATTACH A PHOTOCOPY OF ALL CURRENT PSYCHOLOGY LICENSE(S) OR CERTIFICATE(S) WHICH CONTAIN AN EXPIRATION DATE.**

STATE	LICENSE/CERTIFICATE NUMBER	DATE OF ISSUANCE	CURRENT STATUS
A.			<input type="checkbox"/> ACTIVE <input type="checkbox"/> INACTIVE <input type="checkbox"/> OTHER
B.			<input type="checkbox"/> ACTIVE <input type="checkbox"/> INACTIVE <input type="checkbox"/> OTHER
C.			<input type="checkbox"/> ACTIVE <input type="checkbox"/> INACTIVE <input type="checkbox"/> OTHER
D.			<input type="checkbox"/> ACTIVE <input type="checkbox"/> INACTIVE <input type="checkbox"/> OTHER

34. LIST TITLES AND DEGREES YOU HELD DURING SUPERVISION OF THE APPLICANT.

TITLE	DEGREE	DATE REC'D	UNIVERSITY

35. ARE YOU A RELATIVE OF THE APPLICANT?

YES NO

36. AT LEAST ONE HOUR PER WEEK IN INDIVIDUAL, FACE-TO-FACE SUPERVISION?

YES NO

37. WILL OR DID SUPERVISION OCCUR AT THE TRAINING SETTING? IF NO, EXPLAIN.

YES NO

38. WILL YOU OR DID YOU PERSONALLY ASSUME RESPONSIBILITY FOR CLIENT ASSIGNMENT, CLIENT PROGRESS MONITORING, AND CLIENT CARE?

YES NO

39. WILL YOU OR DID YOU REVIEW AND APPROVE TREATMENT NOTES AND CO-SIGN REPORTS? IF NO, EXPLAIN.

YES NO

40. WILL YOU OR DID YOU REVIEW THE APPLICANT'S EDUCATIONAL TRANSCRIPT AND EXPERIENCE?

YES NO

41. APPLICANT'S DUTIES APPROPRIATE TO HIS/HER GRADUATE EDUCATION AND TRAINING?

YES NO

SECTION V – PROFESSIONAL SETTING – TO BE COMPLETED BY SECONDARY SUPERVISOR

42. NAME OF SETTING (WHERE SUPERVISED EXPERIENCE WILL OR DID OCCUR)

43. ADDRESS OF SETTING (STREET, CITY, STATE, ZIP)

44. TELEPHONE

45. THE ABOVE SETTING WOULD BE BEST DESCRIBED AS (CHECK ONE BOX):

- EDUCATIONAL COUNSELING CENTER
- EDUCATIONAL SETTING
- IN-PATIENT HOSPITAL
- OUT-PATIENT OR DAY HOSPITAL

- MENTAL HEALTH CENTER
- PRIVATE PRACTICE
- RESIDENTIAL CENTER
- OTHER _____

46. NUMBER OF EACH OF THE FOLLOWING LICENSED PROFESSIONALS EMPLOYED IN THIS SETTING:

____ PSYCHOLOGISTS ____ PROFESSIONAL COUNSELORS ____ OTHER
 ____ PSYCHIATRISTS ____ SOCIAL WORKERS _____
 ____ PHYSICIANS (NON PSYCHIATRISTS)

47. WILL OR DID APPLICANT CONSULT AND MEET WITH THE ABOVE PROFESSIONALS?

YES NO

SECTION VI – TO BE COMPLETED BY PRIMARY SUPERVISOR

48.

a. Yes No Employed at the training setting? If not employed, how affiliated with the setting?

b. What is or was your official title at the setting? _____

c. How many hours per week on site at this setting? _____

d. Are you currently supervising or did you supervise other individuals for licensure purposes, including but not limited to psychology licensure?

Yes No If yes, how many _____ psychology _____ other professions _____ profession type/s _____

SECTION VII – TO BE COMPLETED BY SECONDARY SUPERVISOR

49.

a. Yes No Employed at the training setting? If not employed, how affiliated with the setting?

b. What is or was your official title at the setting? _____

c. How many hours per week on site at this setting? _____

d. Are you currently supervising or did you supervise other individuals for licensure purposes, including but not limited to psychology licensure?

Yes No If yes, how many _____ psychology _____ other professions _____ profession type/s _____

SECTION VIII – TO BE COMPLETED BY APPLICANT

50. a. Yes No Employed at the training setting? If not employed, how affiliated with the setting?

b. Title you will hold or held at this setting? _____

c. How many hours per week on site at this setting? _____

51. DATE SUPERVISION BEGAN OR WILL BEGIN. THE NUMBER OF HOURS MUST MEET THE TOTAL NUMBER OF HOURS AS DOCUMENTED ON SECTION X (59).

52. DATE SUPERVISION WILL END OR ENDED

53. a. Yes No Any administrative responsibilities or ownership interest in the setting? If yes, explain.

SECTION IX – SUPERVISED EXPERIENCE - TO BE COMPLETED BY PRIMARY SUPERVISOR WITH INPUT FROM ALL SECONDARY SUPERVISORS

54. DESCRIBE BRIEFLY THE NATURE OF THE TRAINING SETTING(S) WHERE SUPERVISION WILL TAKE PLACE OR TOOK PLACE, INCLUDING A BROCHURE, PAMPHLET, OR OTHER WRITTEN INFORMATION.

55. DESCRIBE TYPE OF CLIENTELE APPLICANT WILL SEE OR SAW, INCLUDING RANGE OF CLIENTS, NATURE OF PRESENTING PROBLEMS, DEMOGRAPHIC DATA, ETC.

56. DESCRIBE TYPES OF DIAGNOSTIC PROCEDURES, INTERVENTION ACTIVITIES AND THERAPEUTIC APPROACHES APPLICANT WILL USE OR USED.

57. DATES OF SUPERVISION OF THE APPLICANT - PRIMARY SUPERVISOR

A. FROM MO DAY YR	TO MO DAY YR	B. FROM MO DAY YR	TO MO DAY YR	C. FROM MO DAY YR	TO MO DAY YR
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58. DATES OF SUPERVISION OF THE APPLICANT - SECONDARY SUPERVISOR

A. FROM MO DAY YR	TO MO DAY YR	B. FROM MO DAY YR	TO MO DAY YR	C. FROM MO DAY YR	TO MO DAY YR
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SECTION X

59. DESCRIBE THE VARIOUS PSYCHOLOGICAL ACTIVITIES TO BE PERFORMED AND EXPERIENCED, OR THAT WERE PERFORMED AND EXPERIENCED, DURING THE PERIOD OF SUPERVISION. SEE 20 CSR 2235-2.040(C) 1 E.

NOTE: Sections A-D Supervision must be a minimum of five (5) hours per week and must include at least three (3) of the four (4) categories.

	DESCRIPTION OF ACTIVITY	Minimum # of hours	Hours/week
A. Treatment team meeting with supervisor and other health professionals		2	
B. Didactic, Grand Rounds, Case Conferences, Lectures, Workshops, Seminars, and/or Peer Supervision.		1	
C. Readings from Books/Journals on psychological health services.		1	
D. Professional Activity. Development/Presentation of seminars, workshops, or lectures; Participation at Local, State, or National Meetings, Relevant Research; Teaching graduate/undergraduate courses.		1	
E. Individual Face-to-Face Supervision		NEEDED 1	
F. Group Supervision			
G. Direct Client Contact		NEEDED 10	
H. Individual Psychotherapy			
I. Group Therapy			
J. Family Therapy			
K. Psychological Testing			
L. Other Psychological activities (Please specify)			
Total number of hours must meet the hours documented on Section VIII (50c)		TOTAL	

SECTION XI – SIGNATURES

60. ATTESTATION OF APPLICANT

I hereby affirm that the foregoing information which has been supplied is true and accurate to the best of my knowledge, information and belief. I further affirm that **if the supervision plan proposed is changed in any way, I will immediately notify the State Committee of Psychologists.**

SIGNATURE

DATE

61a. ATTESTATION OF PRIMARY SUPERVISOR

I hereby affirm that the foregoing information which has been supplied is true and accurate to the best of my knowledge, information and belief. I further affirm that **if the supervision plan proposed is changed in any way, I will immediately notify the State Committee of Psychologists.**

SIGNATURE

DATE

61b. ATTESTATION OF PRIMARY SUPERVISOR

I further affirm that if supervised experience already occurred, this is a verification of that experience and all requirements were met at the time of supervision.

SIGNATURE

DATE

62a. ATTESTATION OF SECONDARY SUPERVISOR(S)

I hereby affirm that the foregoing information which has been supplied is true and accurate to the best of my knowledge, information and belief.

SIGNATURE

DATE

SIGNATURE

DATE

SIGNATURE

DATE

62b. ATTESTATION OF SECONDARY SUPERVISOR(S)

I further affirm that if supervised experience already occurred, this is a verification of that experience and all requirements were met at the time of supervision.

SIGNATURE

DATE

SIGNATURE

DATE

SIGNATURE

DATE