OKLAHOMA STATE BOARD OF EXAMINERS OF PSYCHOLOGISTS

421 NW 13TH STREET, SUITE 180
OKLAHOMA CITY, OK 73103

(405) 522-1333 / boardstaff@psychology.ok.gov / www.psychology.ok.gov

PSYCHOLOGIST APPLICATION FOR HEALTH SERVICE PSYCHOLOGIST CERTIFICATION

IMPORTANT	Return Completed Application to:
Please read and follow all the information on this page to ensure correct and timely processing of your application. **THIS FORM MUST BE TYPED. DO NOT PRINT DOUBLE-SIDED.** **Reminder:** Keep a copy of the completed application in your permanent records. **Please note that the email address you provide will serve as the primary method of communication for the Board regarding your application.**	**Oklahoma State Board of Examiners of Psychologists** boardstaff@psychology.ok.gov

Psychologists who have completed consistent Training Programs, Internship/Residencies and Postdoctoral supervision experience in Clinical, Counseling or School Psychology are eligible for certification as a Health Service Psychologist (HSP).

Applicants who have applied for licensure and are seeking HSP certification must submit the **OSBEP Health Service Psychologist Certification Application** for review and consideration.

The information provided in this application must match the information on your active licensure application currently on file with the Board.

PERSONAL IDENTIFYING INFORMATION

☐ I currently have an active licensure application with the Board and am requesting consideration for Health Service Psychologist (HSP) certification.

Last Name:	**First Name:**	**MI:**
Name as it will appear on license:	**Doctoral Credential**: ☐ Ph.D. ☐ Psy.D.	

CONTACT INFORMATION

MAILING ADDRESS

Address:	**City**:	**State**:	**Zip**:

PHYSICAL ADDRESS ☐ Same as mailing

Address:	**City**:	**State**:	**Zip**:

BUSINESS ADDRESS

Address:	**City**:	**State**:	**Zip**:

PHONE NUMBER / EMAIL

Home Telephone:	**Business Telephone**:	**Cellphone**:
Email Address:		

QUALIFICATION FOR HSP CERTIFICATION

Select One:

☐ **Board Certified-American Board of Professional Psychology: Number** **Specialty:**

☐ **Two years of supervised experience in HSP.** If selected, complete the below.

TWO YEARS OF SUPERVISED EXPERIENCE INFORMATION

To be completed only if qualifying with two years of supervisory experience was selected above.

Doctoral Internship Area (clinical/Counseling, or school):

Director of Training:

Address: City: State: Zip:

Complete Option A or B below:

A. Post-doctoral year at a site where Health Services were provided:

Supervising Licensed Psychologist:

Supervisor's major program area:

Site:

Address: City: State: Zip:

B. Post-doctoral Supervision in an academic or clinical setting:

If postdoctoral supervision is completed in an **academic or clinical research setting,** a minimum of two years isrequired to fulfill the HSP requirements by performing the following activities. An Applicant is required to spend ***50%***of his/her time performing the activities listed below.

All academic or clinical research setting applicants must include direct service/multiple client contacts per week (minimum of five clients) including service in an agency or university-based clinic, or in a private practice under supervision. (minimum of 250 hours per year, for a minimum of two years, over the course of the postdoctoral supervision experience.)	%
An academic or clinical research setting applicant may perform any of the below activities:	%
Modeling and demonstrating clinical techniques, including assessment and therapy.	%
Supervision of clinical services, wherein the faculty supervisor assumes direct responsibility for supervisee's clinical work.	
Conducting workshops for community groups or public presentations on mental health related topics.	%

The undersigned, being duly sworn, deposes and says that the statements contained herein are true, complete, and correct to the best of his/her knowledge and belief; that he/she has not suppressed any information which might affect this application; that he/she is of good moral character, and will conform to the ethical standards and conduct of the profession; that he/she has otherwise met all statutory requirements, and believes him/herself eligible for certification; and that he/she has read and understood this affidavit.

Signature of Applicant **Date**