



Arkansas Department of Health

Nathaniel Smith, MD, MPH, Secretary of Health

Psychology Board

101 E. Capitol Ave., Ste. 415 | Little Rock | AR 72201
501-682-6167 | Fax 501-682-6165

—Statement of Intent to Practice as a Licensed Psychological Examiner—Independent—

NOTE—The Board will accept only legible, signed, original forms without corrections.

This form is to describe all your competencies to practice as a Licensed Psychological Examiner—Independent, regardless of whether you use them in your current work situation.

Name (PRINTED): _____ License Number: _____

- I was licensed before 12/31/1997.
- I was licensed after 12/31/1997 and have completed the 3000 hours of supervised experience required for independent practice.

1. Indicate all types of psychological services you are competent to provide independently. All areas of practice must be supported by coursework and supervised training.

- | | |
|--|--|
| <input type="checkbox"/> Psychoeducational Testing | <input type="checkbox"/> Individual Therapy |
| <input type="checkbox"/> Objective Personality Testing | <input type="checkbox"/> Group Therapy |
| <input type="checkbox"/> Diagnostic Interviewing | <input type="checkbox"/> Couples/Marital Therapy |
| <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Family Therapy |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Biofeedback |
| <input type="checkbox"/> Other (specify) _____ | |

2. Indicate all types of psychological services you are competent to provide only under supervision.

- | | |
|--|---|
| <input type="checkbox"/> Psychoeducational Testing | <input type="checkbox"/> Individual Therapy |
| <input type="checkbox"/> Objective Personality Testing | <input type="checkbox"/> Group Therapy |
| <input type="checkbox"/> Projective Tests | <input type="checkbox"/> Couples/Marital Therapy |
| <input type="checkbox"/> Diagnostic Interviewing | <input type="checkbox"/> Family Therapy |
| <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Biofeedback |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Neuropsychological Assessments |
| <input type="checkbox"/> Other (specify) _____ | |

3. Populations to be served:

- Child Adolescent Adult Geriatric

4. I have read, understood, and agree to abide by:

- Yes No: American Psychological Association’s Ethical Principles of Psychologists and Code of Conduct
 Yes No: ACA §17-97-101 et. Seq., the law that governs the practice of Psychology in Arkansas
 Yes No: Rules and Regulations of the Arkansas Psychology Board

The Board cautions all licensees to confine practice to areas in which you have demonstrated competence through experience and supervised training. The Statement of Intent form MUST be amended anytime you wish to expand your areas of practice. All revisions to the Statement of Intent must be approved by the Board.

Signature: _____

Date: _____