Arkansas Department of Health

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Governor Asa Hutchinson
Renee Mallory, RN, BSN, Interim Secretary of Health
Jennifer Dillaha, MD, Director

2.12

APPLICATION FOR LICENSURE
PSYCHOLOGIST
Post-Doctoral Supervision Form

Please Type or Print

Each direct supervisor of all postdoctoral experience that is submitted as fulfilling the requirement of one full year (2000 hours) of supervised postdoctoral experience must complete a form. You may duplicate this form for this purpose.

Applicant Name:		
Name and Address of Institution (agency, hospital, clinic, etc.) where supervised training was received.		
City:	State:	ZIP Code:
County:	Phone:	Fax:
APA Accredited ☐Yes ☐No	APPIC Member ☐Yes ☐No	
Primary Supervisor:	State:	License #:
Secondary Supervisor:	State:	License #:

TO BE COMPLETED BY SUPERVISOR

Dates of Post-Doctoral Training	From:	To:
Full Time: ☐ Yes ☐ No	If yes, # of hours/week:_____	# of weeks worked: _____
Part Time: ☐ Yes ☐ No	If yes, # of hours/week:_____	# of weeks worked: _____
Total Number of Clock Hours Worked Under Supervision:		
Total Number of Clock Hours of Face-to-Face Supervision:		
Additional Hours of Group Supervision:		

In the space below, please describe supervised activities, including, as applicable, the names of tests used, amount and type of counseling or psychotherapy experience, school or industrial consultation, and the applicant's level of competence in each activity. If additional space is needed, please attach a separate sheet.

I hereby attest that all the above information is true and correct to the best of my knowledge.

_____

Supervisor's Signature *Title* *License #* *Date*