



STATE OF IDAHO

DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES DOPL

PO Box 83720
Boise, Idaho 83720-0063
(208) 334-3233
E-Mail: psy@dopl.idaho.gov
Web: <https://dopl.idaho.gov>

EVALUATION AND ACCREDITATION OF SUPERVISED PRACTICE

Dear Dr.

Candidate _____ has applied for a license to practice Psychology in the State of Idaho. The Idaho Board of Psychologist Examiners requires information from you in order to evaluate and accredit the extent and quality of the candidate's supervised experience. This original form must be completed by the supervisor only and returned directly to the address noted above. Please provide all information requested. Incomplete information will delay the processing of the applicant's file. (Please type or print.)

1. Supervisor name _____
2. Address _____

Street/PO Box	City	State	Zip
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3. Supervisor license # _____ State issuing license _____
4. Supervisor area of specialty _____
5. Inclusive dates of candidate's supervision: From _____ To _____

Mm/dd/yy

Mm/dd/yy

(Record no more than 1 calendar year per form. Use additional forms for each additional or partial year.)
6. **Total hours** of supervised practice during dates noted above: _____
7. **Total hours** of supervisory one-to-one contact during dates noted above: _____
8. Name & nature of the setting in which the candidate's supervised practice took place:

9. Describe the nature of the candidate's duties:

10. State the quality of the candidate's performance while under your supervision:

11. To your knowledge has disciplinary action been taken against the applicant at any time? [] Yes [] No
(If Yes, please attach an explanation.)
12. To your knowledge does the applicant have or ever had an addiction to alcohol or any controlled substance? [] Yes [] No
(If Yes, please attach an explanation.)
13. To your knowledge has the applicant ever been disciplined because of sexual harassment or sexual misconduct? [] Yes [] No
(If Yes, please attach an explanation.)

Supervisor's signature

date