IDAHO BOARD OF PSYCHOLOGIST EXAMINERS

Division of Occupational and Professional Licenses
11341 W. Chinden Blvd., Building #4 Boise ID 83714 or
P.O. Box 83720, Boise ID 83720-0063
Phone: (208) 334-3233 Website: https://dopl.idaho.gov
E-mail: psy@dopl.idaho.gov

APPLICATION FOR PROVISIONAL PRESCRIBING PYCHOLOGIST CERTIFICATION

All Prescribing Psychologist applicants must hold a current, active, unrestricted license as a Psychologist issued by the Idaho Board.

Instructions

Please complete this form by providing the requested information. Signatures must be notarized and the appropriate fees must be attached. The affidavit includes certifying that the applicant will comply with the Idaho laws and rules and scope of practice governing the practice of psychology in Idaho. The laws and rules are available online at the Board's website. Make checks payable to IBOL. All fees must be paid before the application will be processed. All returned checks are subject to a $20.00 fee. Processing will be delayed for applications that do not include a social security number or other documentation required under Idaho Code § 73-122. **Incomplete applications that do not include all the items required (excluding those items that must be sent directly to our office from an issuing authority) will not be processed and will be returned, which will delay licensure.**

PROVISIONAL PRESCRIPTIVE AUTHORITY APPLICATION FEE - $250

Provisional Applicants: This method is for those who have not held a prescribing psychologist license in another jurisdiction or who need additional training to qualify for certification under Idaho's law.

Please provide the following:

☐The completed and notarized application including the signed supervision forms with the appropriate fees attached;

☐Transcripts sent directly from the college/university showing proof of a master's degree in clinical psychopharmacology from an accredited program.

☐Proof of being licensed or certified and in good standing in another state with substantially equivalent requirements to those in Idaho. Certification of licensure must be sent directly from the state where you are licensed, a copy of your license will not meet this requirement.

Supervised practice must consist of a minimum of 2,000 hours of supervision including the following domains:

- Basic science
- Neurosciences
- Physical assessments and laboratory exams
- Clinical medicine and pathophysiology
- Clinical research pharmacology and psychopharmacology
- Clinical pharmacotherapeutics
- Research
- Professional, ethical and legal issues

Supervisors must keep written progress reports at least every six months concerning how the provisional prescribing psychologist is performing in the domains of supervision.

ATTENTION MEMBERS AND SPOUSES OF MEMBERS OF THE ARMED SERVICES

If you are a member of the armed forces, an honorably discharged veteran or the spouse of an active member or veteran of the military, you are entitled to certain benefits because of your service. Those benefits may include expedited processing of your application and credit for military training that is relevant to the occupational license/registration for which you are applying. For a full explanation of eligibility and a comprehensive description of benefits available, see Idaho Code §§ 67-9401-9407. Additionally, active members of the military may be eligible for a waiver of renewal fees and other renewal requirements, see Idaho Code § 67-2602A.

Note: The applicant's signature must be notarized. The applicants must declare the answers provided are true in front of a notary (jurat). The language "subscribed and sworn" must appear before the applicant's signature. An "acknowledgement" where the notary only verifies the identity of the applicant is not acceptable.

If the name on your application does not match the proof of age document or the transcripts, please provide proof of the name change in the form of a marriage certificate, divorce decree or court order.

IDAHO BOARD OF PSYCHOLOGIST EXAMINERS

Division of Occupational and Professional Licenses
11341 W. Chinden Blvd., Building #4 Boise ID 83714 or
P.O. Box 83720, Boise ID 83720-0063
Phone: (208) 334-3233 Website: https://dopl.idaho.gov
E-mail: psy@dopl.idaho.gov

APPLICATION FOR PROVISIONAL PRESCRIBING PYCHOLOGIST CERTIFICATION

A fee of $250 must be submitted with this application.

I hereby submit my qualifications and make application for a Prescribing Psychologist in the State of Idaho under the provisions of Title 54, Chapter 32, Idaho Code, and provide the following:

1. **Full Name** (Mr., Mrs., or Ms.) ______________________________

2. **Address of Record** ______________________________
(The above address is a public record.) Street City State Zip

3. **Mailing Address** ______________________________
(Will be used as address of record if none provided above.) Street/PO Box City State Zip

4. **Idaho License Number** ____________ **Date of Birth** _______/_______/_______ **Social Security No.** ______/______/______
month day year (This is not a public record; required by I.C. § 73-122.)
(Proof of age – a clear and readable color copy of a government-issued photo ID such as a passport, military ID, or valid driver's license must be attached.)

5. **Home Phone** (____)_______________ **Business Phone** (____)_____________ **E-mail** ______________________________
(The above phone number is a public record.)

6. **Are you or your spouse an active member or honorably discharged veteran of the United States Armed Services?**
(To utilize experience or education gained in the military to qualify you for this license, please attach a copy of your DD-214) **( ) Yes ( ) No**

7. **Have you passed the Psychopharmacology Examination for Psychologists (PEP)?** **( ) Yes ( ) No**
(If Yes, we must receive official certification from the interstate reporting service before your application will be processed.)

8. **Are you currently or have you ever been licensed as a psychopharamologist in another state?** **( ) Yes ( ) No**
(If Yes, certification of licensure must be received directly from the issuing authority before your application will be processed.)

9. **Have you been granted prescriptive authority in that state? If yes, please list** ______________________ **( ) Yes ( ) No**
(If Yes, certification of licensure must be received directly from the issuing authority before your application will be processed.)

10. **Attained Master's degree in clinical psychopharmacology from** ______________________________ on ____________
(You must document proof of a master's degree in clinical psychopharmacology from an accredited program. Official university/college transcripts noting that the degree has been conferred must be received by this office directly from the school registrar.)

11. **Have you ever had a professional license, certification, or registration denied, revoked, suspended or otherwise disciplined for any reason or are there any pending complaints against you?** **( ) Yes ( ) No**
(If Yes, a letter of explanation & a copy of the charges & the final order must be received before your application will be processed.)

12. **Have you ever been disciplined due to sexual harassment or sexual misconduct or are there any pending complaints against you?** **( ) Yes ( ) No**
(If Yes, a letter of explanation & a copy of the charges & the final order must be received before your application will be processed.)

13. **Have you ever voluntarily surrendered a professional license, certification, or registration?** **( ) Yes ( ) No**
(If Yes, a written explanation of the circumstances surrounding the surrender must be attached.)

14. **Have you ever been convicted or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction or are there any pending cases against you?**
(Exclude minor traffic offenses but include all misdemeanors, felonies & military court-martials.) **( ) Yes ( ) No**
(If yes, the Criminal Conviction Disclosure Form, official court documents, and probation and parole documents along with any other relevant information must be received with this application.)

15. **Have you ever abused, been dependent on, or been treated for the abuse or dependency of alcohol or any controlled substance?** **( ) Yes ( ) No**
(If Yes, a detailed statement and any supporting documentation regarding intervention, treatment, and current status must be received before your application will be processed.)

AFFIDAVIT

Upon oath I certify each of the following: (1) the responses and information provided in this application and in the attached addendum(s) and documentation are true and correct to the best of my knowledge; (2) I am the applicant named in and who has signed this application; (3) I am a United States citizen or a legal permanent resident or I am otherwise lawfully present in the United States; (4) I have read and will conform to the Laws and Rules governing the profession for which I am seeking a license or authority to practice; (5) I acknowledge and agree the use of intentional misrepresentation or fraud in this application or violation of any Laws or Rules governing the profession for which I am seeking a license or authority to practice shall constitute cause sufficient for denial, suspension, cancellation or revocation of any license or authority applied for or granted to me; (6) I will provide additional or corrected information if material changes occur which would cause responses or information provided in or with this application to be inaccurate or incomplete; (7) I authorize and direct any person, agency, firm, or other entity to release, upon the request of the Idaho Division of Occupational and Professional Licenses or its authorized representative, any information, communication, report, record, statement, disclosure, or recommendation that may have bearing on my eligibility for or maintenance of the license or authority for which I am applying and hereby release and exonerate any of them from any liability of any kind resulting from the release or collection thereof; and (8) I authorize the Division of Occupational and Professional Licenses to release to any other regulatory entity in any jurisdiction any information requested about me that may otherwise be protected or confidential that may have bearing on my eligibility for or maintenance of any license or authority issued or applied for in this or any jurisdiction and hereby release and exonerate them from any liability of any kind resulting from the release thereof.

____
Signature of Applicant

State of ______________, County of _________________, ss.

Subscribed and sworn before me this ______ day of _______________________, 20 _____.

(seal)

____
Notary Public Official Signature
My Commission Expires____________________________________

IDAHO BOARD OF PSYCHOLOGIST EXAMINERS

Division of Occupational and Professional Licenses
11341 W. Chinden Blvd., Building #4 Boise ID 83714 or
P.O. Box 83720, Boise ID 83720-0063
Phone: (208) 334-3233 Website: https://dopl.idaho.gov
E-mail: psy@dopl.idaho.gov

Supervision Agreement Form

APPLICATION FOR APPROVAL OF SUPERVISOR and SUPERVISION PLAN FOR provisional prescribing psychologists
A form must be submitted for each supervisor providing supervision.

1. Applicant (supervisee) Name ____ License #________________
2. Phone (_____) ___________________ E-mail ____
3. Place of Employment ____
4. Mailing Address ____
   Street/PO Box City State Zip
5. Business Address ____
   Street/PO Box City State Zip
6. Work Schedule: ( ) Full time (30hrs/wk) or more ( ) Part time (Hours per week_______)
7. If you are planning to prescribe for pediatric or geriatric patients, please provide the supervising physician(s) specialized training and experience in treating the patient population for which the applicant seeks to prescribe:
   ____

Supervisor Information:

1. Supervisor Name ____ License #________________
2. Primary Supervisor ( ) or Secondary Supervisor ( )
3. New Supervisor ( ) or Change in Supervisor ( )
4. Please provide documentation of your board certification as a psychiatrist or neurologist or of specialized training and experience in the management of psychotropic medication.
5. Business Name ____
6. Business Address ____
7. Nature of the business setting ____
8. Mailing Address ____
9. Phone (_____)____________________ E-mail ____
10. Number of provisional certification holders you currently supervise ____

Supervision Information

1. Describe the types of cases this supervisor will be responsible for and has specialized training and experience:
   ____
   ____
2. Describe the client's served: ____
   ____
   ____
3. Describe the setting where the applicant will practice: ____

Applicant Affidavit

I hereby agree to comply with the supervision plan outlined herein as part of my application for prescribing psychologist certification. I certify that I have reviewed and understand the plan and its requirements and procedures for supervision of my practice and that I will comply with those requirements and procedures in my practice pursuant to the plan.

____
Signature of Applicant

State of ______________, County of _________________, ss.
Subscribed and sworn before me this ______ day of _______________________, 20 _____.

(seal)

____
Notary Public Official Signature
My Commission Expires________________________

Supervisor Affidavit

I hereby agree to serve as the supervisor of the applicant in the supervision plan outlined herein as a part of the applicant's application for prescribing psychologist certification. I certify that I have reviewed and understand the plan and its supervision requirements and procedures and that I will follow those requirements and procedures in my supervision of the applicant's practice pursuant to the plan.

Supervision reports shall be submitted from each supervisor directly to the Board within thirty (30) days following each six (6) month period.

____
Signature of Supervisor

State of ______________, County of _________________, ss.
Subscribed and sworn before me this ______ day of _______________________, 20 _____.

(seal)

____
Notary Public Official Signature
My Commission Expires________________________

PLEASE NOTE prior to a change in supervisors or a change in the supervision agreement, the supervisee must notify the Board and the change must be approved by the board or a designated member of the board prior to the commencement of supervision by a new supervisor or implementation of the change.

Idaho Division of Occupational and Professional Licenses

Brad Little - Governor
Russell S. Barron - Administrator

Qualifications For Provisional Certification of Prescriptive Authority

To be completed by the applicant:

Name:____ Date of Birth:______________

Mailing Address:____

City:__________________________ State:______________ Zip Code:__________________

Personal Phone:_________________________ Business Phone:________________________

Email:____

Clinical Experience:

Clinical experience must include a minimum of four hundred (400) hours consisting of direct patient contact and collaboration with licensed medical providers involving a minimum of one hundred (100) separate patients.

A minimum of four hundred (400) hours of direct patient care? Yes_______ No______

See a minimum of 100 patients? Yes_______ No______

A diverse patient population of patients includes diversity in:

a. Gender Yes_______ No______
b. Different ages Yes_______ No______
c. Range of disorders Yes_______ No______
d. Ethnicity Yes_______ No______
e. Socio-cultural backgrounds Yes_______ No______
f. In-patient and out-patient setting, as possible and appropriate Yes_______ No______

Applicant Signature: _________________________________Date: ___________________

Office Address:
11351 W Chinden Blvd
Boise, ID 83714