



IDAHO DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

BRAD LITTLE - GOVERNOR
RUSSELL S. BARRON - ADMINISTRATOR

CONDITIONAL PRESCRIBING PSYCHOLOGIST APPLICANT INFORMATION

To be completed by the applicant:

NAME: _____ DATE OF BIRTH: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PERSONAL PHONE: _____ BUSINESS PHONE: _____

EMAIL: _____

SUPERVISOR INFORMATION:

To be completed by the supervisor. If you have more than one supervisor, this document is to be completed by each supervisor.

NAME OF SUPERVISOR: _____

LICENSE PROFESSION: _____

LICENSE # _____ LICENSE STATUS: _____

STATE OR JURISDICTION: _____

DESCRIBE SUPERVISOR'S AREA OF PRACTICE IN WHICH SUPERVISOR IS FORMALLY TRAINED
AND/OR LICENSED CERTIFIED: _____

SUPERVISOR ADDRESS: _____

DATE PRACTIUM BEGAN: _____ DATE PRACTICUM ENDED: _____

QUESTIONS FOR SUPERVISOR:

If you did not supervise for the full 2,000 hours and 50 patients, please answer below how many hours and patients you were the supervisor for.

Did the applicant meet the following requirements in Rule 200.02?

A minimum of two thousand (2,000) hours acquired in two (2) years? Yes _____ No _____

See a minimum of 50 patients? Yes _____ No _____

Supervision on a one-to-one basis for a minimum of four (4) hours each month and a minimum of a total of forty-eight (48) hours each year? (One-to-one supervision must be provided face-to-face, telephonically, or, by live video communication) Rule 100.04ii Yes _____ No _____

Supervision must include assessment of the conditional prescribing psychologist with regard to each of the following domains.

- a. Basic science Yes _____ No _____
- b. Neurosciences Yes _____ No _____
- c. Physical assessments and laboratory exams Yes _____ No _____
- d. Clinical medicine and pathophysiology Yes _____ No _____
- e. Clinical & research pharmacology and psychopharmacology Yes _____ No _____
- f. Clinical pharmacotherapeutics Yes _____ No _____
- g. Research Yes _____ No _____
- h. Professional, ethical, and legal issues Yes _____ No _____

Was the primary or secondary supervisor on site? Yes _____ No _____

Did the applicant keep a log of dates and times of supervision? Yes _____ No _____

Did the applicant during initial contact with patients or legal guardians adequately explain his/her status as a licensed psychologist receiving specialized training in psychopharmacology and being under supervision? (Please provide copies of any printed material) Yes _____ No _____

Were you and any secondary supervisors in consultation regarding the applicant's progress, competence, and any deficiencies? Yes _____ No _____

Do you as primary supervisor certify that the applicant has successfully completed the 50 patients as specified and is competent to obtain a prescription certification and all other requirements satisfactorily completed? Yes _____ No _____

PRIMARY SUPERVISOR CERTIFICATION

I _____, the clinical supervisor of the 50-patient practicum certify that all the statements made in this document are true, complete, and correct to the best of my knowledge and made in good faith.

Clinical Signature: _____ Date: _____