State of Idaho
Division Of Occupational and Professional Licenses
Idaho Board of Psychologist Examiners

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Governor
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Administrator

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Verification of Supervised Prescribing Practice

For a complete description of supervision requirements and procedures, see Idaho Code § 54-23 and IDAPA 24.12.01.

Provisional Prescribing Psychologist Information:

Name: _____

Psychologist License #: _____ Provisional Certification of Prescriptive Authority #: _____

Mailing Address: _____

Phone: _____ E-mail: _____ Total Hours of Supervised Prescribing Practice: _____

If applicable, provide total hours for the following patient populations: Pediatric: _____ Geriatric: _____

Total Number of Patients Seen: _____ Total Hours of One-to-One Supervision: _____

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

_____
Applicant Signature

Primary Supervisor Information:

Name: _____ License #: _____State or Jurisdiction: _____

Mailing Address: _____

Phone: _____ E-mail: _____

Number of Hours Supervised: _____ Number of Patients Supervised: _____

Patient Population: ☐General ☐Pediatric ☐Geriatric

☐ By checking this box, you attest that you provided at least four (4) hours per month of one-to-one supervision as required in IDAPA 24.12.01.100.04.a.ii. The total requirement of forty-eight (48) hours per year may be divided between all supervising physicians.

I, _____, certify that the applicant is competent to obtain a Certification of Prescriptive Authority and that all statements made in this section are true, complete, and correct to the best of my knowledge.

_____
Primary Supervisor Signature

Secondary Supervisor Information:

Name: _____ License #: _____ State or Jurisdiction: _____

Mailing Address: _____

Phone: _____ E-mail: _____

Number of Hours Supervised: _____ Number of Patients Supervised: _____

Patient Population: ☐General ☐Pediatric ☐Geriatric

☐ By checking this box, you attest that you provided at least four (4) hours per month of one-to-one supervision as required in IDAPA 24.12.01.100.04.a.ii. The total requirement of forty-eight (48) hours per year may be divided between all supervising physicians.

I, _____, certify that the applicant is competent to obtain a Certification of Prescriptive Authority and that all statements made in this section are true, complete, and correct to the best of my knowledge.

_____

Secondary Supervisor Signature

If more than two (2) supervisors were involved, fill out an additional copy of this form.