State of New Hampshire

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
DIVISION OF LICENSING AND BOARD ADMINISTRATION
7 Eagle Square, Concord, NH 03301-4980
Phone: 603-271-2152

BOARD OF PSYCHOLOGISTS
INTERNSHIP CONFIRMATON FORM

SECTION TO BE COMPLETED BY APPLICANT and send to the Director/provider of the internship experience. (Print legibly)

Legal Name: _____ Phone or Cell #: _____

Home Mailing Address: _____

I am applying for a License as a Psychologist in New Hampshire. The New Hampshire Board of Psychologists requires confirmation of internship supervised clinical experience. **This is your authority to release any information you have in your files, favorable or otherwise.**

Signature: _____ Date: _____

TO BE COMPLETED BY THE SUPERVISOR OF INTERNSHIP EXPERIENCE: *(Print or type legibly)*

Name of Internship Program _____

Name of facility _____

Physical address of facility _____

Was the internship program APA approved at the time of the applicant's attendance? [ ] Yes [ ] No

Was the program under consideration for APA approval? Please attach explanation. [ ] Yes [ ] No

If program was not APA approved, please attach documentation that describes the goals and content of the internship as well as how at least 2 hours per week in learning activities took place. [ ] Yes [ ] No

Number of interns in training at the same time as the applicant: _____

Applicant's title in program _____

Dates in internship program: From (mm/dd/yyyy) _____ to (mm/dd/yyyy) _____

Applicant's experience was : [ ] Full time _____ hr/wk [ ] Part time _____ hrs/ per week

FACE-TO-FACE Individual Supervision: Hours/week _____ Total in internship: _____

Total supervised face-to-face hours in time period above including individual and group supervision: ____

Total Hours of Supervised Clinical Work Experience (_____hrs/wk) **X** (_____weeks) = _____
hours worked X weeks present

This includes all duties of the clinical experience: patient contact, supervision, notes, meetings, all tasks.

Name of applicant's primary supervisor _____

Degree _____ Licensed/Certified # _____ State _____

Was the internship experience successfully completed? [ ] Yes [ ] No.
If No, please explain: _____
_____

Your recommendation concerning licensure:

[ ] Without Reservation [ ] With Reservation [ ] Against licensure

If other than "Without Reservation" attach a detailed explanation.

Name of Supervisor: _____

Supervisor's Title at the time of program: _____ Degree _____

Supervisor's Address: _____

Phone Number: _____ Email: _____

State of Licensure: _____ License Number: _____

Supervisor's Licensed/Certified (Field, Specialty) _____ Issue date: _____

I hereby attest that all of the information contained on the form is true and accurate to the best of my knowledge and belief.

Signature of Supervisor _____ Date _____

The Supervisor of the internship experience shall return the completed form to applicant in a signed sealed envelope.