

\*\*\*FOR OFFICE USE ONLY\*\*\*

**Psychology Checklist**

- Temporary
- Endorsement       Examination
- App. & Fee
- Date: \_\_\_\_\_ Check \_\_\_\_\_
- Transcript
- Exam Results from EPPP
- Lic. Verification from other States
- Supervised Practice Forms:
  - Pre-Doctoral
  - Post-Doctoral
- Curriculum Summary Forms (Non-APA)



**Rhode Island  
Board of Psychology**

Room 104  
3 Capitol Hill  
Providence, RI 02908-5097

**Instructions and Application For  
License As A  
Psychologist**

**Temporary Permit**  
Only for Examination applicants

**Endorsement**       **Examination**  
(From Another State)

\*\*\*FOR OFFICE USE ONLY\*\*\*

License Number:
Issue Date:
Approved for EPPP
Approved for Licensure:
Signature of Board Member
Signature of Board Administrator
ID#:
Receipt #:

License # \_\_\_\_\_

Name \_\_\_\_\_

**MILITARY STATUS ELIGIBILITY** *(Documentation Required)  
see next page for instructions*

Please check ONE of the following criteria for expedited application:

- I am in active military duty or a reservist
- I am a military veteran with honorable discharge
- I am the spouse of someone in active military duty or the spouse of a reservist

*Applicant - Print Name*

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*LAST NAME*

*FIRST NAME*

*MI*

**Phone: (401) 222-2828**

**TTY/TDD: (800) 745-5555**

**Fax: (401) 222-1272**

# LICENSURE REQUIREMENTS

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- Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.
- Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **\$230.00** (an **additional** fee of **\$120.00** is required for Temporary Permit - Endorsement applicants are **NOT** eligible for the Temporary Permit.- Please refer to the Rules and Regulations to determine eligibility) and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE. Please be advised that this is an application fee and includes the first license **only** up until the next expiration date. All Psychologists licenses expire every 2 years on June 30th.
- Official transcripts sent **directly** from your accredited school of Psychology. No student copies will be accepted
- Scores/Certification sent directly from the **Association of State and Provincial Psychology Boards (ASPPB)** (Telephone 1-678-216-1175 or Toll Free 1-800-448-4069) (Website: <http://www.asppb.net>) sent directly to this office.
- Pre-Doctoral Supervised Practice Form - (Form included in this application to be used for that purpose) must be presented in sealed envelopes, either by mail directly from the reference, or submitted by the applicant in an envelope sealed with the reference's signature across the sealed flap.
- Post-Doctoral Supervised Practice Form - (Form included in this application to be used for that purpose) must be presented in sealed envelopes, either by mail directly from the reference, or submitted by the applicant in an envelope sealed with the reference's signature across the sealed flap.
- If you were in a non-APA Program you must submit the Curriculum Summary Form (Form included in this application to be used for that purpose)
- If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that purpose) The Verification Form from the State of original licensure must include test scores obtained on the appropriate level of the EPPP examination (or test scores may be sent directly from EPPP). If test scores are provided, you do not need to contact the EPPP to request the test scores. In addition to test scores, if the required Supervised Practice Prerequisite is provided by the Endorsement State(s) (Refer to Rules & Regulations), then you are not required to submit the Supervised Practice Forms.
- If applying for expedited military status, please complete the Military Expedition Form at the end of this application packet.

## Licensure Information

Please visit the RIDOH website at <http://www.health.ri.gov/licenses> to Verify your license, download Rules and Regulations/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.

## License Certificates

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of \$30.00 made payable to RI General Treasurer.

- I would like to receive a license certificate. I have enclosed a separate check in the amount of \$30.00



# State of Rhode Island and Providence Plantations Board of Psychology

Application for License as a Psychologist/Temporary Permit

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

## 1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/Permit/Certificate. Do not use nicknames, etc.

**NOTE:**  
It is your responsibility to notify the Department of Health Board of any name changes.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden Name, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

## 2. Social Security Number

 -  - 

U.S. Social Security Number

**"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State."**

## 3. Gender

Please select from the dropdown.

## 4. Date of Birth

 /  /  19

Month

Day

Year

## 5. Home Address

It is your responsibility to notify the board of all address changes.

No professional licensee's address (residence or business/employment) will be posted on the Department's Web site.

1st Line Address (Apartment/Suite/Room Number, etc.)

2nd Line Address (Number and Street)

City

State

 - 

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

 - 

Home Phone

 - 

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

## 6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

**This address will appear on the Department of Health web site.**

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

 - 

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

 - 

Business Phone

Extension

 - 

Business Fax

<p><b>7. Preferred Mailing Address</b> Please check <u>ONE</u></p>	<p><input type="checkbox"/> Please use my <b>Home Address</b> as my preferred mailing address</p> <p><input type="checkbox"/> Please use my <b>Business Address</b> as my preferred mailing address</p> <p><b>NOTE:</b> The preferred mailing address that you indicate is the address that will be released for all requests for that information.</p>
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<p><b>8. Qualifying Education</b></p> <p>Please list the name and information about the school that you attended that qualifies you for this license.</p>	<table style="width:100%; border-collapse: collapse;"> <tr> <td colspan="2" style="border: 1px solid black; height: 20px;"></td> </tr> <tr> <td colspan="2" style="font-size: small;">Type of School (University, College, Technical School, etc.)</td> </tr> <tr> <td colspan="2" style="border: 1px solid black; height: 20px;"></td> </tr> <tr> <td colspan="2" style="font-size: small;">Name of School</td> </tr> <tr> <td style="width: 20%;">Date Graduated</td> <td style="width: 20%;"> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td align="center" style="font-size: x-small;">Month</td> <td align="center" style="font-size: x-small;">Year</td> </tr> </table> </td> <td style="width: 60%;">Degree Received: <input type="checkbox"/> Doctorate in Psychology</td> </tr> <tr> <td colspan="2"></td> <td>Is School Accredited by the American Psychology Association (APA)? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>			Type of School (University, College, Technical School, etc.)				Name of School		Date Graduated	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td align="center" style="font-size: x-small;">Month</td> <td align="center" style="font-size: x-small;">Year</td> </tr> </table>			Month	Year	Degree Received: <input type="checkbox"/> Doctorate in Psychology			Is School Accredited by the American Psychology Association (APA)? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Month	Year																		
		Is School Accredited by the American Psychology Association (APA)? <input type="checkbox"/> Yes <input type="checkbox"/> No																	

<p><b>9. Other State License(s)</b></p> <p>Please answer the question and list state(s), if applicable</p>	<p>Have you <u>ever</u> held, or do you currently hold, a license in another state? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the answer to this question is <b>“yes”</b>, enter <u>all other state licenses</u> in Question 10 (below):</p>
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<p><b>10. Licensure</b></p> <p>List all states or countries in which you are now, or ever have been licensed to practice your profession*.</p>	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">State/Country: _____</td> <td style="width: 10%;"><input type="checkbox"/> Active</td> <td style="width: 10%;"><input type="checkbox"/> Inactive</td> <td style="width: 50%;">State/Country: _____</td> <td style="width: 10%;"><input type="checkbox"/> Active</td> <td style="width: 10%;"><input type="checkbox"/> Inactive</td> </tr> <tr> <td>_____</td> <td><input type="checkbox"/> Active</td> <td><input type="checkbox"/> Inactive</td> <td>_____</td> <td><input type="checkbox"/> Active</td> <td><input type="checkbox"/> Inactive</td> </tr> <tr> <td>_____</td> <td><input type="checkbox"/> Active</td> <td><input type="checkbox"/> Inactive</td> <td>_____</td> <td><input type="checkbox"/> Active</td> <td><input type="checkbox"/> Inactive</td> </tr> </table> <p align="center"><b>DOCUMENTATION:</b> You must send a Interstate Verification Form to each entity.</p>	State/Country: _____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive	State/Country: _____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
State/Country: _____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive	State/Country: _____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive														
_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive														
_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive	_____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive														

<p><b>11. Criminal Convictions</b></p> <p>Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.</p> <p>If necessary, you may continue on a separate 8½ x 11 sheet of paper.</p>	<p>Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Abbreviation of State and Conviction<sup>1</sup> (e.g. CA - Illegal Possession of a Controlled Substance):</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 80%;"></td> <td style="width: 10%; text-align: center; font-size: x-small;">Month</td> <td style="width: 10%; text-align: center; font-size: x-small;">Year</td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td align="center" style="border: 1px solid black; width: 20px; height: 20px;"></td> <td align="center" style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td align="center" style="border: 1px solid black;"></td> <td align="center" style="border: 1px solid black;"></td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td align="center" style="border: 1px solid black;"></td> <td align="center" style="border: 1px solid black;"></td> </tr> </table>		Month	Year									
	Month	Year											

<p><b>12. Disciplinary Questions</b></p> <p>Check either Yes or No for each question.</p>	<p>1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are any formal charges pending? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr style="border-top: 1px dashed black;"/> <p>2. Have you ever been denied a license, certificate, registration or permit in any state? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Note:</b> If you answer “Yes” to any question, you are <b>required</b> to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.</p>
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**13. Affidavit of Applicant**

Complete this section and sign.

Make sure that you have completed all components accurately and completely.

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Licensed Psychologist in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Psychology of any change in the answers to these questions after this application and this affidavit is signed.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date of Signature (MM/DD/YY)



Substitute forms are not acceptable, One (1) form is required for each state in which you hold, or have held a license. Copy this form as needed.

# Rhode Island Board of Psychology

Room 104, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-2828

## INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S) (One form for each state)

I am applying for a license to practice as a Psychologist/Temporary Permit in the State of Rhode Island. The Rhode Island Board of Psychology requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Psychology at the above address.

Print/Type Full Name _____	Signature _____	Date _____
Previous Names Used _____	Social Security Number _____	Date of Birth _____
License Number _____	Date Issued _____	

### THIS SECTION TO BE COMPLETED BY THE PSYCHOLOGY BOARD

**Directions for State Board:** Please complete and return this form to the address above *Please verify requirements met in your state:*

Ph.D from APA Accredited School? <input type="checkbox"/> Yes <input type="checkbox"/> No	Licensed by Examination? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not by examination, how was license obtained? Endorsement _____ (State) Other _____ (Ex-plain)	
Applicant has completed and passed the National Certification (EPPP) Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No Score _____	License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	Original Date Issued:	Expiration Date:

\*Two years supervised experience (One of which shall be Post-Doctoral)?  
 Yes  No If YES, please indicate the total number of pre-doctoral and post-doctoral Ph.D. supervised hours: Pre-Doctoral \_\_\_\_\_ Post-Doctoral \_\_\_\_\_

**Questions:**

- Has this licensee ever been investigated by your Board?  Yes  No
- Has this licensee incurred any disciplinary proceedings in your state, or is any action pending?  Yes  No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?  Yes  No
- Do you know of any information that may discredit this person?  Yes  No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

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### Certification:

Signature _____	Date _____
Type or Print Name _____	
Title _____	
Full Name and State of Licensing Board _____	



Please return directly to the Board at the above address. Thank you for your prompt cooperation.



# Rhode Island Board of Psychology

Room 104, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-2828

## PRE-DOCTORAL SUPERVISED PRACTICE FORM - CERTIFICATION OF EXPERIENCE

The individual named below is applying for certification as a Licensed Psychologist in the State of Rhode Island. Prior to certifying the applicant, it is necessary to verify his/her past clinical supervision and/or clinical experience while supervised by you. The applicant has completed Section I and is requesting that you complete Section II. By signing below, the applicant attests that the information is correct to the best of his/her knowledge.

Print/Type Full Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Previous Names Used \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Dates of Clinical Experience under supervision of the practitioner completing Section II. FROM: \_\_\_\_\_ TO: \_\_\_\_\_  
Month Day Year Month Day Year Total number of Pre-Doctoral Supervised Hours \_\_\_\_\_

Description of Applicant's Primary Responsibilities and position:  
\_\_\_\_\_  
\_\_\_\_\_

**INSTRUCTIONS TO APPLICANT:** If you have had more than one supervisor, and evidence is needed from two or more supervisors to document the minimum level of supervised clinical experience required for Licensure, the applicant must complete Section I on each form forwarded to the individual supervisors. It is the responsibility of the applicant to gather all forms completed by supervisors in sealed envelopes with supervisor's signature across the back flap (seal) and mail in one packet to the Rhode Island Board of Psychology.

**EXPERIENCE REQUIREMENTS FOR PSYCHOLOGISTS:** The "Rules and Regulations pertaining to the Licensing of Psychologists", (R5-44-PSY), establishes experience requirements which must be met prior to application for the Psychologist License. "Supervised experience" shall mean the practical application of principles, methods and procedures of the science of psychology, for at least two (2) years, (one year of which must be post-doctoral), full time (35 hours per week) or its equivalent of 1500 clock hours per year for a minimum of 3000 hours and under the supervision of a psychologist certified or licensed pursuant to the statutory provisions for the state in which the supervised experience was obtained.

## SECTION II - THIS SECTION TO BE COMPLETED BY SUPERVISOR

**Instructions to supervisor:** Please complete Section II of this form and return to the applicant. The Rhode Island Board of Psychology requests that the supervisor carefully review the applicant's statements under Section I prior to responding to Items in Section II. Insert completed form in an envelope and seal signing your name across the seal. Return to applicant. Applicant has been instructed to include your sealed envelope in his/her application packet.

**Supervisor's Professional Degree, Discipline and License Information:**  
Degree: \_\_\_\_\_  
Discipline: \_\_\_\_\_  
License Level: \_\_\_\_\_  
License #: \_\_\_\_\_  
License State: \_\_\_\_\_

Agency and State in which Supervision Occurred: \_\_\_\_\_ Agency \_\_\_\_\_ State \_\_\_\_\_

Describe the nature of the Supervision: \_\_\_\_\_

Length and frequency (time-frame) of Supervision: \_\_\_\_\_

**Certification:** I hereby attest the above information in Section II is correct, to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Type or Print Name \_\_\_\_\_ Title \_\_\_\_\_

Supervisor's Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Please return this form to the applicant.*

*Thank you for your cooperation.*



# Rhode Island Board of Psychology

Room 104, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-2828

## POST-DOCTORAL SUPERVISED PRACTICE FORM - CERTIFICATION OF EXPERIENCE

The individual named below is applying for certification as a Licensed Psychologist in the State of Rhode Island. Prior to certifying the applicant, it is necessary to verify his/her past clinical supervision and/or clinical experience while supervised by you. The applicant has completed Section I and is requesting that you complete Section II. By signing below, the applicant attests that the information is correct to the best of his/her knowledge.

Print/Type Full Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Previous Names Used \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Dates of Clinical Experience under supervision of the practitioner completing Section II. FROM: \_\_\_\_\_ TO: \_\_\_\_\_  
Month Day Year Month Day Year Total number of Post-Doctoral Supervised Hours \_\_\_\_\_

Description of Applicant's Primary Responsibilities and position:  
\_\_\_\_\_  
\_\_\_\_\_

**INSTRUCTIONS TO APPLICANT:** If you have had more than one supervisor, and evidence is needed from two or more supervisors to document the minimum level of supervised clinical experience required for Licensure, the applicant must complete Section I on each form forwarded to the individual supervisors. It is the responsibility of the applicant to gather all forms completed by supervisors in sealed envelopes with supervisor's signature across the back flap (seal) and mail in one packet to the Rhode Island Board of Psychology.

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## SECTION II - THIS SECTION TO BE COMPLETED BY SUPERVISOR

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<b>Supervisor's Professional Degree, Discipline and License Information:</b> Degree: _____ Discipline: _____ License Level: _____ License #: _____ License State: _____
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Agency and State in which Supervision Occurred: \_\_\_\_\_ Agency \_\_\_\_\_ State \_\_\_\_\_

Describe the nature of the Supervision: \_\_\_\_\_

Length and frequency (time-frame) of Supervision: \_\_\_\_\_

**Certification:** I hereby attest the above information in Section II is correct, to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Type or Print Name \_\_\_\_\_ Title \_\_\_\_\_

Supervisor's Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Please return this form to the applicant.*

*Thank you for your cooperation.*





# Rhode Island Board of Psychology

Room 104, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-2828

Substitute forms are not acceptable  
Copy this form as needed.

## CURRICULUM SUMMARY FORM (NON-APA PROGRAMS ONLY)

Applicant: Please complete this form which provides a brief summary of your credentials and file it with your application.

Print/Type Full Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Previous Names Used \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Doctoral Degree (Check one):  
 Ph.D  Psy.D  Ed.D  Other (Specify) \_\_\_\_\_

2. Major field of concentration as indicated on official transcript being filed

3. Date doctoral requirements were satisfied, including successful defense of dissertation as indicated on transcript:

4. If major field was in clinical, counseling, school or industrial/organizational psychology, was the program an APA approved one?  Yes  No

5. Dates in which full-time graduate study was pursued:

6. Title of courses in which credits were earned that satisfy the following basic requirements:

(a) Professional ethics and standards:

(b) Statistical methods:

(c) Research methods:

(d) History and systems of psychology:

7. Title of courses in which credits were earned that satisfy the following core requirements:

(a) Biological Bases of Behavior (Physiological psychology, comparative psychology, neuropsychology, sensation and perception, psychopharmacology):

(b) Cognitive-Affective Bases of Psychology (Learning, thinking, emotion and motivation):

(c) Social Bases of Behavior (Group processes, organizational and systems theory):

(d) Individual Differences (Personality theory, human development, abnormal psychology):

8. Title of courses in which credits were earned within the specialty area of the major field of concentration:

9. Location, dates and nature of supervised experience and internship (Indicate if APA-Approved):

10. Name, title and license/certification number of supervising psychologists:

11. Total number of hours of supervised experience:	Practice	One-to-one Weekly Conferences
a) Pre-doctoral:		
b) Post-doctoral:		

12. Possession of ABPP Diploma?  Yes  No (If "Yes", date and field of diploma.)



## Rhode Island Department of Health Military Expedition Form

Please attach this form to the *front* of your completed application and mail to the address shown on the application cover.

Pursuant to Rhode Island General Laws § [5-88-1](#) et seq., upon application, this state may recognize occupational licenses, certificates or permits obtained from other states for military members and their spouses who relocate to this state pursuant to military orders. The Rhode Island Department of Health (RIDOH) will expedite your or your spouse's health professional license application provided the following conditions are met.

### I. PROFESSION/LICENSE TYPE

Please indicate the profession and/or license type you are applying for so that your application can be routed to the correct office:

Profession/License Type: \_\_\_\_\_

### II. MILITARY STATUS

Please check ONE of the following criteria for expedition:

I am in active military duty or a reservist.

I am the spouse of someone in active military duty or the spouse of a reservist.

I am a military veteran with honorable discharge. *You do not need to complete the rest of this application – please skip to the signature line.*

### III. PROOF OF MILITARY STATUS

Please attach a copy of proof of your military status such as one of the following: Leave Earning Statement (LES), Letter from Command, or Copy of Orders

### IV. MILITARY CHANGE OF STATION ORDER

Permanent Change of Station Order

### V. PROOF OF GOOD STANDING

Proof of good standing from the board in the other state in which the person has a license.

### VI. Criminal Background Check (a "BCI") (*unless required in the initial license application*)

BCI completed from the RI Attorney General's Office.

### VII. ATTESTATIONS:

Check all that apply:

No board in any other state has revoked the license for which I am applying as a result of negligence or intentional misconduct.

I have never surrendered an occupational license, certificate, or permit because of negligence or intentional misconduct.

I do not have a complaint, allegation, or investigation currently pending before a board in another state which relates to unprofessional conduct or an alleged crime.

I attest that the above responses and information are true and accurate to the best of my knowledge and that none of the information set forth above is false, erroneous, or defective in any important, as set forth in R.I. Gen. Laws § 11-18-1. I understand that this application is being made to the Rhode Island Department of Health, which shall rely upon my attestation and the information provided in this document.

Signature of Applicant

Date

*On a case-by-case basis RIDOH may grant a temporary license should the military member or spouse need additional time to complete education, training, and/or experience for the licensure in Rhode Island. RIDOH will contact the applicant directly should that be needed.*