

APPLICATION FOR HEALTH SERVICE PSYCHOLOGIST CERTIFICATION

Oklahoma State Board of Examiners of Psychologists

Name _____	Doctoral Degree _____	Year _____
University _____	Department _____	Program Area _____
Internship _____	Area _____	Began _____ Ended _____
Sex _____	Birth date _____	Place _____ Are you a U.S.citizen _____
Business Address _____		
City _____	State _____	Zip _____ Phone _____
Home Address _____		
City _____	State _____	Zip _____ Phone _____
I am, or have been licensed as a Psychologist in the State(s) or Province(s) of: _____		

Qualification for Health Service Psychologist Certification (Complete A or B)

A. ____	Board Certified-American Board of Professional Psychology Number _____ Specialty _____
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B. ____	Two years of supervised experience in Health Services Psychology: (Applicants must complete item 1 and item 2 or 3 below)
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1. *Doctoral Internship-Area* _____ (Clinical/Counseling, or School)
Director of Training _____ Address _____
City _____ State _____ Zip _____

2. *Post-doctoral year at a site where Health Services were provided*
Supervising Licensed Psychologist _____
Supervisor's major program area: _____

Site _____ Address _____
City _____ State _____ Zip _____

3. *Post-doctoral Supervision in an academic setting*

If postdoctoral supervision is completed in an **academic setting**, a minimum of two years is required to fulfill the HSP requirements by performing the following activities. An Applicant is required to spend **50%** of his/her time performing the activities listed below.

Provide approximate percentage of time engaged in the following activities:	%
All academic setting applicants must include item a.	
a. Direct service/multiple client contacts per week (suggested minimum of five clients) including either service in an agency or university-based clinic, or in a private practice under supervision.	
An academic setting applicant may perform any of activities b, c or d.	
b. Modeling and demonstrating clinical techniques, including assessment and therapy.	
c. Supervision of clinical services, wherein the faculty supervisor assumes direct responsibility for supervisee's clinical work.	
d. Conducting workshops for community groups or public presentations on mental health related topics.	

Affidavit

The undersigned, being duly sworn, deposes and says that the statements contained herein are true, complete, and correct to the best of his/her knowledge and belief; that he/she has not suppressed any information which might affect this application; that he/she is of good moral character, and will conform to the ethical standards and conduct of the profession; that he/she has otherwise met all statutory requirements, and believes him/herself eligible for certification; and that he/she has read and understood this affidavit.

Signature of Applicant

Date

State of _____

County of _____

Subscribed and sworn to before me, to certify which witness my hand and seal of this office this ____ day of ____ 20 ____

Notary Public

My commission expires

Return this form to:

Oklahoma State Board of Examiners of Psychologists
201 N.E. 38th Terrace, Suite 3
Oklahoma City, Oklahoma 73105
Telephone: (405) 524-9094
Fax: (405) 524-9427