State of West Virginia
Board of Examiners of Psychologists
P.O. Box 3955
Charleston, WV 25339-3955

Phone: 304-558-3040
Fax: 304-558-0608
Email: psychbd@wv.gov
Web: wvpsychbd.wv.gov

APPLICATION FOR SUPERVISION - PART I

(To Be Completed by the Candidate for Licensure)

Residence Information: Name:	Business Information: Business Name:
Address:	Work Address:
City: State: Zip:	Work City: State: Zip:
Home Telephone:	Position/Title:
Cell:	Work Telephone: Ext:
Email:	Fax:
	Email:
Do you currently reside at this address: Yes/No	Are you currently employed at this location: Yes/No

LISTSUPERVISORS

Please list current supervisor(s) and the supervisor(s) to be added. All these will be listed on new gold card.

PREVIOUS SUPERVISION

Note: In order to receive credit for previously supervised experience, you must provide satisfactory documentation of hours worked under supervision, and your former supervisor must complete and submit a Demonstrable Competency Form. This section is not for new applicants.

Supervisor	Supervision Time Period
Address	To From
Telephone	Estimated Hours

PROPOSED PROFESSIONAL ACTIVITIES

(Please check those which apply)

SETTINGS:						
Community Mental Health Center		Full Time		Part Time		Hours Per Week
State Psychiatric Hospital		Full Time		Part Time		Hours Per Week
Private Mental Health Practice		Full Time		Part Time		Hours Per Week
Private Mental Health Clinic		Full Time		Part Time		Hours Per Week
Private Hospital (Inpatient)						
College/University		Full Time		Part Time		Hours Per Week
School System		Full Time		Part Time		Hours Per Week
Medical Hospital						
Other Agency (Specify)		Full Time		Part Time		Hours Per Week
_____						
Other Private (Specify)		Full Time		Part Time		Hours Per Week
_____		Full Time		Part Time		Hours Per Week

PROPOSED PROFESSIONAL ACTIVITIES (CONTINUED)

FUNCTIONS

ASSESSMENT	ADULT	ADOLESCENT	CHILD
Intellectual			
Personality			
Neuropsychological			
Court, Competency			
Court, Commitment			
Forensic, Civil			
Forensic, Criminal			
Learning, Educational			
Report Writing			
Disability			
Other (Specify) _____			

THERAPY	ADULT	ADOLESCENT	CHILD
Individual			
Couples			
Family			
Group			

CONSULTATION	ADULT	ADOLESCENT	CHILD
Schools			
Court			
Industry			
Hospitals			
Other (Specify) _____			

SPECIALITY AREAS	ADULT	ADOLESCENT
Administrative/Training		
Affective Disorders		
Anxiety Disorders		
Chemical Dependency		
Chronically Mentally Ill		
DD/MR/Autism		
Elderly/Aging		
Eating Disorders		
Learning Problems		
Medical Illness/Pain		
Sexual Abuse		
Other (Specify) _____		

SPECIALITY TECHNIQUES	ADULT
Crisis Intervention	
Teaching/Skills Training	
Hypnosis	
Relaxation Training	
Desensitization	
Biofeedback	
Other (Specify) _____	

GENERAL THEORETICAL ORIENTATION

STATEMENT OF AGREEMENT

I attest to the fact that the above-indicated information is true in fact. I agree to abide by the APA Ethical Code. I understand my practice of psychology is done under license and supervision of the assigned supervisor.

_____ (Candidate's Signature)

_____ (Supervisor's Signature)