For Board Use Only

Date of Application____________ $____________ Application Fee CK#____________ App#____________

Date of Oral Examination________________________Oral Examination Results________________________

License Number______________________Date Issued____________________ Expires__________________

Date Child Support Checked:____________________Y/N Date ASPPB Data Bank Checked______________Y/N

Date of licensure fee paid:___________CK#_________$__________ 1/4 1/2 3/4 1 year prorated

South Dakota Board of Examiners of Psychologists

810 N. Main St., #298 • Spearfish, SD 57783-2446 • Phone: (605) 642-1600

GENERAL INFORMATION (Please Type)

1. Name____ 2. Degree________________________
   (Last) (First) (MI)
   Social Security Number______________________________
3. Business Address____
   (Street or P.O. Box) (City) (State) (Zip)
   Business Phone (__________)____________________________
4. Home Address____
   (Street or P.O. Box) (City) (State) (Zip)
   Home Phone (__________)____________________________
5. Date of Birth_____/_____/______ Email ____
6. Race (Please circle one): White • Black or African American • American Indian or Alaskan Native • Asian
   Native Hawaiian or Other Pacific Islander • Not Listed or Prefer not to answer • Not applicable
7. Gender (Please circle one): Male • Female • Prefer not to answer • Not applicable
8. Ethnicity (Please circle one): Hispanic • Nonhispanic • Prefer not to answer • Not applicable
9. Diplomate of American Board of Professional Psychology? Yes ☐ No ☐
10. Are you or have you ever been licensed as a Psychologist in any other State or Province?
    Please send a Verification of Licensure Form to each State or Province to be completed and returned directly to the Board Office.

    Give States/Provinces____

    Original Date______________________ Number__________________ Expiration Date__________________

    Give States/Provinces____

    Original Date______________________ Number__________________ Expiration Date__________________

    Give States/Provinces____

    Original Date______________________ Number__________________ Expiration Date__________________

    Give States/Provinces____

    Original Date______________________ Number__________________ Expiration Date__________________
11. Have you ever taken the Professional Examination Service examination for licensure or certification in psychology? Yes ☐ No ☐

    If yes, in which States/Provinces?______________________________________ Date__________________
    If yes, please have scores sent directly to the above address by EPPP.
12. Has any State/Province rejected your application or revoked your professional license or certificate? Yes ☐ No ☐

13. Has any professional association rejected your applicaiton for membership or revoked a membership you held? Yes ☐ No ☐
If yes, give comlete details on a separate sheet.

14. Has any State/Province Regulatory Board or any professional organization determined that you committed unprofessional conduct? Yes ☐ No ☐
If yes, give comlete details on a separate sheet.

15. Have you ever been convicted of a crime other than misdemeanor traffic offenses? Yes ☐ No ☐
If yes, give complete details on a separate sheet, including copies of the court's judgement and any written decisions in that case.

16. Have you ever been accused in a court of law of any civil or criminal misconduct, other than misdemeanor traffic offenses, which is not listed elsewhere in your responses to this application? Yes ☐ No ☐
If yes, give complete details on a separate sheet, including copies of the court's judgement and any written decision in that case.

17. SDCL 25-7A-56 prohibits the issuance or renewal of any state regulated license if an applicant owes $1,000 or more in past due child support. Do you owe $1,000 or more in past due child support? Yes ☐ No ☐

18. Is your spouse an active duty member of the armed forces? Yes ☐ No ☐
If yes, was your spouse subject to military transfer to South Dakota? Yes ☐ No ☐
If yes, did you leave employment to accompany your spouse to South Dakota? Yes ☐ No ☐

19. EDUCATION OR TRAINING Please have transcripts sent directly to the Board office.

	University or College	Address (City, State, Zip)	Dates Attended (xx/xx/xxxx-xx/xx/xxxx)	Degree	Major Subject
a.					
b.					
c.					
d.					
e.					

20. DOCTORAL DEGREE:
Major Advisor____________________

Department____________________

Title of Dissertation____________________

21. **Please attach a sheet arranging your courses to the content areas of biological bases of behavior, cognitive-affective bases of behavior, social bases of behavior, individual differences. You must complete this requirement for your application to be approved.**

22. INTERNSHIP. (Please have supervisor complete internship form)
Name of Facility____________________

Address____________________
(Street or P.O. Box) (City) (State) (Zip)

Date: (From)________________(To)________________

Total Number of Internship Hours Completed:____________________

Nature of Training:____________________

Name of Direct Supervisor:____________________

Supervisor's Title:____________________

23. List major postdoctoral psychological experience (list supervisor, number of hours and dates):______________________

____

____

24. My primary areas of intended professional practice are:______________________________________

____

____

25. PROFESSIONAL EXPERIENCE (Please list current position first)

a. Employer Name (current)______________________ Employer Business Type: (Please circle one) *Unknown • Individual • LLC Partnership • Corporation Association • LLP • Other*

Employer Address____
(Street or P.O. Box) (City) (State) (Zip)

Start Date:______________________ Primary Responsibilities______________________

____

____

Supervisor____

b. Position______________________ Organization______________________

Address____
(Street or P.O. Box) (City) (State) (Zip)

Date:______________________ Primary Responsibilities______________________

____

____

Supervisor____

c. Position______________________ Organization______________________

Address____
(Street or P.O. Box) (City) (State) (Zip)

Date:______________________ Primary Responsibilities______________________

____

____

Supervisor____

d. Position______________________ Organization______________________

Address____
(Street or P.O. Box) (City) (State) (Zip)

Date:______________________ Primary Responsibilities______________________

____

____

Supervisor____

e. Position____Organization________________________________

Address____
(Street or P.O. Box) (City) (State) (Zip)

Date:____Primary Responsibilities____________________

____

____

Supervisor____

I declare and affirm under the penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

____
Signature of Applicant

____
Date

The undersigned, having appeared before me and being identified as the same individual by appropriate identification, being sworn, deposes and says that he/she is the person who executed this application; that the statements herein contained are true in every respect; that he/she has not suppressed any information that might affect this application.

Sworn to before me this_________________________

day of_____________________,__________________

____
Signature of Notary Public

My commission expires_________________________

The Board of Psychologists does adhere to the Human Relations Act of 1972 and therefore does not discriminate against applicants on the basis of race, sex, religion or national origin.

In accordance with the Americans with Disabilities Act, if you so desire special accommodations please contact this office 60 days prior to exam.

For Board Use Only
Date Received: ________________
$____________ CK#______________
Approved By: ____________________
Relicensure Period: ______________

Application for Relicensure

Board of Examiners of Psychologists

810 N. Main Street #298
Spearfish, SD 57783
Ph. 605-642-1600

***Please be advised the license renewal fee is $300.00 payable by check or money order.**

License # ___________________________

Please send all correspondence to my: _____ Mailing Address _____ Employment Address

Licensee Name: ____
(Last) (First) (Middle) (Maiden)

Mailing Address: ____
(Street or P.O. Box) (City) (State) (Zip)

Home Telephone: (______) ___________________ Work Telephone: (______) ________________

Employer Name: ____

Employer Address: ____
(Street and PO Box) (City) (State) (Zip)

Email Address (Optional): ____________________________________

☐ **The above is an address change**

☐ **I WILL NOT be renewing.** Please return form to the board office with the above information completed and be sure to sign the form. No other information is necessary.

Since the original date of your South Dakota Psychologist License	Yes	No
1. Has this or any other state rejected your application or revoked your professional license or certificate? If yes, provide full details on a separate sheet.		
2. Has any professional association rejected your application for membership or revoked a membership you held? If yes, provide full details on a separate sheet.		
3. Have you been found guilty of unprofessional conduct by a duly constituted professional organization or convicted by a state board of psychologist examiners of such unprofessional conduct? If yes, provide full details on a separate sheet.		
4. Have you been convicted by a court of law for any offense in connection with your practice as a Psychologist? If yes, provide full details on a separate sheet.		
5. Have you been convicted of a felony after being licensed in the state of South Dakota? If yes, provide full details on a separate sheet.		
6. SDCL 25-7A-56 prohibits the issuance or renewal of any state regulated license if an applicant owes $1,000 or more in past due child support. Do you owe more than $1,000 in past due child support?		

(Over)

I, ______________________________ (print name) hereby apply for licensure renewal by the State of South Dakota Board of Examiners of Psychologists. I declare and affirm under the penalties of perjury that this renewal application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

______________________________ (Signature)

______________________ Date (mm/dd/yyyy)

_______Please initial here that you have enclosed the **$300.00** renewal fee payable by check or money order. Please make checks payable to the SD Board of Examiners of Psychologists.

SOUTH DAKOTA BOARD OF EXAMINERS OF PSYCHOLOGISTS CONTINUING EDUCATION REPORT FORM.

In South Dakota Law the number of CEU hours has not been specified, but you must complete SOME continuing education. Please list the continuing education that you obtained below. You may attach additional sheets if needed.

Date(s) of Program	**Name of Presenter/Organization**	**Format (Webinar, Self-Directed, Seminar)**	**Program Title**

SOUTH DAKOTA BOARD OF EXAMINERS OF PSYCHOLOGISTS
RELEASE AND WAIVER FOR STATES/PROVINCES

TO BE COMPLETED BY APPLICANT

Instructions: You must complete this form and send to any state/providence that you have been licensed or certified in. Please request that they send the records to:

SD Board of Examiners of Psychologists
810 N. Main St., #298
Spearfish, SD 57783

Please make enough copies of this Release and Waiver Form so that you can sign an original for each state, as well as an original to this office.

I,____, an applicant for licensure as a Psychologist in

South Dakota, do hereby authorize the State of____
(Name of Regulator Board or Agency You Were Licensed In)

____ ______________________
(Agency Address) (State) (Zip) Telephone

to release all information in its possession that relates or many relate to my fitness to practice Psychology to the South Dakota Board of Examiners of Psychologists or its designee, and I authorize the South Dakota Board of Examiners of Psychologists or its agents or employees to consider any or all of such information on the attached application. This authorization, release and waiver specifically applies to my application. This authorization, release and waiver specifically applies to all information in possession of the above named regulatory board or agency, including all materials deemed privileged or confidential, and I hereby direct the named regulatory agency or board to release such information to the South Dakota Board of Examiners of Psychologists or its designee.

I hereby also specifically waive any procedural due process rights, whether based in common law, statute or constitution of any state, province or the United States, that would otherwise entitle me to a hearing before release of the materials referred to above.

In consideration of the above name regulatory board or agency releasing any information in its possession concerning me, I,____, on behalf of myself, my spouse, legal representatives, heirs and assigns, hereby release, waive, discharge, and agree to hold harmless and indemnify the South Dakota Board of Examiners of Psychologists, the State of South Dakota, the South Dakota Board of Examiners of Psychologists officers, agents and employees from and against any and all claims, actions, suits, damages and liabilities arising or allegedly arising from the release of the information.

Dated this______________________day of______________________, 20________.

______________________________ ______________________________
Applicant Witness

____
Witness

STATE OF______________________________)
) SS
COUNTY OF______________________________)

On this, the__________________day of______________________________, 20__________, before me, the undersigned officer, personally appeared____, known to
(Applicant)

me or satisfactorily proven to be the person whose name is subscribed to within the instrument and acknowledged that he/she executed the same for the purposes therein contained.

IN WITNESS WHEREOF, I have set my hand and official seal.

Notary Public______________________________

My Commission Expires______________________

SOUTH DAKOTA BOARD OF EXAMINERS OF PSYCHOLOGISTS

810 N. Main St., #298
Spearfish, SD 57783
605-642-1600

FORM FOR THE VERIFICATION OF ALL PAST/PRESENT LICENSURE

To The Applicant: Complete the top portion of this form and send to the Licensing Authority/Regulatory Board in the state or Canadian Province in which you were licensed or certified.

FULL NAME: ____
(Last Name) (First Name) (Middle) (Maiden)

ADDRESS: ____
(Mailing) (City) (State) (Zip)

LICENSE OR CERTIFICATION NUMBER: ______________ EXPIRATION DATE ______________

ORIGINAL DATE OF LICENSURE/CERTIFICATION ______________________________

• •

To the Licensing Authority/Regulatory Board: Please provide the information requested below and return directly to our Board address.

I, an Authorized Board Representative of ______________________________,
(state or province)

hereby certify that the above applicant is/was licensed at the level of ______________________, in
(licensure title)

good standing, was granted a State Certificate/License Number ______________________ to

practice Psychology in the state/province of ______________________, on the basis of:

_____Exemption _____Written Examination _____Reciprocity _____Endorsement _____Oral Examination _____Other
If other, please explain on a separate sheet.

DATE & YEAR ISSUED: ______________________ EXPIRATION DATE: ______________

I further certify that our records ____________ do ____________ do not show information concerning this individual that is derogatory in nature. The above individual has/has not been reported to HIPDB or ASPPB for disciplinary reason by this board.

Explanation of derogatory information: ______________________________
____
____

Name of Authorized Board Representative ______________________________
(Signature)

____
(Print name)

____
(Date)

Board Address: ______________________
Mailing Address

____
City, State, Zip

(SEAL)

Board Telephone (______) ______________
Email Address ______________________
Web Site ______________________
Please enclose a copy of your state or province licensing/certification law for psychologists.

Board Use:
Received ______________

Supervisor please return the completed form directly to:

South Dakota Board of Examiners of Psychologists
810 N. Main St., #298
Spearfish, SD 57783

Apt #________________
(For Board Use)

This application for licensure cannot be processed until this completed form is received by the Board of Examiners.

PREDOCTORAL INTERNSHIP SUPERVISION CONFIRMATION FORM

Part I. TO BE COMPLETED BY APPLICANT AND SENT TO INTERNSHIP DIRECTORS

Applicant's Name:____
(Last) (First) (MI)

________________________ ____________
(Signature of Applicant) (Date)

Part II. INTERNSHIP TRAINING DIRECTOR

The above-named individual has applied for licensure as a psychologist in the State of South Dakota. You are being asked to certify the supervised predoctoral psychology internship of this applicant. Attesting to this applicant's internship training is a critical element of the licensing process. Any misstatements by a licensed psychologist in completing this form may constitute unethical/unprofessional conduct. Please complete this form as objectively and candidly as possible. **NO PORTION OF THE REMAINDER OF THIS FORM MAY BE FILLED IN BY THE APPLICANT.**

Part III. INFORMATION ABOUT INTERNSHIP

The internship must be an organized training program designed to provide the intern with a planned programmed sequence of training experiences, emphasizing breadth and quality of training.

Name of Program:____

Internship Facility:____

Address of:____
(Street, P.O. Box) (City) (State) (Zip)

Phone Number:(________)____________________

1. At the time of this applicant's internship was the internship program APA-Approved? Yes ❒ No ❒

   Is the internship program presently APA-Approved? Yes ❒ No ❒

2. Name of agency psychologist who is designated to be responsible for the integrity and quality of the training program:

________________________________ State/License #________________
(Last) (First) (MI) (Degree) (State) (Lic #)

Part III. INFORMATION ABOUT INTERNSHIP (continued)

1. Inclusive dates of applicant's internship:

   Beginning: ______________________ Termination date: ________________________

2. Applicant's title during the internship: ____

3. Applicant's position during the internship: ____________________________________

4. Total number of internship hours completed by applicant: __________________________

5. Internship was full time ____________________ or part-time ____________________
   (hours/week) (hours/week)

6. Number of other interns in training during this applicant's internship: ________________

7. Number of licensed psychologists on the internship training faculty: _________________

8. Percentage of time applicant's supervision was provided by licensed psychologists: ________

9. Percentage of time applicant's supervision was provided by persons other than licensed psychologists: __________; specify supervisor's profession or discipline: ______________

10. Percent of time applicant spent in direct client contact: ___________________________

11. Number of hours per week applicant spent in face-to-face individual supervision: __________

12. Number of additional hours per week applicant spent in learning activities in which the applicant was actively involved: ________________

IMPORTANT:
PLEASE RETURN WITH THIS COMPLETED FORM A WRITTEN STATEMENT OR BROCHURE WHICH DESCRIBES THE GOALS AND CONTENT OF THE INTERNSHIP, WHICH STATES CLEAR EXPECTATIONS FOR THE QUALITY AND QUANTITY OF THE TRAINEES'S WORK, AND WHICH IS AVAILABLE TO PROSPECTIVE INTERNS.

Submission of a written statement or brochure is required for this form to be complete·

Part IV. INFORMATION ABOUT INTERN

1. During the period of supervised experience, what percent of the applicant's direct service time was spent in service of the following age categories:
   Preschool: ______________
   School Age: ______________
   Adolescent: ______________
   College: ______________
   Adult: ______________
   Senior Citizen: ______________ Total 100%

2. Please describe the work load and training activities of the applicant: ______________
   ____
   ____
   ____
   ____
   ____

3. Based on your overall experience with this applicant, do you personally attest to the competence, professional judgment and ethical conduct requisite to the practice of psychology? Yes ❒ No ❒

   IF NO, please explain:

4. Have you ever had any relationship with this applicant other than a supervisory relationship? Yes ❒ No ❒

   If YES, please explain:

5. Is this applicant qualified by internship training to administer and interpret projective tests? Yes ❒ No ❒

6. What is the applicant not qualified to do in the practice of psychology? ______________
   ____
   ____

7. Would you hire this applicant as a professional psychologist? Yes ❒ No ❒

   If NO, please explain:

8. Do you have any reservations that would assist the South Dakota Board of Examiners of Psychologists in evaluating this applicant's qualifications to engage in the practice of psychology? Yes ❒ No ❒

   If YES, please explain:

Part V. INFORMATION ABOUT SUPERVISOR

1. Name ____ Title ______________________

2. Current Address ____
(P.O. Box, Street) (City) (State) (Zip)

3. Current Phone Number (________)____________________(________)____________________
(Work) (Fax)

4. Highest Degree Earned ____

5. Title at time applicant was supervised ____

6. Are you a licensed psychologist? Yes ❐ No ❐

7. If you are a licensed psychologist, please list:

   State/Province ________________________________ Level ______________________

   License # ____________________________________ Date Acquired ________________

   If you are a licensed psychologist in any other states/province, please list:

   State/Province _____________License # _____________Date Acquired_____________

   If you are not licensed or certified, please complete the following:

   Major subject of degree: ____

   Title of department and school granting degree: ______________________________

   ____

   Number of years worked in the capacity as a professional psychologist: ____________

I DO / DO NOT recommend this applicant for licensure in psychology.

I declare and affirm under the penalties of perjury that this Supervision Confirmation Form has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

____ ____________________
Internship Director's/Supervisor's Signature Date

SOUTH DAKOTA BOARD OF EXAMINERS OF PSYCHOLOGISTS

RELEASE AND WAIVER FOR SUPERVISORS

INSTRUCTIONS: You must complete this form and send to your supervisors along with the appropriate supervisory form. Please make enough copies of this Release and Waiver Form so that you can sign an original for each supervisor.

****

I, ______________________________, the applicant named in the attached and foregoing application for licensure as a Psychologist in South Dakota, do hereby authorize _______________

____

____

(NAME OF SUPERVISOR)

to release all information in its possession that relates or may relate to my fitness to practice Psychology to the South Dakota Board of Examiners of Psychologists or its designee, and I authorize the South Dakota Board of Examiners of Psychologists or its agents or employees to consider any or all of such information in passing on the attached application. This authorization, release and waiver specifically applies to all information in possession of the above named supervisor, including all material deemed privileged or confidential, and I hereby direct the named supervisor to release such information to the South Dakota Board of Examiners of Psychologists or its designee.

I hereby also specifically waive any procedural due process rights, whether based in common law, statute or constitution of any state, province or the United States, that would otherwise entitle me to a hearing before release of the materials referred to above.

In consideration of the above named supervisor releasing any information in its possession concerning me, I ________________________, on behalf of myself, my spouse, legal representatives, heirs and assigns, hereby release, waive, discharge, and agree to hold harmless and indemnify the ____________________________________

____

(NAME OF SUPERVISOR)

the State of South Dakota, the South Dakota Board of Examiners of Psychologists and their officers, agents and employees from and against any and all claims, actions, suits, damages and liabilities arising or allegedly arising from the release of the information.

Dated this ___________ day of ______________________, ____________.

______________________________ ______________________________

Applicant Witness

____

Witness

STATE OF ________________________________)

COUNTY OF ______________________________)

On this __________ day of ___________________________, _______, before me, _________________________________, the undersigned officer, personally appeared _________________________________, known to me or satisfactorily proved to be the person whose name is subscribed to the within instrument and acknowledged to me that __he executed the same for the purposes therein contained.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal on the date above first written.

____
Notary Public

State of _____________________________

My Commission Expires: _____________________

(SEAL)

Please return the completed form directly to:

South Dakota Board of Examiners of Psychologists
810 N. Main St., #298
Spearfish, SD 57783

Applicant's Name: ____
(Last) (First) (MI)

This form applies only to applicants whose internships were not APA approved or APA accredited. Was your internship program APA approved? Yes No

If yes, please sign ______________________________
If no, please complete the following:

APPLICANT PREDOCTORAL INTERNSHIP CONFIRMATION FORM

***Please attach the written materials about your internship.**

1) Name and describe the setting (e.g., hospital, outpatient clinic, school, consortium, etc.) of your internship site:
____
____

2) What was your internship program's goal? ______________________________
____
____

3) Duration of internship(# of months): ________ (# of hours) ________ Start Date ________ End Date ________
Was the internship continuous for the period indicated? Yes No
If no, please explain____
____

4) Describe the population(s) (e.g., children, adults, minorities, homeless, chronically mentally ill, etc) to which you provided direct psychological services: ______________________________
____
____

5) Describe the types of psychological services (e.g., individual therapy, group psychotherapy, psychological evaluations, etc.) you provided to patients/clients: ______________________________
____
____
____

Number of evaluations you completed during your internship: ______________

*Please specify the types of evaluations you completed and specific tests administered (e.g., neuro-psychological, full batteries including intellectual and projective and objective personality measures, etc.)
____
____
____
____

Approximate number of patients/clients seen per week: ______________

6) Approximate number of hours spent in face-to-face psychological services per week: ____________

7) Were you provided a formal written policies and procedures (e.g., due process and grievance procedures, intern performance evaluation, goals and objective, etc.) when beginning your internship: Yes No

8) Number of hours spent per week in: Individual, Face-to-Face Supervision _______
Group Supervision__________ Other________ please explain ________________________________
____

9) Number of full-time doctoral-level psychologists that were licensed, registered, or certified and served as primary supervisors at internship site: ____

*Did supervisors carry clinical responsibility for the cases being supervised (e.g., countersigning documentation or having their name on the treatment plan or summary)? Yes No

10) Name of Program/Training Director: ____

*Was this person licensed, registered, or certified to practice psychology in the jurisdiction in which the internship was located? Yes No
If no, where were they licensed? ____

*Number of hours per week the Program/Training Director was on site: _______________________

11) Number of interns at your site (including yourself): ________________

*How many interns were full-time? ___________ Half-time? ______________
*If not called "Interns", what title was used? ______________________

12) Total number of hours spent in didactic activities: __________________

__________________Case Conferences
__________________Seminars
__________________In-service Training
__________________Grand Rounds
__________________Other (please specify)____

13) Did your program utilize fee splitting or productivity arrangements for interns where they are expected to generate all or part of their stipend through clinical billings? Yes No

Additional Comments:

Provide a copy of the program description or brochure, which outlines the goals and content of the internship.
Provide a copy of the due process procedures.
Provide a copy of your internship evaluation forms.
Provide a copy of your internship completion certificate

____ ________________________
Applicant's Signature Date

Date Receive in Board Office______________
Applicant Number____________________

POST-DOCTORAL PSYCHOLOGICAL EXPERIENCE FORM

Supervisor please return the completed form directly to:
South Dakota Board of Examiners of Psychologists
810 N. Main St. #298
Spearfish, SD 57783-2447

The application for licensure cannot be processed until this completed form is received by the Board of Examiners.

TO BE COMPLETED BY APPLICANT

Applicant's Name:____
(Last) (First) (MI)

Applicant's Signature:______________________________ ______________
(Signature) (Date)

TO BE COMPLETED BY SUPERVISING PSYCHOLOGIST

The above-named individual has applied for licensure as a psychologist in the State of South Dakota. South Dakota licensing law requires one year of post-psychological experience as a prerequisite for licensure. You are being asked to certify the post-doctoral psychological experience of this applicant. Attesting to this applicant's post-doctoral training is a vital element of the licensing process. Any misstatements by a licensed psychologist in completing this form may constitute unethical/ unprofessional conduct. Please complete this form as objectively and candidly as possible.
NO PORTION OF THE REMAINDER OF THIS FORM MAY BE FILLED IN BY THE APPLICANT.

1. Name, address and number of agency where psychological experience was obtained:

____
(Name)
____
(Mailing address)
____
(City) (State) (Zip)
____
(Telephone) (Fax Number)

2. Name, address and phone number of psychologist responsible for supervising the applicant's psychological experience:

____
(Name)
____
(Mailing address)
____
(City) (State) (Zip)
____
(Telephone) (Fax Number)

State/Province where Supervisor licensed:______________________________

License #________________________Date issued________________Current Yes/No

3. Inclusive dates of applicant's psychological experience:

Staring date________________________Completion date________________

4. Applicant's title during psychological experience:______________________

5. Applicant's position during psychological experience:____________________

____

6. Applicant worked full time____________________or part-time________________
(hours per week) (hours per week)

(Over)

7. During the period of supervised experience, what percent of the applicant's direct service time was spent in service of the following age categories:

   Preschool: __________%
   School Age: __________%
   Adolescent: __________%
   College: __________%
   Adult: __________%
   Senior Citizen: __________% Total 100%

8. Please describe the nature of the applicant's psychological experience:______________________
   ____
   ____
   ____
   ____
   ____

9. Based on your overall experience with this applicant, do you personally attest to the competence, professional judgement and ethical conduct perquisite to the independent unsupervised practice of psychology?
   YES ☐ NO ☐

   If NO, please explain:

10. What is the applicant not qualified to do in the practice of psychology (You may attach a separate sheet, if necessary)?____
    ____
    ____

11. Would you hire this applicant as a professional psychologist?
    YES ☐ NO ☐

    If no, please explain (You may attach a separate sheet, if necessary):

12. Do you have any reservations that would assist the South Dakota Board of Examiners of Psychologists in evaluating this applicant's qualifications to engage in the practice of psychology?
    YES ☐ NO ☐

    If YES, Please explain

I DO/ DO NOT recommend this applicant for licensure in psychology.
(Please Circle)

I declare and affirm under the penalties of perjury that this experience form has been completed by me, and to the best of my knowledge and belief, is in all things true and correct.

____ ____________________

Signature of Supervising Psychologist Date

SOUTH DAKOTA BOARD OF EXAMINERS OF PSYCHOLOGISTS
RELEASE AND WAIVER FOR STATES/PROVINCES

TO BE COMPLETED BY APPLICANT

Instructions: You must complete this form and send to any state/providence that you have been licensed or certified in. Please request that they send the records to:

SD Board of Examiners of Psychologists
810 N. Main St., #298
Spearfish, SD 57783

Please make enough copies of this Release and Waiver Form so that you can sign an original for each state, as well as an original to this office.

I,______________________________, an applicant for licensure as a Psychologist in

South Dakota, do hereby authorize the State of______________________________
(Name of Regulator Board or Agency You Were Licensed In)

______________________________ ______________________________
(Agency Address) (State) (Zip) Telephone

to release all information in its possession that relates or many relate to my fitness to practice Psychology to the South Dakota Board of Examiners of Psychologists or its designee, and I authorize the South Dakota Board of Examiners of Psychologists or its agents or employees to consider any or all of such information on the attached application. This authorization, release and waiver specifically applies to my application. This authorization, release and waiver specifically applies to all information in possession of the above named regulatory board or agency, including all materials deemed privileged or confidential, and I hereby direct the named regulatory agency or board to release such information to the South Dakota Board of Examiners of Psychologists or its designee.

I hereby also specifically waive any procedural due process rights, whether based in common law, statute or constitution of any state, province or the United States, that would otherwise entitle me to a hearing before release of the materials referred to above.

In consideration of the above name regulatory board or agency releasing any information in its possession concerning me, I,______________________________, on behalf of myself, my spouse, legal representatives, heirs and assigns, hereby release, waive, discharge, and agree to hold harmless and indemnify the South Dakota Board of Examiners of Psychologists, the State of South Dakota, the South Dakota Board of Examiners of Psychologists officers, agents and employees from and against any and all claims, actions, suits, damages and liabilities arising or allegedly arising from the release of the information.

Dated this____________day of____________, 20________.

______________________________ Applicant

______________________________ Witness

______________________________ Witness

STATE OF______________________________)
COUNTY OF______________________________) SS

On this, the____________day of______________________________, 20__________, before me, the undersigned officer, personally appeared______________________________, known to
(Applicant)
me or satisfactorily proven to be the person whose name is subscribed to within the instrument and acknowledged that he/she executed the same for the purposes therein contained.

IN WITNESS WHEREOF, I have set my hand and official seal.

Notary Public______________________________

My Commission Expires______________________________

SOUTH DAKOTA BOARD OF EXAMINERS OF PSYCHOLOGISTS

810 N. Main St., #298
Spearfish, SD 57783
605-642-1600

FORM FOR THE VERIFICATION OF ALL PAST/PRESENT LICENSURE

To The Applicant: Complete the top portion of this form and send to the Licensing Authority/Regulatory Board in the state or Canadian Province in which you were licensed or certified.

FULL NAME: ____
(Last Name) (First Name) (Middle) (Maiden)

ADDRESS: ____
(Mailing) (City) (State) (Zip)

LICENSE OR CERTIFICATION NUMBER: ________________ EXPIRATION DATE ______________

ORIGINAL DATE OF LICENSURE/CERTIFICATION ______________________________

• •

To the Licensing Authority/Regulatory Board: Please provide the information requested below and return directly to our Board address.

I, an Authorized Board Representative of ______________________________________,
(state or province)

hereby certify that the above applicant is/was licensed at the level of ______________________, in
(licensure title)

good standing, was granted a State Certificate/License Number ______________________ to

practice Psychology in the state/province of ______________________, on the basis of:

_____Exemption _____Written Examination _____Reciprocity _____Endorsement _____Oral Examination _____Other
If other, please explain on a separate sheet.

DATE & YEAR ISSUED: ______________________ EXPIRATION DATE: ______________

I further certify that our records ______________ do ______________ do not show information concerning this individual that is derogatory in nature. The above individual has/has not been reported to HIPDB or ASPPB for disciplinary reason by this board.

Explanation of derogatory information: ______________________________________
____
____

Name of Authorized Board Representative ______________________________________
(Signature)

____
(Print name)

____
(Date)

Board Address: ______________________
Mailing Address

____
City, State, Zip

(SEAL)

Board Telephone (______) ______________
Email Address ______________________
Web Site ______________________
Please enclose a copy of your state or province licensing/certification law for psychologists.

Board Use:

Received ______________