Virginia Department of Health Professions
Board of Psychology

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INTERNSHIP VERIFICATION
CLINICIAL PSYCHOLOGIST

This form is used to compile required information and verification from your director of internship training about your clinical internship.

TO BE COMPLETED BY APPLICANT: Complete the top portion of this form **only**.

Last Name:	First Name:	Middle/Maiden Name:	Suffix:

Date of Birth: (MM/DD/YYYY)	Last 4 digits of Social Security Number: XXX-XX- ___ ___ ___ ___
Applicant's Student ID Number:	Email Address:

TO BE COMPLETED BY DIRECTOR OF INTERNSHIP TRAINING: Please provide official verification of information requested below. The completed form containing a wet/original or verifiable electronic signature can be emailed directly to the Board at psy@dhp.virginia.gov or returned to the applicant for inclusion in their online application being submitted to the Virginia Board of Psychology.

Part I:

Internship Facility Name:	
Internship Facility Address:	
Start Date: (MM/DD/YYYY)	End Date: (MM/DD/YYYY)

Part II:

Please check the appropriate category for your internship program. *Non-accredited internships must provide a copy of their handbook/brochure for review.*	**Accredited**	**Meets Equivalent Standards**
Accredited by the American Psychological Association (APA)	☐	☐
A member of the Association of Psychology Postdoctoral and Internship Centers (APPIC)	☐	☐
Accredited by Canadian Psychological Association (CPA)	☐	☐
Designated by the Association of State and Provincial Psychology Boards/National Register of Health Service Psychologists	☐	☐

Part III:

Describe the nature of the internship program. Please describe the emphasis and experience in the diagnosis and treatment of persons with moderate to severe mental disorders.

Printed Name _____ Title: _____

Signature of Training Director _____Date _____

Wet/Original or Verifiable Electronic Signature Only