



VERIFICATION OF POST-DEGREE SUPERVISION

This form is to be filled out when supervision is completed.

Applicant's Name		Social Security/Virginia DMV Control Number	
Applicant's Mailing Address:		Telephone Number:	
Applicant's practice name, address and telephone number (place where supervised residency occurred):			
Supervisor's Name		Professional Title	
Is supervisor licensed as a mental health professional? Yes [] No []		If yes, in which jurisdiction(s)?	
License Title(s)		License number(s) and expiration date(s)	
Clinical experience? Yes [] No []		If yes, number of years	
Telephone Number:		E-Mail Address	
Fax Number:			
Business Name and Address			
Employment Position			
Applicant's position under your supervision		Length of time under your supervision: From: _____ To: _____ Month/Day/Year Month/Day/Year	
Total number of residency hours: _____		Was residency? (Please check one) _____ Part time _____ Full time	
Number of hours per week of individual, face-to-face supervision this applicant received in clinical practice:			
<u>Total</u> number of hours of individual, face-to-face supervision received by this applicant:			
Number of hours per week of group supervision this applicant received in clinical practice:			
<u>Total</u> number of hours of group supervision received by this applicant:			



For clinical psychology applicants:

I certify that, during the course of supervision of this resident, I have assessed the resident's skills in the following areas of practice as specified below:

	<u>Demonstrates Competency to Practice</u>	<u>Does Not Demonstrate Competency</u>	<u>Not Assessed</u>
1. Appropriate diagnosis of mental disorders according to standards of the profession	_____	_____	_____
2. Ordering or providing of treatments according to need	_____	_____	_____
3. Psychological evaluation or assessment of personal characteristics	_____	_____	_____
4. Interpreting or reporting on scientific theory in psychology	_____	_____	_____

For school psychology applicants:

I certify that, during the course of supervision of this resident, I have assessed the resident's skills in the following areas of practice as specified below:

	<u>Demonstrates Competency to Practice</u>	<u>Does Not Demonstrate Competency</u>	<u>Not Assessed</u>
1. Psychological assessment, evaluation and diagnosis relative to the assessment of individual characteristics that directly relate to learning or behavioral problems that impact education.	_____	_____	_____
2. Professional advisement and interpretative services with children or adults for amelioration or prevention of problems that impact education.	_____	_____	_____
3. Educational or vocational consultation or direct educational services, related to learning problems and related adjustments of individuals or groups, to schools, agencies, organizations or individuals.	_____	_____	_____
4. Development of programs designed to improve class situations and acting as a catalyst for teacher involvement in adaptations and innovations.	_____	_____	_____



Virginia Department of
Health Professions
Board of Psychology

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In your opinion, is the applicant competent to practice under the license for which he or she has applied? Yes [] No []

If no, please explain:

Additional comments:

Supervisor's Signature

(Month/Day/Year)