VIRGIN ISLANDS BOARD OF PSYCHOLOGICAL EXAMINERS

Checklist for Applicant

Please use this checklist to make sure you have submitted all necessary documents in your application for licensing as a psychologist or associate psychologist in the U.S. Virgin Islands.

_______ Completed application form.

_______ Required Application fee ($125.00) made payable to Board of Psychology Examiners).

_______ Verification of licensure in another jurisdiction (if applicable).

_______ Release of Information form signed.

_______ Final graduate psychology transcript (to be sent directly to the address below)

_______ Course descriptions from appropriate catalogs and/or course syllabi with faculty names and credentials (if program is not regionally accredited by the Council on Post-secondary Accreditation of the U.S. Department of Education).

_______ Verification of completion of internship.

_______ Attestation of Experience by Supervisor(s) to meet the hours required other than in the internship (to be mailed directly to the address below).

Please submit all items to:

Virgin Islands Board of Psychological Examiners
Department of Health
1303 Hospital Ground, Suite 10
St. Thomas, VI 00802
VIRGIN ISLANDS BOARD OF PSYCHOLOGY EXAMINERS

APPLICATION FOR LICENSE
PSYCHOLOGIST OR PSYCHOLOGICAL ASSOCIATE

Please complete all questions in order for your application to be processed. A current, original application form must be completed, signed, notarized, and returned to the Secretary of the Virgin Islands Board of Psychology Examiners with a postmark of no less than sixty (60) days prior to the examination. No application material may be faxed to the Board. A non-refundable application fee must accompany your application.

________________________
E-Mail Address

Last Name __________________________ First Name __________________________ Middle Initial __________________________

Social Security Number __________________________ Date of Birth __________________________ Place of Birth __________________________

Residential Address __________________________ Mailing Address __________________________

City __________________________ State __________________________ Zip Code __________________________ Residential Phone __________________________

Are you currently involved in the practice of psychology? □ Yes □ No If yes, complete the following:

Business Name __________________________ Business Address __________________________

City __________________________ State __________________________ Zip Code __________________________ Business Phone __________________________

Have you been license or certified by a psychology regulatory board in any jurisdictions, or made application to such a board? □ Yes □ No

If you answered yes above, indicate the jurisdiction, date of licensure of certification, and license or certificate number. If only an applicant, indicate the jurisdiction and status of application.
Have you passed the examination for professional practice in Psychology?
☐ Yes  ☐ No  If so, in which state(s)? ________________________________________________________

Have you ever been denied a professional license or certificate, or privilege of taking an examination, or had a professional license or certificate ever disciplined in any way (e.g. denied, suspended, reprimanded, censured, restricted, limited, placed on probation, revoked, etc.) by any licensing authority?

☐ Yes  ☐ No  If yes to any, provide details on an attached sheet.

Have you ever been convicted of, or entered of plea of guilty or nolo contendere to any felony or misdemeanor other than a minor traffic violation?

☐ Yes  ☐ No  If yes to any, provide details on an attached sheet.

What do you consider your primary area of specialty in psychology? (check one)
☐ Clinical  ☐ Counseling  ☐ School  ☐ Other (specify)_______________________________________

List the full name of all psychological organizations of which you are a member.

__________________________________________________________________________________________

If applying on the basis of a doctoral degree, was your doctoral program APA accredited through the duration of your enrollment in the program?  ☐ Yes  ☐ No

If yes, give the date of full APA approval. __________________________

Education.: List full name of institution and location beginning with the most recent.

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<tr>
<th>Institution</th>
<th>Department</th>
<th>City</th>
<th>State</th>
<th>Date Enrolled</th>
<th>Date Graduated</th>
<th>Awarded</th>
<th>Major</th>
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Specialty Training/Continuing Education: (If this is a new application, note all significant training. If a renewal application, indicate continuing education with the past two years.)

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<tr>
<th>From</th>
<th>To</th>
<th>Course Sponsor</th>
<th>Course Name</th>
<th>Course Location</th>
<th>#Days</th>
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Professional Experience and Employment: List all professional experience in chronological account order, beginning with the present position, to cover the complete time from, and including any graduate practicum, internships, etc. Also include any periods of unemployment, employment in fields other than psychology, etc. (i.e., do not leave any gaps in time). Attach additional sheets if necessary using the same format.

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<tr>
<th>Date: Month/Year</th>
<th>Full Time Equivalency</th>
<th>Organization</th>
<th>Position Held</th>
<th>Direct Supervisor</th>
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Affidavit: After completing all parts of this application, have the following Affidavit completed by a Notary Public.

State/Territory of __________________________________________ City/County of __________________________________________

_____________________________________________ personally appeared before me, and having been duly sworn (or affirmed), according to law, made the following affidavit, to wit:

I am of good moral character, the signature hereto is my own signature and each and every statement made in this application (including the several parts hereto attached and which form part hereof) was made by me, and is in all respects true and correct to the best of my knowledge and belief.

__________________________________________
Signature of Applicant

Sworn to or affirmed) and subscribed before me this ________ day of ______________________ 20_____.

__________________________________
Notary Public

My commission expires ________________ 20_____.

OFFICIAL SEAL
VERIFICATION OF LICENSURE

APPLICANT IS REQUIRED TO COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH HE/SHE ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE PSYCHOLOGY. IF NEEDED, YOU MAY XEROX THIS FORM FOR ADDITIONAL COPIES.

To Whom It May Concern:

I am being considered for licensure in the Territory of the U.S. Virgin Islands. The V.I. Board of Psychological Examiners requires that this form be completed by each state in which I am now or have ever been licensed to practice my profession. Enclosed is my authorization for release of information. Kindly forward this form directly to: VI Board of Psychological Examiners, Department of Health, 1303 Hospital Ground, Suite 10, St. Thomas, VI 00802.

Applicant’s Signature

Name: ________________________________
Address: ________________________________

My License No. in your State: ________________________________

This section is to be completed and signed by an official of the state board and returned directly to the VI Board of Psychological Examiners.

State of: ________________________________ License # ________________ Issued: ________________________________

Full Name of Licensee: ________________________________

By: Endorsement/Reciprocity ________________ EPPP ________________ Local State Exam ________________

National Board/Commission ________________________________

Name of Board/Commissioner ________________________________

Is license current and in good standing? _____ If NO, furnish details. ________________________________

Has any disciplinary action ever been taken against the above named Psychologist? _____ If YES, furnish details. ________________________________

Comments, if any: ________________________________

Signed: ________________________________
Title: ________________________________
State Board: ________________________________
Date: ________________________________

Board Seal
AUTHORIZATION FOR RELEASE OF INFORMATION

In order for the Virgin Islands Board of Psychological Examiners to assess and verify my educational background and professional qualifications, I hereby authorize the Board to:

• make inquiries concerning such information about me to my employers (past and present), hospital(s), institution(s) or organization(s), my references, all governmental agencies and instrumentalities (local, state, federal or foreign);

• authorize the release of such information and copies of related records and documents to the Virgin Islands Board of Psychological Examiners;

• authorize the Board to disclose to such persons, employers, hospitals, institutions, organizations, references, governmental agencies and instrumentalities identifying and other information about me sufficient to enable the Board to make such inquiries;

• release from liability all those who provide information to the Virgin Islands Board of Psychological Examiners in good faith and without malice in response to such inquiries.

__________________________________  ____________________________
Signature of Applicant                  Date

__________________________________
Print Name

Subscribed and sworn to before me this ________ day of _______________________ 20_______.

__________________________________
Notary Public

My commission expires ______________________ 20______.

BOARD SEAL
VIRGIN ISLANDS BOARD OF PSYCHOLOGICAL EXAMINERS

Supervisor’s Statement of Candidate’s Experience

To be completed by candidate:

Print Full Name _________________________________________________
(First)                               (Middle)                           (Last)

Address: __________________________________________________________________________________

Telephone: _________________________________ E-mail: __________________

******************************************************************************************

To be completed by supervisor:

1. Name of supervising psychologist ___________________________   Print Name

2. Name of Agency ____________________________________________

3. Type of Agency ____________________________________________

4. Address of Agency __________________________________________

5. Telephone Number __________________________________________

6. Licensure Status of Supervisor: State or Jurisdiction of License______________________________
   License number _____________________________ Date of License __________________________

7. Site of Supervision of Candidate _________________________________________________________
   (indicate hospital, clinic, university, etc.)
   Address ____________________________________________

8. Total hours clinical work completed by candidate under my supervision _______________________.

9. Frequency of Supervision: I provided _________ hour(s) of Individual, face to face supervision to this
   candidate, from _____________ to _____________
   Month/Year   Month/Year

Signature ____________________________________ Date __________________________

Supervisor, please return directly to:

V.I. Board of Psychological Examiners
   Department of Health
   1303 Hospital Ground, Suite 10
   St. Thomas, VI  00802