

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.

_____		_____
Last Name		E-Mail Address
_____	_____	_____
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 (eg. 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.

Institution	Department	City	State	Date Enrolled	Date Graduated	Awarded	Major

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.)

From	To	Course Sponsor	Course Name	Course Location	#Days	#Hours

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.

Date: Month/Year From	To	Full Time Equivalency	Organization	Position Held	Direct Supervisor

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 _____
Name of State

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