



LICENSURE as a CLINICAL PSYCHOLOGY by ENDORSEMENT Paper Application Checklist Instructions

IMPORTANT NOTICE:

Upon completion of the enclosed paper application for licensure by **Endorsement**, you will be required to submit to the Virginia Board of Psychology the below supporting documentation with your application. Prior to **mailing** the enclosed application and below supporting documentation to the Board for consideration, we recommend that you review the [Regulations Governing the Practice of Psychology](http://www.dhp.virginia.gov/psychology/) available on the Board's website at www.dhp.virginia.gov/psychology/ to ensure you are applying for the correct application type and have met the requirements for this application type. Pursuant to 18VAC125-20-30(B) of the [Regulations Governing the Practice of Psychology](http://www.dhp.virginia.gov/psychology/), all fees submitted to the Board are **non-refundable**.

We also strongly encourage you to review your application packet to ensure all forms are complete and included. A complete application packet provides the best opportunity to avoid delays in the application review process. You should make every effort to mail all the below information in **one** complete packet to the Board office for consideration.

REQUIRED DOCUMENTATION

- APPLICATION:** The attached application must be completed and mailed to the Virginia Board of Psychology.
- APPLICATION FEE:** A **\$200.00** application fee by check, cashier's check or money order made payable to the **Treasurer of Virginia** must be mailed with your application. Your application will not be reviewed or considered until you have submitted payment. Pursuant to 18VAC125-20-30(B), all fees submitted to the Board are **non-refundable**.
- VERIFICATION OF LICENSURE/CERTIFICATION** Provide license verification of all other health and mental health professional licenses, certificates, or registrations ever held in Virginia or any jurisdiction of the United States or Canada, **whether current or expired**. Please send the enclosed verification form to the issuing jurisdiction (s). This verification form should be completed by the issuing jurisdiction (s) and sent back to you and included in your application packet. *(Some jurisdictions charge a fee for this service. Check with that jurisdiction before sending the form. If the jurisdiction requires submitting this information directly to Virginia's Board office, please have them indicate your name on the form so that it can be included with your packet for evaluation.)*

-or-

You can provide an online verification printed from the licensing jurisdiction's website if the online verification provides **all** of the following information; the licensee name, license number, license type, issue and expiration date, and whether disciplinary action has ever occurred.

NPDB SELF-QUERY: A current report from the U.S. Department of Health and Human Services National Practitioners Data Bank (NPDB) must be submitted. You may request a self-query at <https://www.npdb.hrsa.gov/>

FUTHER DOCUMENTATION OF ONE OF THE FOLLOWING:

1. **National Registry:** Provide evidence of current credential issued by the National Registered of Health Service Psychologists; or,
2. **ABPP:** Current diplomate status in good standing the American Board of Professional Psychology in a category comparable to the one in which licensure is sought; or,
3. **CPQ:** A Certificate of Professional Qualification in Psychology (CPQ) issued by the Association of State and Provincial Psychology Board (ASPPB); or,
4. **Verification of five years of active licensure:** Provide evidence of 5 years of active licensure in a category comparable to the one in which licensure is sought with at least 24 months of active practice within the last 60 months immediately preceding your licensure application; or
5. **Less than five years of active practice or less than 24 months of active practice within the last 60 months:** Documentation of current psychologist licensure in good standing *obtained by standards substantially equivalent* to the *education, experience and examination* requirements as set forth in the Regulations for the category in which licensure is

sought by submitting the following:

- a. Certified copy of the original application submitted directly from the out-of-state licensure agency or a copy of the regulations in effect at the time of initial licensure.
- b. Verification of a passing score on all parts of the Examination for Professional Practice of Psychology that were required at the time of original licensure; and
- c. Official transcripts documenting the graduate work completed and the degree awarded in the category in which licensure is sought. The transcript must be included in your application packet **or** emailed electronically directly to the Board at psy@dhp.virginia.gov via a secured electronic transcript service used by the school (for example: eScript or parchment). **Photocopied transcripts will not be accepted.**

ADDITIONAL SUPPORTING DOCUMENTATION (if applicable)

PROOF OF NAME CHANGE: Documentation must be provided to show each name change(s) if your name has ever been legally changed from the time you attended school or were licensed in other jurisdictions or other than what is listed on your application. Acceptable forms of documentation include a **photocopy** of a marriage license, court order or divorce decree.

CRIMINAL CONVICTIONS, PAST ACTIONS or POSSIBLE IMPAIRMENTS: If you answer “YES” to any of the questions in **Part IV** of the application, please include a detailed explanation **and** supporting documentation. *Please refer to [Guidance Document 125-2](#), available on the Board’s website, for a list of required documentation that will be needed regarding criminal convictions, past actions, or possible impairments.*

GENERAL INFORMATION

- Applications are processed in the order received. Please allow adequate processing time for applications. Applications that are complete, fully documented and meet the minimum requirements for the [Regulations Governing the Practice of Psychology](#) will be processed within **30 days** of receipt of a **complete** application packet.
- Check your license status by going to: [License Lookup](#) (*license information is posted in real time).
- Please notify the Board in writing within 60 days of a name change or address change by completing the **Name/Address Change Form** available on the Board’s website at www.dhp.virginia.gov/psychology/.
- An incomplete application for licensure will be retained on file for one (1) year. If not completed within one year of receipt, a new application and fee will be necessary.
- Providing false or misleading information as well as omitting information in response to information requested in the application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing registration or license.
- Pursuant to [Virginia Code § 54.1-2400.02](#) addresses of licensees/supervisees are made available to the public. Normally, the Address of Record is the publicly disclosed address. If you do not want your Address of Record to be made public, you may provide a second, publicly disclosable address (e.g. work or practice address). If you would like your Address of Record to be publically available please complete both sections with same address on the application.
- Pursuant to [Virginia Code § 54.1-116 \(A\)](#), you are required to submit your social security number or your control number issued by the *Virginia* Department of Motor Vehicles*. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided for by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities. **NO LICENSE WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FAILED TO DISCLOSE ONE OF THESE NUMBERS.**
- Application and required documentation should be **mailed** to:

Department of Health Professions
Attn: Board of Psychology
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233

End of instructions



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Check the appropriate category for which you qualify:

<input type="checkbox"/> National Registry	<input type="checkbox"/> ABPP	<input type="checkbox"/> CPQ	<input type="checkbox"/> Five years of active practice	<input type="checkbox"/> Less than five years of active practice
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TO BE COMPLETED BY APPLICANT

Part I. Applicant Identification & Contact Information

Applicant's Last Name:	First Name:	Middle/Maiden Name:	Suffix:
Social Security Number or Virginia DMV Control Number _____		Date of Birth: (MM/DD/YYYY) ____ / ____ / _____	

Published Address: *This address is subject to public disclosure under the Freedom of Information Act. You may provide an address other than a residence, such as a Post Office Box or practice location if you wish.*

Address:

City:	State:	Zip Code:
_____	_____	_____

Address of Record: *The address information you provide below is your address of record with the Board. Please be advised that all notices from the Board, to include licenses and other legal documents, will be sent to the address of record provided. If you provided a different public address above, this address is not subject to public disclosure under the Freedom of Information Act and will not be sold or distributed for any other purpose.*

Address:

City:	State:	Zip Code:
_____	_____	_____

Home Number: (____) _____ - _____	Alternate Number: (____) _____ - _____
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Email Address:

Part II. Education Information: *List in chronological order each graduate school or other institution where course work has been completed.*

Institution Name:	Type of Degree Received:	Date Graduated: ____ / ____ / _____
Institution Name:	Type of Degree Received:	Date Graduated: ____ / ____ / _____

Part III. Licensure History Information: *List in order of attainment all the states in which you now hold or have ever held a health or mental health license, certification or registration, whether current or expired.*

State	Type of License/Certificate	License/Certificate Number	Issued Date	Current Status

Part IV. Licensure Questions: <i>Applicant must answer the following questions. Affirmative responses to any questions on this application will require additional information to be submitted. Please refer to Guidance Document 125-2 for a list of required documentation that will be needed regarding criminal convictions, past actions, or possible impairments. Failure to disclose any information related to these questions may be grounds for denial, reprimand, or imposition of terms, suspension or revocation of your license and/or registration.</i>					
1.	Have you ever been denied the privilege of taking an occupational licensure, certification or registration examination? <i>If Yes, on a separate sheet of paper please provide a full detailed explanation that includes what type of occupational examination, where (jurisdiction), when (dates) and why denied and attach documents referenced in Guidance Document 125-2.</i>		<input type="checkbox"/>	Yes <input type="checkbox"/>	No
2.	Have you ever been censored, warned, terminated, or requested to withdraw from your employment with any health care facility, agency or practice? <i>If Yes, on a separate sheet of paper please provide a full detailed explanation.</i>		<input type="checkbox"/>	Yes <input type="checkbox"/>	No
3.	Have you ever been convicted, pled guilty to or pled Nolo Contendere to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor? (Including convictions for driving under the influence, but excluding traffic violations) Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, does not have to be disclosed. <i>If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 125-2.</i>		<input type="checkbox"/>	Yes <input type="checkbox"/>	No
4.	Have you ever voluntarily surrendered a license, certification or registration while under investigation? <i>If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 125-2.</i>		<input type="checkbox"/>	Yes <input type="checkbox"/>	No
5.	Are you the respondent in any pending or unresolved Board action in another jurisdiction or in a malpractice claim? <i>If Yes, on a separate sheet of paper please provide a full detailed explanation.</i>		<input type="checkbox"/>	Yes <input type="checkbox"/>	No
Additional Questions					
1.	A. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? <i>If Yes, on a separate sheet of paper please provide a full detailed explanation</i>		<input type="checkbox"/>	Yes <input type="checkbox"/>	No
	B. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? <i>If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 125-2.</i>		<input type="checkbox"/>	Yes <input type="checkbox"/>	No
2.	A. Within the past five years, have you been disciplined by any entity? <i>If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 125-2.</i>		<input type="checkbox"/>	Yes <input type="checkbox"/>	No
	B. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? <i>If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 125-2.</i>		<input type="checkbox"/>	Yes <input type="checkbox"/>	No
3.	Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? <i>“Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Clinical Psychologist.</i> <i>If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 125-2.</i>		<input type="checkbox"/>	Yes <input type="checkbox"/>	No
4.	Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? <i>“Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Clinical Psychologist.</i> <i>If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 125-2.</i>		<input type="checkbox"/>	Yes <input type="checkbox"/>	No
5.	Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? <i>“Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Clinical Psychologist.</i> <i>If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 125-2.</i>		<input type="checkbox"/>	Yes <input type="checkbox"/>	No

6. Within the past five years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? <i>If Yes, on a separate sheet of paper please provide a full detailed explanation and attach documents referenced in Guidance Document 125-2.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Part V. Military Service

1. Are you a <u>spouse</u> of someone who is on federal active duty orders pursuant to Title 10 of the U. S. Code or of a veteran who has left active-duty service within one year of submission of this application <u>and</u> who is accompanying your spouse to Virginia or an adjoining state or the District of Columbia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you active-duty military?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Part VI. Certification: *This application is not valid unless properly certified by your original, electronic, or e-signature.*

I certify by my signature below that I am the person applying for licensure and meet the qualifications required by Virginia laws and regulations. I certify that I have carefully read the laws and regulations Governing the Practice of Psychology in the Commonwealth of Virginia, which are available at <https://www.dhp.virginia.gov/psychology/>.

Further, I certify by my signature below that the information provided on this application has been personally provided and reviewed by me, and that statements made on the application are true and complete. I understand that providing false or misleading information, as well as omitting information, in response to information required in this application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing license/certificate/registration.

I agree to the above certification.

SIGNATURE:	DATE:
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ORIGINAL, ELECTRONIC, OR E-SIGNATURE REQUIRED



APPLICANT OUT-OF-STATE LICENSURE VERIFICATION

IMPORTANT NOTICE:

This form must be completed by both the applicant and the jurisdiction/State Board that issued the applicant a health or mental health license, certification or registration. **The Applicant should complete Part I of this form ONLY.** The State Board should complete Part II of this form. The completed form should be returned to the applicant for inclusion in their application packet to be sent to the Virginia Board of Psychology or the State Board can send the form electronically to the Virginia Board at psy@dhp.virginia.gov

TO BE COMPLETED BY APPLICANT: Complete the top portion only and send this form to the jurisdiction (s)/State Board (s) that issued you a health or mental health license, certification or registration. **(fee may be required).**

Part I. Applicant's Identification & Contact Information

Last Name:	First Name:	Middle/Maiden Name:	Suffix:
Last 4 digit of Social Security Number: XXX-XX- ____ - ____		Date of Birth: (MM/DD/YYYY) ____ / ____ / ____	
Address:			
City:		State:	Zip Code: ____ - ____ - ____
Email Address:			

TO BE COMPLETED BY STATE BOARD: Please provide official verification of applicant's licensure information requested below and mail or email completed form to applicant or directly to the Virginia Board of Psychology. **If emailing this form to the Virginia Board, please use the subject line: Applicant Licensure Verification (ref: Applicant's Name)**

Part II. Applicant's Licensure Information

Title of License:	License Number:
Issue Date: (MM/DD/YYYY) ____ / ____ / ____	Expiration Date: (MM/DD/YYYY) ____ / ____ / ____
License Obtained by: <input type="checkbox"/> Examination <input type="checkbox"/> Endorsement <input type="checkbox"/> Reciprocity <input type="checkbox"/> Grandfathered <input type="checkbox"/> other _____	
Status of License: <input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive <input type="checkbox"/> other _____	
Has license ever been denied, suspended, revoked, placed on probation or otherwise disciplined? <i>If yes, please attach certified copy of order issued by State Board.</i>	YES <input type="checkbox"/> NO <input type="checkbox"/>

I certify the above information to be true in every respect, according to the record on file with the

(Title of Board)

Name of Authorized Licensure Official: _____

Title of Authorized Licensure Official: _____

Telephone Number: _____

Email Address: _____

Date: _____

STATE SEAL



Virginia Department of
Health Professions
 Board of Psychology

Perimeter Center
 9960 Mayland Drive, Suite 300
 Henrico, VA 23233-1463

Email: psy@dhp.virginia.gov
 Phone: (804) 367-4697 E-Fax: (804) 767-3626
 Website: www.dhp.virginia.gov/psychology/

VERIFICATION of POST-LICENSURE ACTIVE PRACTICE as a CLINICAL PSYCHOLOGIST

IMPORTANT NOTICE:

To validate your active post-licensure practice as an *independent* clinical psychologist, you must submit the Post-Licensure Active Practice form completed by your employer, a colleague, peer or a licensed practitioner who can attest to your *post-licensure* active practice in clinical psychology for 24 of the last 60 months immediately preceding your licensure application. If you have had several jobs, please submit multiple verification forms equaling to a minimum of 24 months.

The applicant should complete the top portion of this form **only**, then provide this form to the professional reference who can verify your post-licensure clinical active practice. The completed form should be returned to the applicant for inclusion in their application packet that must be sent to the Virginia Board of Psychology.

TO BE COMPLETED BY APPLICANT

I, _____ (*printed legal name of applicant*), hereby authorize past and present employers, businesses, professional associates and personal references to release to the Virginia Board of Psychology (“Board”) any information requested by the Board in connection with the processing of my application.

 Signature of Applicant

 Date

TO BE COMPLETED BY REFERENCE

Last Name of Reference:	First Name:	Middle/Maiden Name:	Suffix:
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Type of License Held:	License Number:
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Email Address of Reference: _____

Relationship to Applicant: _____

I, _____ (*printed legal name of reference*), declare under perjury under the laws of the Commonwealth of Virginia that _____ (*printed name of applicant*), candidate for licensure as a Clinical Psychologist in the Commonwealth of Virginia was in active **post –**

licensure clinical practice at _____ (*name of location*)

_____ (*street address of location*)

_____ (*City*) _____ (*State*) _____ (*Zip Code*)

from _____ (*Start Date: MM/DD/YYYY*) to _____ (*End Date: MM/DD/YYYY*).

 Signature of Reference

 Date