



**APPLICATION INSTRUCTIONS FOR  
REGISTRATION OF RESIDENCY  
IN CLINICAL OR SCHOOL PSYCHOLOGY  
(POST-GRADUATE DEGREE SUPERVISED EXPERIENCE)**

Upon completion of the **Registration of Residency application** you will be required to submit to the Board office the following items in a *single* packet:

- Fee:** The \$50.00 initial Registration of Residency (one supervisor) fee is non-refundable.  
The \$25.00 add/change Registration of Residency (one supervisor) fee is non-refundable.
- Verification of Education:** An official graduate transcript should be sent directly to you from the graduate school in a **sealed envelope**.
- Supervisor Information:** If your supervisor is not licensed in Virginia, the Licensure Verification for Out-of-State Supervisor (Form 7) must be submitted.

**Read the Virginia Board of Psychology Regulations carefully for the requirements for a Resident in Training for a Licensed Clinical or School Psychologist.**

Please allow adequate processing time for applications. Applications that are complete, fully documented and meet the minimum requirements of the **Regulations Governing the Practice of Psychology** will be processed within 30 days. The Board office provides individual feedback to each applicant in writing.

**YOU SHALL NOT BEGIN COUNTING HOURS TOWARDS LICENSURE UNTIL YOU HAVE RECEIVED WRITTEN BOARD APPROVAL.**

**\*\*PLEASE USE BLUE OR BLACK INK AND WRITE LEGIBLY.\*\***

*Please make a copy of the completed form for your records and send the original form to the board office for processing.*



**REGISTRATION OF RESIDENCY  
POST-GRADUATE DEGREE SUPERVISED EXPERIENCE**

*clinical psychology*

*school psychology*

**TO BE COMPLETED BY SUPERVISEE (Please type or print in black ink):**

Name (Last)	(First)	(Middle Initial)	(Maiden)
Social Security Number		Date of Birth (MM/DD/YY)	
Mailing Address (Street and/or Box Number, City, State, Zip Code)			
Email address		Telephone Number	
Name of work site where training hours towards licensure will be obtained		Telephone Number of Work Site	
Physical Address of work site where training hours towards licensure will be obtained (Street, City, State, Zip Code)			
Are you the spouse of a member of the U. S. military who has been transferred to Virginia and who had to leave employment to accompany your spouse to Virginia?			<p align="center"><b>YES      NO</b></p> <p align="center">[ ]      [ ]</p>
<b>EDUCATION:</b> List in chronological order the name and location of each graduate school or other institution where graduate course work has been completed. <b>OFFICIAL GRADUATE TRANSCRIPTS MUST BE SUBMITTED DIRECTLY TO THE BOARD OFFICE PRIOR TO APPROVAL OF SUPERVISION.</b> (See instruction sheet for details.)			
Institution Name		Dates of Attendance (MM/YY)	
		From:                      To:	
Major		Concentration	
Type of Degree Received		Date Degree Conferred	
Institution Name		Dates of Attendance (MM/YY)	
		From:                      To:	
Major		Concentration	
Type of Degree Received		Date Degree Conferred	
Institution Name		Dates of Attendance (MM/YY)	
		From:                      To:	
Major		Concentration	



Type of Degree Received	Date Degree Conferred
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**Ethics Attestation:** Please answer the ten questions below.

**If you answer yes to any question, include a detailed explanation AND supporting documentation. Refer to Guidance Document 125-2 for detailed information on the requirements with a criminal conviction, past actions or possible impairment.**

- |     |   |     |    |
|-----|---|-----|----|
| 1.  | 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?   | Yes | No |
| (A) | Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior?  | Yes | No |
| 2.  | Have you ever been censored, warned, terminated, or requested to withdraw from your employment with any health care facility, agency, or practice?  | Yes | No |
| 3.  | Within the past five years, have you been disciplined by any entity?  | Yes | No |
| (A) | Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior?  | Yes | No |
| 4.  | Have you voluntarily surrendered your license, certification or registration while under investigation?   | Yes | No |
| 5.  | Have you ever been denied the issuance of a license, certification, or registration, or denied the privilege of taking an occupational examination by a licensing agency. If yes, provide detail(s), jurisdiction(s) and date(s).   | Yes | No |
| 6.  | Have you ever been convicted of, pled Nolo Contendere to, or entered into a plea agreement for a violation of any federal, state or local statute, regulation, or ordinance? (This includes convictions for under the influence, but does not include other 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.   | Yes | No |
| 7.  | 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? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Resident in Psychology or School Psychology. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to and ability to safely practice. You may consider providing this documentation with your application, send this documentation directly to the Board.)  | Yes | No |
| 8.  | 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? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Resident in Psychology or School Psychology. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.)  | Yes | No |
| 9.  | 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? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Resident in Psychology or School Psychology. If yes, please provide a full explanation. NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider his documentation with your application, or have your provider send this documentation directly to the Board.) | Yes | No |



10. Within the past 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? If yes, please provide a full explanation and any associated orders or letters from the entity. (NOTE: The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application, or have the program send this documentation directly to the Board.) Yes      No

**TO BE COMPLETED BY SUPERVISOR (Please type or print legibly in blue or black ink):**

Name (Last, First)	(Middle Initial)	(Maiden)	(Suffix)
Business Name and Address (Street and/or Box Number, City, State, Zip Code)			
Email address	Telephone Number Business: Fax:		
Type of Professional License	Virginia License Number		
Initial License Date	Licensure Expiration Date		

**SUPERVISION TO BE PROVIDED: A one-year, full-time residency is defined as a minimum of two hours of individual, face-to-face supervision per week. Part-time supervision must include at least one hour per week of face-to-face supervision. Two hours of group supervision may be substituted for one of the hours of individual face-to-face supervision.**



**SERVICES TO BE RENDERED BY THE TRAINEE WHILE IN SUPERVISION:** Include population of clients to receive service, assessments to be used, and counseling techniques to be used.

I, \_\_\_\_\_, declare under penalty of perjury under the laws of the Commonwealth  
 (Supervisor)

of Virginia that I will not provide supervision to \_\_\_\_\_ in areas outside of the  
 (Resident)

competencies of my license to practice as a \_\_\_\_\_. As supervisor, I assume responsibility  
 (License of Supervisor)

for the clinical activities of the individual registered under my supervision. We hereby agree to this supervision contract which is being registered with the Board of Psychology. I further attest that I have read and understand the regulations pertaining to residents in Virginia.

**Signature of Supervisor:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 (Month/Day/Year)



Virginia Department of  
**Health Professions**  
Board of Psychology

9960 Mayland Drive, Suite 300  
Henrico, VA 23233-1463  
[www.dhp.virginia.gov/psychology](http://www.dhp.virginia.gov/psychology)

Email: [psy@dhp.virginia.gov](mailto:psy@dhp.virginia.gov)  
(804) 367-4697 (Tel)  
(804) 767-3626 (Fax)

**Signature of Resident:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*(Month/Day/Year)*

**Date:** \_\_\_\_\_

**Signature of Authorized Representative of Sponsoring Agency**  
*(if applicable)*

*(Month/Day/Year)*