

**IDAHO BOARD OF PSYCHOLOGIST EXAMINERS**  
**BUREAU OF OCCUPATIONAL LICENSES**  
700 West State Street, Boise ID 83702 or  
P.O. Box 83720, Boise ID 83720-0063  
Phone: 208-334-3233 Fax: 208-334-3945  
E-Mail: [PSY@ibol.idaho.gov](mailto:PSY@ibol.idaho.gov) Web: [www.ibol.idaho.gov](http://www.ibol.idaho.gov)

**APPLICATION FOR PRESCRIBING PSYCHOLOGIST CERTIFICATION**

All Prescribing Psychologist applicants must hold a current, active, unrestricted license as a Psychologist issued by the Idaho Board.

**Instructions**

Please complete this form by providing the requested information. Signatures must be notarized and the appropriate fees must be attached. The affidavit includes certifying that the applicant will comply with the Idaho laws and rules and scope of practice governing the practice of psychology in Idaho. The laws and rules are available online at the Board's website. Make checks payable to IBOL. All fees must be paid before the application will be processed. All returned checks are subject to a \$20.00 fee. Processing will be delayed for applications that do not include a social security number or other documentation required under Idaho Code § 73-122.

**CERTIFICATION of PRESCRIPTIVE AUTHORITY APPLICATION FEE - \$250**

**Certification Applicants:** This method is for those who hold a current Idaho psychology license and have completed their provisional training and are not applying by endorsement from another state. **Please provide the following:**

- The completed and notarized application with the appropriate fees attached;
- Proof of having completed the provisional training.

**Endorsement Applicants:** This method is for those who have been licensed as a prescribing psychologist in another state with requirements substantially similar to Idaho's. Please note that you must already hold your Idaho psychology license or be applying for it at the same time as this application. **Please provide the following:**

- The completed and notarized endorsement application with the appropriate fees attached;
- Proof of being licensed or certified and in good standing in another state with substantially equivalent requirements to those in Idaho. Certification of licensure must be sent directly from the state where you are licensed, a copy of your license will not meet this requirement.
- A copy of the laws and/or rules showing the requirements for prescribing psychologists from the state where you are licensed.

Those seeking licensure who have NOT held a prescriptive license in Idaho or any other state must utilize the Application for Provisional Prescribing Psychologist Certification.

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**APPLICATION FOR PRESCRIBING PSYCHOLOGIST CERTIFICATION**

**A fee of \$250 must be submitted with this application.**

I hereby submit my qualifications and make application for a Prescribing Psychologist in the State of Idaho under the provisions of Title 54, Chapter 32, Idaho Code, and provide the following:

**1. Full Name** \_\_\_\_\_

**2. Address of Record** \_\_\_\_\_

(The above address is a public record.) Street City State Zip

**3. Mailing Address** \_\_\_\_\_

(Will be used as address of record if none provided above.) Street/PO Box City State Zip

**4. License Number** \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Social Security No.** \_\_\_\_/\_\_\_\_/\_\_\_\_

month day year Not a public record; collected by I.C. § 73-122

**5. Home phone** (\_\_\_\_) \_\_\_\_\_ **Business phone** (\_\_\_\_) \_\_\_\_\_ **E-mail** \_\_\_\_\_

(The above phone number is a public record.)

**6. Have you passed the Psychopharmacology Examination for Psychologists (PEP)?** ( ) Yes ( ) No

(If Yes, we must receive official certification from the interstate reporting service before your application will be processed.)

**7. Are you currently or have you ever been licensed in another state?** ( ) Yes ( ) No

(If Yes, certification of licensure must be received directly from the issuing authority before your application will be processed.)

**8. Have you been granted prescriptive authority in that state? If yes, please list** \_\_\_\_\_ ( ) Yes ( ) No

(If Yes, certification of licensure must be received directly from the issuing authority before your application will be processed.)

**9. Attained Master's degree in clinical psychopharmacology from** \_\_\_\_\_ **on** \_\_\_\_\_

(You must document proof of a master's degree in clinical psychopharmacology from an accredited program. Official university/college transcripts noting that the degree has been conferred must be received by this office directly from the school registrar.)

**10. Have you completed clinical experience including 400 hours of direct patient contact and collaboration with a licensed medical provider involving at least 100 patients?** ( ) Yes ( ) No

(Please provide proof of your training.)

**11. Have you completed 2,000 hours of supervision as a provisional permit holder?** ( ) Yes ( ) No

(Please provide proof of your training if it was not completed in Idaho.)

**12. Have you ever had a professional license, certification, or registration denied, revoked, suspended or otherwise disciplined for any reason?** ( ) Yes ( ) No

(If Yes, a letter of explanation & a copy of the charges & the final order must be received before your application will be processed.)

**13. Have you ever been disciplined due to sexual harassment or sexual misconduct?** ( ) Yes ( ) No

(If Yes, a letter of explanation & a copy of the charges & the final order must be received before your application will be processed.)

**14. Have you ever voluntarily surrendered a professional license, certification, or registration?** ( ) Yes ( ) No

(If Yes, a written explanation of the circumstances surrounding the surrender must be attached.)

**15. Have you ever been convicted or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction? (Exclude minor traffic offenses but include all misdemeanors, felonies & military court-martials.)** ( ) Yes ( ) No

(If Yes, a detailed statement, a summary of the charges, the final order, any probation or parole documentation, and any other relevant information must be received before your application will be processed.)

**16. Have you ever abused, been dependent on, or been treated for the abuse or dependency of alcohol or any controlled substance?** ( ) Yes ( ) No

(If Yes, a detailed statement and any supporting documentation regarding intervention, treatment, and current status must be received before your application will be processed.)

**AFFIDAVIT**

Upon oath I certify each of the following: (1) the responses and information provided in this application and in the attached addendum(s) and documentation are true and correct to the best of my knowledge; (2) I am the applicant named in and who has signed this application; (3) I am a United States citizen or a legal permanent resident or I am otherwise lawfully present in the United States; (4) I have read and will conform to the Laws and Rules governing the profession for which I am seeking a license or authority to practice; (5) I acknowledge and agree the use of intentional misrepresentation or fraud in this application or violation of any Laws or Rules governing the profession for which I am seeking a license or authority to practice shall constitute cause sufficient for denial, suspension, cancellation or

revocation of any license or authority applied for or granted to me; (6) I will provide additional or corrected information if material changes occur which would cause responses or information provided in or with this application to be inaccurate or incomplete; (7) I authorize and direct any person, agency, firm, or other entity to release, upon the request of the Idaho Bureau of Occupational Licenses or its authorized representative, any information, communication, report, record, statement, disclosure, or recommendation that may have bearing on my eligibility for or maintenance of the license or authority for which I am applying and hereby release and exonerate any of them from any liability of any kind resulting from the release or collection thereof; and (8) I authorize the Bureau of Occupational Licenses to release to any other regulatory entity in any jurisdiction any information requested about me that may otherwise be protected or confidential that may have bearing on my eligibility for or maintenance of any license or authority issued or applied for in this or any jurisdiction and hereby release and exonerate them from any liability of any kind resulting from the release thereof.

\_\_\_\_\_  
Signature of Applicant

State of \_\_\_\_\_, County of \_\_\_\_\_, ss.  
Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

(seal)

\_\_\_\_\_  
Notary Public Official Signature  
My Commission Expires \_\_\_\_\_