

**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 PROVISIONAL 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.

**PROVISIONAL PRESCRIPTIVE AUTHORITY APPLICATION FEE - \$250**

Provisional Applicants: This method is for those who have not held a prescribing psychologist license in another jurisdiction or who need additional training to qualify for certification under Idaho's law.

**Please provide the following:**

- The completed and notarized application including the signed supervision forms with the appropriate fees attached;
- Transcripts sent directly from the college/university showing proof of a master's degree in clinical psychopharmacology from an accredited program.

Either

- 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.

Supervised practice must consist of a minimum of 2,000 hours of supervision including the following domains:

- Basic science
- Neurosciences
- Physical assessments and laboratory exams
- Clinical medicine and pathophysiology
- Clinical research pharmacology and psychopharmacology
- Clinical pharmacotherapeutics
- Research
- Professional, ethical and legal issues

Supervisors must keep written progress reports at least every six months concerning how the provisional prescribing psychologist is performing in the domains of supervision.

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**APPLICATION FOR PROVISIONAL 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** (Mr., Mrs., or Ms.) \_\_\_\_\_
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. **Idaho 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 as a psychopharmacologist 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 ever had a professional license, certification, or registration denied, revoked, suspended or otherwise disciplined for any reason or are there any pending complaints against you?** ( ) 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.)
11. **Have you ever been disciplined due to sexual harassment or sexual misconduct or are there any pending complaints against you?** ( ) 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.)
12. **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.)
13. **Have you ever been convicted or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction or are there any pending cases against you?** ( ) Yes ( ) No  
**(Exclude minor traffic offenses but include all misdemeanors, felonies & military court-martials.)**  
(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.)
14. **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 \_\_\_\_\_

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**Supervision Agreement Form**

APPLICATION FOR APPROVAL OF SUPERVISOR and SUPERVISION PLAN FOR provisional prescribing psychologists  
A form must be submitted for each supervisor providing supervision.

1. Applicant (supervisee) Name \_\_\_\_\_ License # \_\_\_\_\_
2. Phone (\_\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_
3. Place of Employment: \_\_\_\_\_
4. Mailing address \_\_\_\_\_  
Street/PO Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
5. Business address \_\_\_\_\_  
Street/PO Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
6. Work Schedule: ( ) Full time (30hrs/wk) or more ( ) Part time (Hours per week \_\_\_\_\_)
7. If you are planning to prescribe for pediatric or geriatric patients, please provide the supervising physician(s) specialized training and experience in treating the patient population for which the applicant seeks to prescribe: \_\_\_\_\_  
\_\_\_\_\_

**Supervisor Information:**

1. Supervisor Name: \_\_\_\_\_ License # \_\_\_\_\_
2. Primary Supervisor ( ) or Secondary Supervisor ( )
3. Please provide documentation of your board certification as a psychiatrist or neurologist or of specialized training and experience in the management of psychotropic medication.
4. Business Name \_\_\_\_\_
5. Business Address \_\_\_\_\_
6. Nature of the business setting \_\_\_\_\_
7. Mailing Address \_\_\_\_\_
8. Phone (\_\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_
9. Number of provisional certification holders you currently supervise \_\_\_\_\_

**Supervision Information**

1. Describe the types of cases this supervisor will be responsible for and has specialized training and experience:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. Describe the client's served: \_\_\_\_\_

4. Describe the setting where the applicant will practice: \_\_\_\_\_

**Applicant Affidavit**

I hereby agree to comply with the supervision plan outlined herein as part of my application for prescribing psychologist certification. I certify that I have reviewed and understand the plan and its requirements and procedures for supervision of my practice and that I will comply with those requirements and procedures in my practice pursuant to the plan.

\_\_\_\_\_  
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 \_\_\_\_\_

**Supervisor Affidavit**

I hereby agree to serve as the supervisor of the applicant in the supervision plan outlined herein as a part of the applicant's application for prescribing psychologist certification. I certify that I have reviewed and understand the plan and its supervision requirements and procedures and that I will follow those requirements and procedures in my supervision of the applicant's practice pursuant to the plan.

Supervision reports shall be submitted from each supervisor directly to the Board within thirty (30) days following each six (6) month period.

\_\_\_\_\_  
Signature of Supervisor

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

(seal)

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

**PLEASE NOTE prior to a change in supervisors or a change in the supervision agreement, the supervisee must notify the Board and the change must be approved by the board or a designated member of the board prior to the commencement of supervision by a new supervisor or implementation of the change.**