



Washington State Department of

Health

Board of Psychology Credentialing

PO Box 47877

Olympia, WA 98504-7877

360-236-4700

# Professional Reference Request

Print Clearly

Note: Please be advised upon receipt of written request, this form may be released to the applicant. You may choose to provide the applicant with a copy of your completed form. However addresses and telephone numbers will not be released.

The person asking you to complete this form is applying for licensure as a psychologist in Washington State. Applicants must provide documentation from supervisors that they have met the supervised experience requirements for licensure. This form identifies several categories of supervised experience. These categories are defined in rules adopted by the Examining Board of Psychology. These rules are found in the Washington Administrative Code (WAC) which can be searched on the following site: <http://apps.leg.wa.gov/wac/default.aspx?cite=246.924>. The rules for the four categories of supervised experience are as follows: [WAC 246-924-049](#), "Practicum"; [WAC 246-924-053](#), "Preinternship"; [WAC 246-24-056](#), "Internship"; and, [WAC 246-924-059](#), "Post-doctoral supervised experience."

If you are being asked to complete this form for an applicant because their original supervisor is deceased or cannot be located, please document that information below. Provide as much of the requested information as appropriate given your position based on the information and records available to you at your facility or institution, including any personal knowledge of the applicant's supervised experience.

For each response below please attach any additional explanation if necessary.

\_\_\_\_\_ has applied for a license as a psychologist in the State of Washington and has given your name as a reference. Please return directly to the address listed above.  
Name of Applicant

**Applicant:** Do not complete anything below this line.

Your Name

Organization	Position		
Address	City	State	Zip Code

If you are providing information because the applicant's original supervisor is deceased or cannot be located, provide the following information:

Original supervisor's name	Original supervisor's position
Original supervisor's license number and state license held	

# Professional Reference Request (Cont.)

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Name of facility/institution where applicant obtained supervised experience

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Applicant's position title

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1. Type of supervised hours (may be more than one):

Practicum    Preinternship    Internship    Post-doctoral

Are the supervised hours you're attesting to the :  Original submission    Resubmission

Please provide an explanation as to why the hours are being resubmitted:

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2. Describe briefly the applicant's duties as you knew them in the position listed above: \_\_\_\_\_

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3. If you were a supervisor of the applicant's **practicum**, please complete the following:

- A. Dates of supervised experience: From \_\_\_\_\_ To \_\_\_\_\_
- B. Total number of hours of practicum experience you supervised: \_\_\_\_\_ (300 hours are required.)
- C. Practicum hours spent in supervision (see [WAC 246-924-049](#) for the definition of "supervision" in the Practicum)? \_\_\_\_\_

4. If you were a supervisor of the applicant's **preinternship** experience, please complete the following:

- A. Dates of supervised experience: From \_\_\_\_\_ To \_\_\_\_\_
- B. Number of hours of direct client contact providing assessment and intervention services: \_\_\_\_\_
- C. Number of hours of regularly scheduled, formal face-to-face individual supervision that addresses the direct psychological services provided by the applicant: \_\_\_\_\_
- D. Number of hours of other learning activities such as case conferences, seminars on applied issues, conducting cotherapy with a staff person including discussion of a case, and group supervision: \_\_\_\_\_

5. If you were a supervisor of the applicant's **internship** experience, please complete the following:

- A. Was the internship site APA accredited or approved by APPIC?    Yes    No
- B. Dates of supervised experience: From \_\_\_\_\_ To \_\_\_\_\_
- C. Number of hours of direct client contact providing assessment and intervention services: \_\_\_\_\_
- D. Number of hours of regularly scheduled, formal face-to-face individual supervision that addresses the direct psychological services provided by the applicant: \_\_\_\_\_

## Professional Reference Request (Cont.)

- F. Number of hours of other learning activities such as case conferences, seminars on applied issues, conducting cotherapy with a staff person including discussion of a case, and group supervision: \_\_\_\_\_
6. If you were a supervisor of the applicant's **post-doctoral** or other experience, please complete the following:
- A. Dates of supervised experience: From \_\_\_\_\_ To \_\_\_\_\_
- B. Total number of hours of professional activity you supervised: \_\_\_\_\_
- C. Total number of hours of individual face-to-face supervision you provided: \_\_\_\_\_
7. Do you have any concerns in recommending this applicant for a license in the state of Washington for independent practice?  Yes  No If yes, please comment specifically. Include any other information you consider relevant.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
8. Is there any other information about this candidate which you believe should be provided to the Examining Board of Psychology?  Yes  No If yes, please explain.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Select which category(ies) apply to you and mark the appropriate box(es):

- A. If you provided supervision for the applicant for his/her Preinternship, Internship, or Post-doctoral supervised experience, identify with the category of credentialing that applied to you at the time you provided the supervision. If you select "Other," identify your credential status under the applicable laws in your state or province.
- Psychologist with two years post-licensure experience.
- Psychiatrist with three years of experience beyond residency.
- Social worker, Mental Health, or Marriage and Family Therapist with five years post-licensure experience.
- Doctoral level psychologist with three years post-doctoral experience who is exempt from licensure under [RCW 18.83.200](#).
- Other \_\_\_\_\_
- \_\_\_\_\_

## Professional Reference Request (Cont.)

License Number: \_\_\_\_\_ Date of Original License: \_\_\_\_\_

- B. If you provided supervision for the applicant for his/her Practicum, enter the following information about your position in that facility or institution where the Practicum occurred and any health profession credential you held at that time.

Position Title: \_\_\_\_\_

Health Profession Credential: \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_