

Please return the completed form directly to:

South Dakota Board of Examiners of Psychologists

810 N. Main St., #298
Spearfish, SD 57783-2447

Applicant's Name _____
(Last) (First) (MI)

This form applies only to applicants whose internships were not APA approved or APA accredited.

Was your internship program APA approved? Yes No

If yes, please sign _____

If no, please complete the following:

APPLICANT PREDOCTORAL INTERNSHIP CONFIRMATION FORM

***Please attach the written materials about your internship.**

1) Name and describe the setting (eg., hospital, outpatient clinic, school, consortium, etc.) of your internship site:

2) What was your internship program's goal? _____

3) Duration of internship (# of months): _____ (# of hours) _____

Start Date

End Date

Was the internship continuous for the period indicated? Yes No

If no, please explain: _____

4) Describe the population(s) (e.g., children, adults, minorities, homeless, chronically mentally ill, etc.) to which you provided direct psychological services: _____

5) Describe the types of psychological services (e.g., individual therapy, group psychotherapy, psychological evaluations, etc.) you provided to patients/clients: _____

Number of evaluations you completed during your internship: _____

*Please specify the types of evaluations you completed and specific tests administered (e.g., neuropsychological, full batteries including intellectual and projective and objective personality measure, etc.)

Approximate number of patients/clients seen per week: _____

- 6) Approximate number of hours spent in face-to-face psychological services per week: _____
- 7) Were you provided formal written policies and procedures (e.g., due process and grievance procedures, intern performance evaluation, goals and objective, etc.) when beginning your internship: Yes No
- 8) Number of hours spent per week in:
 Individual, Face-to-Face Supervision _____
 Group Supervision _____
 Other _____
 Please explain: _____

- 9) Number of full-time doctoral-level psychologists that were licensed, registered, or certified and served as primary supervisors at internship site: _____
 *Did supervisors carry clinical responsibility for the cases being supervised (e.g., countersigning documentation or having their name on the treatment plan or summary)? Yes No
- 10) Name of Program/Training Director: _____
 *Was this person licensed, registered, or certified to practice psychology in the jurisdiction in which the internship was located? Yes No
 If no, where were they licensed? _____
 *Number of hours per week the Program/Training Director was on site: _____
- 11) Number of interns at your site (including yourself): _____
 *How many interns were full-time? _____ Half-time? _____
 *If not called "Interns", what title was used? _____
- 12) Total number of hours spent in didactic activities: _____
 _____ Case Conferences
 _____ Seminars
 _____ In-service Training
 _____ Grand Rounds
 _____ Other (please specify) _____

Additional Comments:

- Provide a copy of the program description or brochure, which outlines the goals and content of the internship.
- Provide a copy of the due process procedures.
- Provide a copy of your internship evaluation forms.
- Provide a copy of your internship completion certificate.

Applicant's Signature

Date