POST-DOCTORAL PSYCHOLOGICAL EXPERIENCE FORM

Supervisor please return the completed form directly to:
South Dakota Board of Examiners of Psychologists
810 N. Main St., #298
Spearfish, SD 57783-2447

The application for licensure cannot be processed until this completed form is received by the Board of Examiners.

TO BE COMPLETED BY APPLICANT

Applicant’s Name ___________________________________________
(First) ___________________________ (Last) ___________________________
(MI) ___________________________

Applicant’s Signature ________________________________ (Signature)
______________________________________________ (Date)

TO BE COMPLETED BY SUPERVISING PSYCHOLOGIST

The above-named individual has applied for licensure as a psychologist in the State of South Dakota. South Dakota licensing law requires one year of post-psychological experience as a prerequisite for licensure. You are being asked to certify the post-doctoral psychological experience of this applicant. Attesting to this applicant’s post-doctoral training is a vital element of the licensing process. Any misstatements by a licensed psychologist in completing this form may constitute unethical/unprofessional conduct. Please complete this form as objectively and candidly as possible.

NO PORTION OF THE REMAINDER OF THIS FORM MAY BE COMPLETED BY THE APPLICANT.

1. Name, address and number of agency where psychological experience was obtained:

   (Name)_________________________________________________________

   (Mailing address)_________________________________________________

   (City) __________________________________________________________
   (State) ___________________________ (Zip) ___________________________

   (Telephone) ________________ (Fax Number) _______________________

2. Name, address and phone number of psychologist responsible for supervising the applicant’s psychological experience:

   (Name)_________________________________________________________

   (email address)_________________________________________________

   (Mailing address)_________________________________________________

   (City) __________________________________________________________
   (State) ___________________________ (Zip) ___________________________

   (Telephone) ________________ (Fax Number) _______________________

State/Province where Supervisor licensed: ________________________________

License # _________________________ Date issued _________________________ Current: Yes ☐ No ☐

3. Inclusive dates of applicant’s psychological experience:

   Starting date ___________________________ Completion date ___________________________

4. Applicant’s title during psychological experience: ________________________________

July 2018
5. Applicant’s position during psychological experience: ____________________________________________________________
________________________________________________________________________________________________________

6. Applicant worked full time _______________________________ or part-time _______________________________
   (hours per week)                                           (hours per week)

I declare and affirm under the penalties of perjury that this experience form has been completed by me, and to the best of my knowledge and belief, is in all things true and correct.

_________________________________________________________  ______________________________
Signature of Supervising Psychologist                                   Date