



# Ohio Board of Psychology

## **FORM F: DOCTORAL PROGRAM VERIFICATION OF ALL PRE-INTERNSHIP TRAINING**

*To be completed by the Doctoral Program DCT or School Psychology  
Doctoral Program Coordinator*

Please print, complete this 4-page form, sign and date, and submit it directly to the Ohio Board.

Fax to 614-728-7081 or email to [info@psy.ohio.gov](mailto:info@psy.ohio.gov)

Thank you for your assistance.

*Please Print Clearly*

Name of Student/Applicant for Ohio Licensure:
Name of Academic Institution:
Doctoral Degree Program: <input type="radio"/> Clinical <input type="radio"/> Counseling <input type="radio"/> School <input type="radio"/> Combined <input type="radio"/> Other: _____
Doctoral Program accreditation/designation/approval: <input type="radio"/> APA <input type="radio"/> CPA <input type="radio"/> ASPPB/NR <input type="radio"/> NASP
Name of DCT/School Psychology Doctoral Program Coordinator:

### **Pre-Internship Doctoral Program Training Experiences**

**Instructions to the DCT, Coordinator, or designee:** **1)** Please list chronologically **each** supervised training experience **starting with the earliest placement**, collaborating with the student's terminal master's program as necessary to compile a complete list. The resulting exhaustive list of pre-internship training experiences will allow the Board's Entrance Examiner to determine: at what point the academic and supervised experience prerequisites were met (a minimum of 400 introductory practicum hours and 48 graduate semester hours of coursework in psychology or 72 graduate quarter hours of coursework in psychology); and, therefore, which pre-internship training experiences are candidates for consideration toward the 3,600 hour sequence of training. **2)** Please note that each supervisor listed below will be asked to complete for the Board a form specific to each supervised experience/placement, with additional details and an evaluation. **3)** Please do not provide a "range" for the weekly hours on the placement. Please provide a number, which may be an average if the placement was not a predetermined weekly number of hours on site. **4)** Please print clearly.

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Name of Student/Applicant for Ohio Licensure: \_\_\_\_\_

**Verification of Pre-Internship Training Experience**

Name of Facility/Training Site:

Telephone number: (     )

Dates of Training Experience: \_\_\_ / \_\_\_ / \_\_\_ through \_\_\_ / \_\_\_ / \_\_\_

Supervising Psychologist(s):

Supervised psychological procedures:

Weekly hours on placement:

Total hours of supervised experience on this placement:

**Verification of Pre-Internship Training Experience**

Name of Facility/Training Site:

Telephone number: (     )

Dates of Training Experience: \_\_\_ / \_\_\_ / \_\_\_ through \_\_\_ / \_\_\_ / \_\_\_

Supervising Psychologist(s):

Supervised psychological procedures:

Weekly hours on placement:

Total hours of supervised experience on this placement:

**Verification of Pre-Internship Training Experience**

Name of Facility/Training Site:

Telephone number: (     )

Dates of Training Experience: \_\_\_ / \_\_\_ / \_\_\_ through \_\_\_ / \_\_\_ / \_\_\_

Supervising Psychologist(s):

Supervised psychological procedures:

Weekly hours on placement:

Total hours of supervised experience on this placement:

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<b>Verification of Pre-Internship Training Experience</b>	
Name of Facility/Training Site:	
Telephone number: (     )     )	
Dates of Training Experience: ___ / ___ / ___ through ___ / ___ / ___	
Supervising Psychologist(s):	
Supervised psychological procedures:	
Weekly hours on placement:	
Total hours of supervised experience on this placement:	

<b>Verification of Pre-Internship Training Experience</b>	
Name of Facility/Training Site:	
Telephone number: (     )     )	
Dates of Training Experience: ___ / ___ / ___ through ___ / ___ / ___	
Supervising Psychologist(s):	
Supervised psychological procedures:	
Weekly hours on placement:	
Total hours of supervised experience on this placement:	

<b>Verification of Pre-Internship Training Experience</b>	
Name of Facility/Training Site:	
Telephone number: (     )     )	
Dates of Training Experience: ___ / ___ / ___ through ___ / ___ / ___	
Supervising Psychologist(s):	
Supervised psychological procedures:	
Weekly hours on placement:	
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**Pre-Internship Training Experiences and Competencies Attained**

Pursuant to OAC § 4732-9-01, psychological training supervision shall provide sequential and increasingly complex and independent experiences to assure an organized and planned development of: attitudes and identity as a professional psychologist; professional, ethical, and legal responsibilities; communication skills; critical judgment; and, competencies in the broad areas of interpersonal skills, psychological assessment, psychological interventions, and ethical decision making. Training experiences shall follow developmentally appropriate academic and technical preparation.

**Please provide a final evaluation of the student's performance during pre-internship training experiences, an assessment of the student's competencies at the conclusion of the above-listed experiences, and recommendations for areas of post-doctoral training and/or independent practice and needs for additional professional development** *(please feel free to attach an evaluation in lieu of completing this section)*

Name of Director of Clinical Training/Coordinator: \_\_\_\_\_

License# \_\_\_\_\_ State/Province \_\_\_\_\_

Signature \_\_\_\_\_

Date: \_\_\_\_\_

Fax this completed, signed form to 614-728-7081 or email to [info@psy.ohio.gov](mailto:info@psy.ohio.gov)

Thank you.