New Mexico Regulation and Licensing Department
BOARDS AND COMMISSIONS DIVISION
State Board of Psychologist Examiners
2550 Cerrillos Road▪ PO Box 25101 ▪ Santa Fe, New Mexico 87504
(505) 476-4622 ▪ Fax (505) 476-4545 ▪ www.rld.state.nm.us

APPLICATION FOR CONDITIONAL PRESCRIPTION CERTIFICATE

All information provided is public information except as provided by the New Mexico Inspection of Public Records Act.

You are responsible for insuring that all needed information on your application has been forwarded to the Board Office under separate cover or with this application form.

- $150.00 non-refundable application fee required at time of application. *When you provide a check as payment, you authorize the State of New Mexico to either use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction*
- Copy of Master's transcript or Certificate of work in psychopharmacology
- Verification of malpractice insurance coverage
- Copy of New Mexico Psychologist License
- Verification of Experience by Training Program
- Supervisor verification of 80-Hour Practicum in Primary Health Care
- Supervisor verification of 400-Hour Practicum Treating a Minimum of 100 Patients with Pharmacotherapy.
- Copy of 80-Hour Evaluation by Supervisor in Primary Health Care Setting
- Midterm and final evaluation forms completed by supervisor of 400-hour practicum
- Proposed Supervisory Plan for Conditional Prescribing Psychologist

The Board may, at its discretion, require additional information or documentation.

Staple one (1) passport-type photograph on white background taken within the last six months.

APPLICATION INFORMATION

LEGAL NAME:_____
Last First M. Any Other Name Used

Date of Birth:_____ E-mail address:_____

Telephone Number: W:(___)_____ Social Security Number_____

Mailing Address:_____
Number and Street City, State Zip

Business Address:_____
Number and Street City, State Zip

LICENSURE

Do you have an active, unrestricted license to practice psychology in New Mexico? | Yes | No |

If Yes: Date issued:_____ License No.:_____

Do you hold other professional licenses? | Yes | No |

Type	State	Date issued	License No.

Please list _____

PSYCHOPHARMACOLOGY EXAM FOR PSYCHOLOGISTS

Have you taken the Psychopharmacology Exam for Psychologists (PEP)? | Yes | No |
If yes, your scores must be sent to the Board office.

If you have not taken the PEP, indicate the date you plan to take it:_____

POSTDOCTORAL TRAINING IN PSYCHOPHARMACOLOGY

Institution you attended:_____

Location & Address:_____

Date Completed:_____ Name of Program Director:_____

Was your program an organized program of education consisting of didactic instruction of no fewer than 450 hours? | Yes | No |

Check the type of institution attended:

	An institution of higher education that has a postdoctoral program of psychopharmacological education for psychologists and is accredited by a regional body recognized by the U.S. Department of Education or the Council for Higher Education Accreditation.
	A continuing education provider approved by the American Psychological Association that offers a program of psychopharmacology education for psychologists
	A continuing education program of professional development in psychopharmacology for psychologists that is administered in collaboration with a school if the applicant successfully completed 450 classroom hours of didactic study referred to in Subsection E of 16.22.23.8 NMAC prior to January 1, 2004.

Eighty-hour practicum (Attach supervisor verification)

Where completed:_____ Date completed:_____

Name of Supervisor:_____

Was this program monitored by the program you attended?	Yes	No

400-hour/100 patient practicum (Attach supervisor verification)

Where completed:_____ Date completed:_____
Name of Supervisor:_____

Was this program monitored by the program you attended?	Yes	No

MALPRACTICE INSURANCE

Do you have malpractice insurance that will cover your prescribing as well as psychotherapy?	Yes	No

List any limits of coverage and the name of the carrier._____
_____
_____
_____

QUESTIONS RELATED TO ETHICAL STANDARDS

Have you ever been called before the Committee on Ethics of any professional organization or State Licensing Board?	Yes	No

Has any action been taken against you by:

a. another licensing jurisdiction?	Yes	No
b. a professional psychologist association of which you are or have been a member?	Yes	No
c. a government agency?	Yes	No

Have you ever failed to report to the board the surrender of a license or other authorization to practice psychology in another jurisdiction or the surrender of membership on a health care staff or in a professional association following, in lieu of, or while under a disciplinary investigation by any of those authorities for acts or conduct that would constitute grounds for action?	Yes	No

Have you voluntarily surrendered your license in another jurisdiction?	Yes	No
Have you ever been convicted of, or pled guilty or *nolo contendere* to a violation of any federal or state statute, any city or county ordinance, or law of a foreign country?	Yes	No
Are you now or have you ever engaged in any activities that misrepresent your professional qualifications, affiliation, or purposes, or those of institutions, organizations, products and/or services with which you are associated?	Yes	No
Have you ever been denied a license or certificate as a psychologist in any jurisdiction or country, or been denied the right to take an examination?	Yes	No
Have you ever had any license or certificate as a psychologist or psychologist associate suspended or revoked?	Yes	No
Are you now under investigation by any other licensing board?	Yes	No
Are there any complaints pending against you in another licensing jurisdiction?	Yes	No
Are you currently more than thirty (30) days in arrears in payment of amounts required to be paid pursuant to an outstanding judgment and order for child support in New Mexico?	Yes	No

If you answered 'yes' to any of the above, use a separate sheet, and provide a detailed explanation.

AFFIDAVIT AND NOTARIZATION

The undersigned, being duly sworn, upon his/her oath deposes and says that he/she is the person making the foregoing statements and that they are made in good faith and are true in every respect. By executing this application, the undersigned also acknowledges that he/she has read the Code of Ethics for Psychologists and, if issued a license, agrees to conform with and support the Code of Professional Ethics, Rules and Regulation of the New Mexico State Board of Psychologist Examiners, and the Professional Psychologist Act. **I certify that all the statements made in this application are true, complete, and correct to the best of my knowledge and belief and are made in good faith.**

_____

Signature of Applicant Date

I _____ a Notary Public in
and for said County, in the State of _____
DO HEREBY CERTIFY THAT:
_____personally known to be the same person whose name is subscribed in the foregoing instrument, appeared before me this day in person, and acknowledged that he/she signed, said document for the uses and purposes therein set forth.

GIVEN UNDER MY HAND AND NOTARIAL SEAL THIS

_____DAY OF_____, 200__

_____
Notary Public

My Commission Expires_____

VERIFICATION BY SUPERVISOR OF 80-HOUR PRACTICUM IN PRIMARY HEALTH CARE

PLEASE NOTE: This form is **to be completed by the supervisor and sent to the Board office**

SUPERVISOR 80-HOUR PRACTICUM

The Board of Psychologist Examiners has received an application for a conditional prescription certificate as a prescribing psychologist from the applicant named below. (To be filled out by Applicant and forwarded on to the Director of the training program)

Applicant:_____

Address:_____

City & State:_____

Telephone No._____

Please provide requested information and return this form directly to the Board office as indicated on the bottom of the next page.

SUPERVISOR

Name:_____

Address:_____

City & State:_____

Telephone No._____

Supervisor, please describe the area of practice in which you are formally trained, certified, or licensed?_____

NEW MEXICO LICENSURE

Is your medical license current and unrestricted? Yes □ No □
Date New Mexico medical license was issued:_____
License Number and Type of License:_____

State Board of Psychologist Examiners
CONDITIONAL PRESCRITION CERTIFICATE APPLICATION

Do you hold any other professional licenses in this or any other jurisdiction? Yes ☐ No ☐
If you answered 'yes' please list:

License No.	**Type**	**State**	**Status (Active/Inactive)**

Name and Address of Applicant's Training Director:_____

_____

Date Practicum Began:_____ Date Practicum Ended:_____

1. Have you sent an evaluation form about this applicant to the Director of Training discussing the student's adequate development of skills in:
   a. Assessing a diverse and significantly ill medical population? Yes ☐ No ☐
   b. Observing the progression of illness and continuity of care of individual patients? Yes ☐ No ☐
   c. Adequately assessing vital signs? Yes ☐ No ☐
   d. Demonstrating competent laboratory assessment? Yes ☐ No ☐
   e. Demonstrating competence in physical and health assessment techniques? Yes ☐ No ☐

2. Has the student successfully completed the eighty-hours of supervised experience with you as specified in the Prescribing Psychologist Act? Yes ☐ No ☐

Please provide any comments you might have regarding this applicant's practicum. Include any information you consider relevant regarding this applicant.

_____

_____

_____

_____

As the Clinical Supervisor of the 80-Hour Practicum, I certify that all of the statements made in this document are true, complete, and correct to the best of my knowledge and belief and are made in good faith.

_____ _____

Date Signature of Clinical Supervisor

Please mail completed form directly to the Board Office at:
New Mexico Board of Psychologist Examiners
P. O. Box 25101
Santa Fe, New Mexico 87504

VERIFICATION BY SUPERVISOR OF 400-HOUR PRACTICUM TREATING A MINIMUM OF 100 PATIENTS WITH PHARMACOTHERAPY

PLEASE NOTE: To be completed by the supervisor

PRIMARY SUPERVISOR 400-HOUR/100-PATIENT PRACTICUM

The Board of Psychologist Examiners has received an application for a conditional certificate as a prescribing psychologist from the applicant named below. (To be filled out by Applicant and forwarded on to the Director of the training program)

Applicant:_____

Address:_____

City & State:_____

Telephone No._____

Please provide requested information and return this form directly to the Board office as indicated on the bottom of the next page.

SUPERVISOR

Name:_____

Address:_____

City & State:_____

Telephone No._____

Supervisor, please describe the area of practice in which you are formally trained, certified or licensed. If you are not a psychiatrist, please indicate your experience and training in prescribing psychotropic medications:_____

NEW MEXICO LICENSURE

Is your medical license current and unrestricted? Yes ☐ No ☐
Date New Mexico medical license was issued:_____
License Number and Type of License:_____

Do you hold any other professional licenses in this or any other jurisdiction? Yes ☐ No ☐
If you answered 'yes' so, please list:

License No.	**Type**	**State**	**Status (Active/Inactive)**

Name and Address of Applicant's Training Director:_____

_____

SECONDARY SUPERVISOR, if applicable:

Name:_____

Address:_____

City & State:_____

Telephone No._____

Is your license current and unrestricted? Yes ☐ No ☐
Date New Mexico license was issued:_____

Do you hold any other professional licenses in this or any other jurisdiction? Yes ☐ No ☐

If you answered 'yes' please list:

License No.	**Type**	**State**	**Status (Active/Inactive)**

Please describe the practice area in which you are formally trained, certified and/or licensed.

_____

_____

_____

_____

1. Was the 400-Hour Practicum part of the psychopharmacology training program from which the applicant obtained his/her certification or degree? Yes ☐ No ☐
2. Did the practicum meet the following requirements?
    a. A minimum of 100 separate patients? Yes ☐ No ☐
    b. A range of disorders listed in the DSM? Yes ☐ No ☐
    c. Both acute and chronic conditions? Yes ☐ No ☐
    d. Did the 400 hours include only time spent with patients to provide evaluation and psychopharmacotherapy and time spent in collaboration with treating healthcare providers? Yes ☐ No ☐

e. Was there diversity including gender, ages throughout the life-cycle, various ethnicities, socio-cultural backgrounds, economic backgrounds, as much as possible within the psychologist's area of practice Yes □ No □

3. Was the primary or secondary supervisor onsite? Yes □ No □
4. Did the applicant consult with your or any secondary supervisors, as appropriate, before making decisions about the pharmacological treatment of patients? Yes □ No □
5. Did the primary/secondary supervisor(s) review the charts & records? Yes □ No □
6. Was there at least one hour of supervision for every eight hours of Patient contact ? Yes □ No □
7. Did the applicant keep a log of the dates & times of supervision? Yes □ No □
8. Was the practicum completed in no less than six months and no more than three years? Yes □ No □
9. Was the practicum completed within the 5 years preceding this application? Yes □ No □
10. Did the applicant, during the initial contact with patients or legal guardians, adequately explain his/her status as a licensed psychologist receiving specialized training in psychopharmacology while under supervision? (Please provide copies of any printed material) Yes □ No □
11. Did the applicant maintain a log, without patient ID, which included basic identifying data? Yes □ No □
12. Did you, as a supervisor, write at least two formal evaluations of the applicant, preferably at the midpoint and at the end of the practicum, assessing progress, competence, and describing any deficiencies where competency had not been achieved? Yes □ No □
13. Did you, as supervisor, submit copies of these evaluations to the applicant & Training Director? Yes □ No □
14. Were you and any secondary supervisors in consultation regarding the applicant's progress, competence, and deficiencies, if any? Yes □ No □
15. Do you, as primary supervisor, certify that the applicant has successfully completed the 400-Hour/100-Patient practicum, as specified in the Prescribing Psychologist Act and is competent to obtain a conditional prescription certificate, all other requirements being satisfactorily completed? Yes □ No □

As the primary clinical supervisor of the 400-Hour/100-Patient practicum, I certify that all of the statements made in this document are true, complete, and correct to the best of my knowledge.

Date	Printed Name and Signature of Clinical Supervisor

Please mail completed form to the Board Office at:
New Mexico State Board of Psychologist Examiners
P.O. Box 25101
Santa Fe, NM 87504

PROPOSED SUPERVISORY PLAN

for

CONDITIONAL PRESCRIPTION CERTIFICATE

Applicant: Please fill out your name and submit the Form to be completed by your Supervisor(s) who will send it directly to the Board Office.

NAME OF APPLICANT:_____

To be completed by: Primary Supervisor

Primary Supervisor Name:_____

Address:_____

City & State:_____

Telephone No.:_____

Please describe the area of practice in which you are formally trained, certified and/or licensed. If you are not a psychiatrist, please indicate your experience and training in prescribing psychotropic medications.

_____

_____

_____

_____

License No._____ State:_____ Date of Initial License:_____

Is your license current and unrestricted?	Yes	No

Do you have any other license in this or any other jurisdiction? If yes, explain below.	Yes	No

License No.	**Type**	**State**	**Status Active/Inactive**

To be completed by: Secondary Supervisor, if applicable.

Secondary Supervisor Name:_____

Address:_____

City & State:_____

Telephone No.:_____

Please describe the area of practice in which you are formally trained, certified and/or licensed. If you are not a psychiatrist, please indicate your experience and training in prescribing psychotropic medications.

_____

_____

_____

_____

License No._____ State:_____ Date of Initial License:_____

Is your license current and unrestricted?	Yes	No

Do you have any other license in this or any other jurisdiction? If yes, explain below.	Yes	No

License No.	**Type**	**State**	**Status Active/Inactive**

To be completed by: Primary Supervisor

List the beginning and end dates of the two-year supervised practice covered by the plan.
Approximate beginning date:_____ Ending date:_____

List the setting(s) in which the conditional prescribing psychologist will practice and the hours per week worked at each setting._____

_____

_____

List duties and clinical responsibilities of the conditional prescribing psychologist._____

_____

_____

List the location(s) where the supervision will occur and with whom.

List the areas in which the primary and secondary supervisor(s), if any, have specialized skills to render competent supervision.

List the **License** number and name of all the psychologists with conditional prescription certificates that you will be supervising during this time period:

Describe the manner in which the conditional prescribing psychologist will be represented to the public, including all written communications and public announcements. (Please enclose copies of any printed materials.)

Is there any direct or indirect financial agreement between or among the conditional prescribing psychologist and the primary and secondary supervisor(s)? If yes, please describe the agreements on a separate page.	**Yes**	**No**

Describe any other information necessary to clarify the nature and scope of the supervision.

Provide a statement specifying the manner in which supervision and clinical and professional responsibility will be provided during the named supervisor's absence (for instance, during vacations or unexpected events that require said supervisor to be absent for any period of time).

As the primary supervisor, will you provide supervision on a one-to-one basis for at least 4 hours per month for a total of at least 46 hours of one-to-one supervision per year?	**Yes**	**No**

As the supervising physician, will you have access to and will you review records relating to the treatment of patients under your supervision?	**Yes**	**No**
As the primary supervisor will you contact any secondary supervisor(s) at least once (?) every six months to obtain written or verbal progress reports concerning the performance of the prescribing psychologist ?	**Yes**	**No**
Will the supervision be provided either face-to-face, telephonically, or by live tele-video communication?	**Yes**	**No**
Will you, as primary supervisor, inform any secondary supervisor(s) of any concerns about the performance of the conditional prescribing psychologist?	**Yes**	**No**
Will you maintain a supervision log containing dates, duration, and place/method of supervision, the same identification code for patients as used by the psychologist with a conditional prescribing certificate, and a brief description of the content of supervision?	**Yes**	**No**
Will you, as primary supervisor, maintain a log of contacts with the secondary supervisor(s)?	**Yes**	**No**
Will you review the results of laboratory tests as appropriate?	**Yes**	**No**

PRIMARY SUPERVISOR AGREEMENT

I, the undersigned, as a New Mexico licensed physician, knowledgeable in the administration of psychotropic medications, agree to supervise Dr. _____who holds a conditional certificate as a prescribing psychologist.

I have read the above document and agree to comply with the terms and conditions described above. I understand that the supervisory plan may be modified if I deem appropriate by submitting to the application committee for its approval, a modified plan agreed to be me, any secondary supervisors, and the conditional prescribing psychologist. The intent of my modified plan would be to best reflect the psychologist's needs for supervision.

_____ _____

Printed Name and Signature of Supervisor Date

_____ _____

Printed Name and Signature of Psychologist Supervisee Date

SECONDARY SUPERVISOR AGREEMENT

Please complete this form for each Secondary Supervisor. Make as many copies of this form as needed.

Secondary Supervisor

Will you, as secondary supervisor, inform the primary supervisor of any concerns about the conditional prescribing psychologist you are supervising?	**Yes**	**No**
Will you maintain a supervision log containing dates, duration, place and method of supervision, the same identification code for patients as used by the conditional prescribing psychologist and a brief description of the content of supervision?	**Yes**	**No**
Will you review the results of laboratory tests as appropriate?	**Yes**	**No**

I, _____, a New Mexico licensed physician and secondary supervisor, agree to supervise Dr. _____, who holds a conditional certificate as a prescribing psychologist. I have read the above document and agree to comply with the terms and conditions described above.

_____ _____
Printed Name and Signature Date

_____ _____
Printed Name and Signature of Applicant/ Psychologist Supervisee Date

Supervisor: Please mail completed form to:
New Mexico State Board of Psychologist Examiners
P.O. Box 25101
Santa Fe, NM 87504

TRAINING PROGRAM VERIFICATION OF EXPERIENCE

Board of Psychologist Examiners
P. O. Box 25101• Santa Fe, New Mexico • 87504
(505) 476-4622

To the Training Director of a program of psychopharmacology

A. REQUEST FOR INFORMATION

The Board of Psychologist Examiners has received an application for a conditional certificate as a prescribing psychologist from the applicant named below. (To be filled out by Applicant and forwarded on to the Director of the training program)

Applicant:
Address:
City & State:
Telephone No.

Your name has been submitted by the applicant as a Director of the Training of that program. The Board has not received applicants from your program before. Therefore, we will need to complete an extensive review of the program to determine if it fulfills requirements of the New Mexico Prescribing Psychologist Act.

Please provide the Board with the information requested below and return this form directly to the Board office at the above listed address.

B. INFORMATION ABOUT THE TRAINING DIRECTOR

Training Director's Name: _____
Title and position of employment: _____
Institution of employment: _____
Address: _____
City & State: _____
Telephone No.: _____

Please describe your training in psychopharmacology:

_____
_____
_____
_____
_____
_____
_____

Do you hold a license as a psychologist? Yes No
State: _____ Year license awarded: _____

Do you hold a license to prescribe psychotropics? Yes No

State: _____ Year license awarded: _____

Do you hold any other professional licenses in this or other jurisdictions? Yes No
If you answered 'yes' please list:

State	**License Type**	**When awarded**

C. INFORMATION ABOUT THE PROGRAM

Please circle the appropriate answer:

Does the applicant's psychopharmacology training meet the following criteria?

1. The program was an integrated program of study. Yes No

2. The program had an identifiable body of students at different levels of matriculation. Yes No

3. The program was clearly identified and labeled as a psychopharmacology program and specified its intent to educate and train psychologists to prescribe psychotropic medications. Yes No

4. The program had a formally designated program director who was a psychiatrist or a doctoral psychologist trained in the area of psychopharmacology and licensed to practice in the jurisdiction

where the program is offered. Yes No

5. The training director was primarily responsible for directing the training program and had administrative authority commensurate with those responsibilities. Yes No

6. The training director's credentials and expertise were consistent with the program's mission and goal to train psychologists to prescribe psychotropic medications. Yes No

7. The program provided information regarding the minimum level of achievement required for postdoctoral trainees to satisfactorily progress through and complete the training program, as well as evidence that it adhered to the minimum. Yes No

8. The program had formally designated instructors and supervisors in a sufficient number to accomplish the program's education and training. Yes No

9. Supervisors held an active, unrestricted license in their field of practice in the jurisdiction in which the program resides or where the supervision was being provided. Yes No

10. The program's supervisors and instructors had sufficient expertise, competence, and credentials in the areas in which they taught or supervised. Yes No

11. The program's instructors and supervisors participated actively in the program planning, implementation, and evaluation. Yes No

12. The program, with appropriate involvement from its training supervisors, instructors, and trainees, engaged in a self-study process that addressed:

    A. Expectations for the quality and quantity of the trainees' preparation and performance in the program;
    B. Training goals and objectives for the trainees and the trainees' views regarding the quality of the training experience and the program;
    C. Procedures to maintain current achievements or to make changes as necessary;
    D. Goals, objectives, and outcomes in relation to local, regional, and national changes in the knowledge base of psychopharmacology training. Yes No

13. The program followed the guidelines for psychopharmacology training

of postdoctoral psychologists established by the American Psychological Association. Yes No

14. Does the program include didactic instruction of no fewer than 450 class-room hours in at least the following core areas:
    - Neuroscience,
    - Pharmacology,
    - Psychopharmacology,
    - Physiology,
    - Pathophysiology
    - Appropriate and relevant physical assessment Clinical pharmacotherapeutics . Yes No

15. The training program assures that every student completes necessary training in the basic sciences (physiology, chemistry, biochemistry, the biological bases of behavior and psychopharmacology). Yes No

16. The program provides on-line access to a library of sufficient diversity and of a level to support the advanced study of the psychopharmacological treatment of mental disorders to students not in residence, wherever they may reside. Access remains available throughout all didactic and clinical phases of the training program. Yes No

17. Frequent face-to-face evaluation and discussion are included in the didactic training. Yes No

18. The program provided formal, written, measurement of the mastery of the course content. Yes No

19. The program demonstrated in its written materials or course syllabi integration of the following areas into the training : socio-cultural issues in psychopharmacological treatment, ethno-pharmacology, use of translators, the cultural context of compliance and non-compliance with prescribed medications, creating a culturally appropriate environment to meet patient care treatment and language needs, and working collaboratively with traditional healers. Yes No

D. SUBSTANTIATION

1. Please provide documentation that your program addresses the requirements stated above by providing as much of the following material and inserting checkmarks next to the documentation forwarded to the Board.

_____ Program curriculum

_____ University Catalog Description

_____ Relevant Policy Manual

_____ Relevant Student Handbook

_____ Resume of Director

_____ Resumes of Faculty

_____ Evaluation of program by external experts or associations

2. Does the program maintain a website? Yes No
If so, please give url: _____

E. EVALUATION OF THE APPLICANT

1. Do you, as training director, certify that the applicant successfully completed didactic training as outlined above? Yes No

2. Eighty-Hour Practicum

SUPERVISOR
Name:

Address:

City & State:

Telephone No.

Describe the supervisor's area of practice in which he or she is formally trained, certified or licensed?

_____
_____
_____
_____
_____
_____

License #_____ State:_____ Date of Initial License_____

Was the 80-hour practicum part of the psychopharmacology training program from which the applicant obtained the certification or degree? Yes No

Did your program receive an evaluation form about this applicant from this supervisor, which discusses the student's adequate skill development in:

Assessing a diverse and significantly medically ill population Yes No

Observing the progression of illness and continuity of care of individual patients Yes No

Adequately assessing vital signs Yes No

Demonstrating competent laboratory assessment Yes No

Was the 80-hour practicum completed from full-time to over thirty weeks? Yes No

3. 400 Hour Practicum in Psychopharmacology

PRIMARY SUPERVISOR
Name:

Address:

City & State:

Telephone No.

Describe the supervisor's area of practice in which he or she is formally trained, certified or licensed.

_____
_____
_____
_____
_____
_____

License #_____ State:_____ Date of Initial License_____

SECONDARY SUPERVISOR 1
Name:

Address:

City & State:

Telephone No.

Describe the supervisor's area of practice in which he or she is formally trained, certified or licensed.

_____
_____
_____
_____
_____
_____

License #_____ State:_____ Date of Initial License_____

SECONDARY SUPERVISOR 2
Name:

Address:

City & State:

Telephone No.

Describe the supervisor's area of practice in which he or she is formally trained, certified or licensed.

_____
_____
_____
_____
_____
_____

License #_____ State:_____ Date of Initial License_____

SECONDARY SUPERVISOR 3
Name:

Address:

City & State:

Telephone No.

Describe the supervisor's area of practice in which he or she is formally trained, certified or licensed.

_____
_____
_____
_____
_____
_____

License #_____ State:_____ Date of Initial License_____

- Was the 400-hour practicum part of the psychopharmacology training program from which the applicant obtained his/her certification or degree? Yes No

- Did the applicant submit a 400-hour practicum plan to the Practicum Director? Yes No

- Did the practicum meet the following requirements?

  A. A minimum of 100 separate patients? Yes No

  B. A range of disorders listed in the most recent DSM? Yes No

  C. Both acute and chronic conditions? Yes No

  D. 400 hours included time spent with patients to provide evaluation and pharmacotherapy, and time spent in collaboration with treating healthcare practitioners? Yes No

  E. Was there diversity, including gender, ages throughout the life cycle, various ethnicities, socio-cultural background, various economic backgrounds as much as possible within the psychologist's area of practice? Yes No

  F. Was the primary or secondary supervisor on-site? Yes No

  G. Did the primary/secondary supervisor(s) review charts and records? Yes No

  H. Was there at least one hour of supervision for every eight hours of direct service? Yes No

  I. Did the applicant keep a log of dates & times of supervision? Yes No

  I. Was the practicum completed in no less than 6 months and no more than three years? Yes No

  K. Was the practicum completed within the 5 years preceding this application? Yes No

  L. Is there evidence that during the initial contact with patients or guardians, the status of applicant as a licensed psychologist receiving specialized training in psychopharmacology and who is under supervision was Fully explained?

	Yes	No
- Did the applicant and the training program keep records of time spent during the practicum?	Yes	No
- Does the program have a coded log, without patient ID, submitted by the applicant, which includes for each of the 100 patients: age, gender, diagnosis, and time spent in treatment	Yes	No
- Does the program have at least two formal written evaluations of the applicant, completed by the primary supervisor, for the practicum experience assessing progress, competence, and deficiencies?	Yes	No
- Did the supervisor(s) certify in writing that the applicant's performance was satisfactory for the practicum?	Yes	No
- Do you, as training director, certify that the applicant has adequately completed a 400-our/100-patient practicum	Yes	No

4. Overall evaluation

1. I would rate this student's performance under my training as:
   (Please circle one)

   Excellent Acceptable Not Acceptable Unable to Evaluate

2. REMARKS: The Board would appreciate any information regarding your evaluation in Item 1 above. Please include any information you consider to be relevant regarding the applicant.

As Director of Training, I _____ certify that all of the statements made in this document are true, complete, and correct to the best of my knowledge and belief and are made in good faith.

_____ _____

Date Signature of Training Director/Supervisor

Please mail completed form directly to the Board Office at:

New Mexico Board of Psychologist Examiners
P. O. Box 25101
Santa Fe, New Mexico 87504