Preliminary Questionnaire Form
Post-Doctoral Training for Prescribing Psychologists (RXPP)

Name: Date of Submission:

DOB:

Home Address:

City, State, Zip Code:

Primary Email: Alternate Email:

Cell Phone#: Work Phone#:

Current Employer:

Employment Address:

City, State, Zip Code:

Degree Information

Highest Degree Completed: Date of Completion:

Discipline:

Academic Institution Granting Degree:

APA Accredited: YES NO

License Information

State of current licensure: License #:

Date licensed first issued:

Submittal Checklist: (Please email each of the five documents together in scanned PDF or mailed packet)

1.Completed Preliminary Questionnaire Form	☐
2. Copy of Unrestricted License to Practice Psychology	☐
3. Copy of Unofficial Graduate Transcripts	☐
4. Copy Updated Résumé or Curriculum Vita	☐
5. Brief Letter of Intent	☐