INSTRUCTIONS FOR CLINICAL PSYCHOTHERAPY LICENSURE

Please read all instructions and review the statutes and regulations, before beginning to complete the application. The statutes and regulations can be found on our website, www.ksbsrb.ks.gov.

1. Answer all questions completely and accurately. The burden of proof in satisfying to the Board that you are eligible for licensure is upon you. Thus, if you have been convicted of a felony or if there have been other past or current events that potentially raise questions about your ability to merit the public trust, you may be required to appear before the Board to explain these matters.

2. The correct application fee must accompany your application. Your check or money order should be made payable to the "Behavioral Sciences Regulatory Board" or "BSRB". **ALL FEES ARE NON-REFUNDABLE.** The application fee is $100.00.

3. As part of the application process, each applicant is required to provide an official transcript from the Registrar’s office of the college or university where your degree was granted and where any additional applicable graduate coursework was taken. Please direct the school to send the transcript directly to the Board office. **We cannot accept transcripts sent directly from the applicant.**

4. If you are currently an LMLP in Kansas, skip to # 7. If not, please review the following:
   a) As part of your completed application packet you are required to submit three (3) completed Professional Reference Forms. After completing Section 1, mail these forms directly to each of the three individuals that will serve as your professional references. Each of your references should complete the reference form and return it to you. You will then include these reference forms with your application and any other required material to the BSRB. **NOTE:** The individuals referencing you should seal the envelopes and then sign the back of the sealed envelopes so that the Board is assured of the confidentiality and integrity of the referencing process. **The Board will NOT accept references that are not in sealed, signed envelopes.**
   b) By regulation, your references must be from individuals that are licensed or authorized by law to practice psychology or a related behavioral science field. The professional references shall be familiar with your work as a psychologist and not related to you.
   c) One of the references must be from the individual that provided direct clinical supervision of your on-site graduate program practicum. If this person is unavailable, the graduate program director or any person with knowledge of the applicant's practicum experience on the basis of the applicant's practicum records shall submit the reference.

5. You will need to have your supervisor(s) complete the post-graduate attestation form(s) completely. Any hours that are already on file and approved will be included with these attestations.

6. It is extremely important for you to understand that the Board cannot determine whether you are eligible to sit for the examination until all the key application materials have been received and approved by the BSRB.

7. If you have not already passed the examination at the clinical level, once you are eligible, you will be provided information about scheduling and can contact the examination center with any questions regarding the examination.

8. If you are or have ever been licensed, registered, or certified as a masters level psychologist or licensed clinical psychotherapist in another state, you will need to have the former state board(s) complete the Out-of-State Clearance Form. They should send the completed form directly to us.

9. **When you submit your application to the Board office the following items should be included:**
   - If you are currently an LMLP in Kansas:
     - The completed application form (please complete all pages so that your application will not have to be returned);
     - The $100.00 application fee made payable to the BSRB by check, money order, or credit card;
     - Post-Graduate Supervisor Attestation(s).
   - If you are **not** currently an LMLP in Kansas, you will also need to submit the following documentation:
     - The three (3) completed Professional Reference Forms;
     - The Verification of Masters Degree Practicum Form;
     - The Academic Background Form;
   - These additional items need to be sent directly to the board office by the appropriate institutions:
     - Exam scores, if applicable.
     - The Out-of-State Clearance Form, if you were licensed in another state, submitted directly to the board office;
     - Your official transcript; submitted directly from the university to the board office.

10. Please allow 30 days for review of your application. You may now check the status of your application on our website www.ksbsrb.ks.gov, under “Applicants.”
APPLICATION FOR LICENSURE AS A CLINICAL PSYCHOTHERAPIST

Application Fee: $100.00 check, money order or credit card made payable to BSRB

I. Identifying information: (Please type or print clearly in ink)

Legal Name: ____________________________________________________________

Last Name: _______________________________ First Name: __________________________ Middle Name: __________________________

Maiden/Other names used: __________________________

Gender: __________________

Date of Birth: ___________________

Social Security Number: ________________________________ (Note: Your social security number is required pursuant to 42 U.S.C.S. § 666(a)(13), K.S.A. 74-148 and K.S.A. 74-139, and may be used for child support enforcement purposes or provided to the Kansas director of taxation upon request.)

Ethnic Information: African American _______ Native American _______ Asian Indian _______ Asian-Other _______

(Optional) Hispanic _______ Pacific Islander _______ White – Non Hispanic _______ Other _________________

(Please Specify)

Languages that you speak: English ________ Spanish _______ Sign ________ Other __________________________

(Optional)                                                            (Please Specify)

Preferred E-Mail Address: ____________________________________________

Preferred Mailing: Home____ Business____

Home Phone: ________________________________

Cell Phone (optional): __________________________

Home Address: ______________________________________________________

City: ___________________________________ State: ___________ Zip+4: __________

Business Phone: ________________________________

Business Name: ______________________________________

Business Address: _________________________________________________

City: ___________________________________ State: ___________ Zip+4: __________

Address of Record: (Note: The address of record is not required. It is a separate address that will be kept on file to be given out when requested by the public through the Kansas Open Records Act. If you do not indicate an address of record, your preferred mailing address will be used.)

Street Address: ______________________________________________________

City: ___________________________________ State: ___________ Zip+4: __________

II. General Background Information:

A. Are you currently registered by BSRB as the unlicensed assistant of a licensed Kansas psychologist? Yes____No____

If “yes”, list the name(s) and licensure number(s) of the licensed psychologist(s):

_________________________________________________________________________________________

B. Have you ever filed any application for licensure or registration in Kansas? Yes____No____

If “yes”, please answer the following questions:

1. When: __________________________ For which credential: __________________________

2. Under what name:

C. Do you currently hold, or have you ever held a certificate, registration or license to practice in one of the behavioral or health sciences in another state or jurisdiction? Yes____No____

If “yes”, please answer the following questions:

1. When: __________________________ For which credential: __________________________

2. Under what name:

3. In which state or jurisdiction:

If you currently hold, or have ever held a certificate, registration, or license to practice in one of the behavioral or health sciences in another state or jurisdiction, you will need to have the former state Board(s) complete the Out-of-State Clearance Form. Upon completion, they should send the form directly to us.
III. Merit of the Public Trust:
A. Please answer the following questions. Note: If the answer to any of the items 1 through 9 in this section is "Yes", submit as part of your application a signed, dated type-written explanation that gives specific details including disposition of the matter.

1. Have you ever been charged with or convicted of a felony or misdemeanor other than a traffic violation? Yes____ No____

2. Have you ever had a complaint filed with a professional association or a psychology certifying, licensing, or registering body against you for alleged unethical behavior or unprofessional conduct? Yes____ No____

3. Have you ever had disciplinary action taken against you for unethical behavior, unprofessional conduct or any other grounds? Yes____ No____

4. Have you used any alcohol, narcotic, barbiturate other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent within the last 2 years? Yes____ No____

5. Have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice behavioral sciences with reasonable skill and safety within the past 2 years? Yes____ No____

6. Have you used controlled substances which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the direction of a licensed health care provider within the past 2 years? Yes____ No____

7. Has any state, jurisdiction, providence, or professional organization denied your application for credentials or professional membership? Yes____ No____

8. Have you ever been sued for malpractice, or agreed to pay a settlement in a malpractice suit? Yes____ No____

9. Has any governmental agency ever substantiated allegations made against you for physical, mental or emotional abuse or neglect, sexual abuse, or exploitation of (1) a child, (2) a resident of an adult care home, medical care facility, psychiatric hospital or state institution for the mentally retarded, or (3) an adult? Yes____ No____

Note: If you are currently licensed as an LMLP, you may skip over Sections IV and V. Proceed to Section VI--Supervised Post Graduate Experience.

IV. Educational Qualifications:
A. Transcript(s): As part of the application process, each applicant is required to provide an official transcript from the Registrar’s office of the college or university where your degree was granted and where any additional applicable graduate coursework was taken. Please direct the school to send the transcript directly to the Board office. We cannot accept transcripts sent directly from the applicant.

B. List all accredited colleges or universities you have attended at the graduate level:

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<th>INSTITUTION</th>
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<th>DEGREE RECEIVED</th>
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C. Give other name(s) under which your coursework was taken or your degree was conferred, if different from the name you use now:

D. Submit at the time of application the completed Academic Background Form.
E. At the time of application, submit the completed Professional Reference Forms in their unopened envelopes that have been signed across the seal by each reference. These references must be from three individuals that are licensed or authorized by law to practice psychology or a related behavioral sciences field, that are not related to you, and that can attest to your professional competency and character. Note: If you completed a graduate program practicum, any on-site practicum supervisor needs to complete a Professional Reference Form. If this person is unavailable, the graduate program director or any person with knowledge of the applicant’s practicum experience on the basis of the applicant’s practicum records shall submit the reference.

F. Provide the names and mailing addresses of the three individuals who completed the Professional Reference Forms on your behalf. Please place an asterisk/star (*) next to the person(s) that provided the direct supervision of your on-site graduate program practicum.

Name:____________________________________________________________________
Address:________________________________________________________________
Name:____________________________________________________________________
Address:________________________________________________________________
Name:____________________________________________________________________
Address:________________________________________________________________

V. 750 Clock Hours Practicum:
A. Did you, as part of the degree requirements for a masters degree in psychology or a masters degree in clinical psychology, complete at least a 750 clock hour practicum? Yes____No____
If “yes”, complete the remaining items in this section and then proceed to the next section (Section VI).
If you answered “no” to the above question, then proceed directly to Section VI.

B. List the name and mailing address of each agency where your university-approved masters level psychology practicum was served:
Name:                      Address:                      
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

C. Dates of Practicum: ____________________________________

D. Number of hours worked per week: ______________ Total number of practicum hours completed: _______

E. Names of On-site Practicum Supervisors:
__________________________________________________________________________
__________________________________________________________________________

F. At the time of application, submit in the unopened envelope that has been signed or stamped across the seal by the graduate program director, the completed Verification of Masters Degree Psychology Practicum Form. Note: This form must be completed by the psychology program director from the college or university that academically supervised the masters degree psychology practicum experience.

VI. Supervised post-graduate experience:

List the name and current address of the supervisors that have submitted post-graduate supervisors’ attestations in support of your application for licensure, the settings where the experience was gained, and the dates of the experience:

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<th>Name of Supervisor</th>
<th>Current Address</th>
<th>Setting of Experience</th>
<th>Dates of Employment</th>
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VII. Examination:

A. If you have not previously taken the Examination for Professional Practice of Psychology (EPPP) developed by the Association of State and Provincial Psychology Boards (ASPPB) and achieved a score of at least 70 percent correctly answered items, you will be notified in writing if you are eligible to register and sit for the examination. Applicants must first satisfy the educational requirements in order to be authorized by Behavioral Sciences Regulatory Board (BSRB) to register for the examination.

B. Have you previously taken and passed the EPPP examination at 70% or higher? Yes____No____
   If “yes”, complete the remaining items in this section before proceeding to the next section.

   If you answered “no” to the above question, proceed directly to Section VIII.

C. Location of the examination:__________________________________________________________

D. Date exam was taken:_________________________________________________________________

E. Arrange for the Board's receipt of the official test scores by requesting that the Professional Examination Service (or the out-of-state credentialing board) send the scores directly to you in an envelope that is signed (or officially stamped) across the sealed envelope. At the time of making application, submit the test scores in the unopened envelope that has been signed or stamped across the seal by the Interstate Reporting Service.

VIII. Applicant’s Attestation:

A. I have reviewed the licensure eligibility requirements prior to submitting this application. Yes____No____

B. I have completed the application materials and procedures honestly and in good faith. Yes____No____

C. I understand that the members and staff of BSRB are compelled by law to uphold, implement and enforce the licensure statutes and regulations as written. Yes____No____

D. I understand that all state records pertaining to application and licensure may be used to conduct research or program evaluation, but any such research will not personally identify the applicants or licensees, either directly or indirectly. Yes____No____

E. I understand that the Board has the statutory authority to refuse to grant licensure to, or may suspend, revoke, condition, limit, qualify, or restrict the license of any individual that has knowingly made a false statement on a BSRB form required for licensure or licensure renewal. Yes____No____

F. I have read and am familiar with the statutes and regulations that govern the practice of clinical psychotherapy in the state of Kansas. Yes____No____

G. I understand that once the Board receives my application I am bound by the statutes and regulations governing the practice of clinical psychotherapy in Kansas. Yes____No____

Signature:_____________________________________________ Date: ______________________________________

NAME or ADDRESS CHANGE: It is the applicant's responsibility to notify the Board in writing of any name or address change that might occur during the application process.
APPLICATION FOR LICENSURE AS A CLINICAL PSYCHOTHERAPIST: LCP

Verification of Masters Degree Practicum Form

**Instructions:** Section 1 is to be completed by the applicant and then sent to the Dean, Director or Chairperson of the Masters Psychology Program for completion. Please include a self-addressed stamped envelope. Additional copies of this form may be made and used as needed by the applicant. The applicant shall submit the completed Verification of Masters Degree Practicum Form in the unopened envelope that has been signed or stamped across the seal by the graduate program director at the time of application. Section 2 is to be completed by the Masters Psychology Program Dean, Director or Chairperson, signed across the sealed envelope and then returned to the applicant.

### I. SECTION 1: This section is to be completed by the applicant:

| A. Name: | ____________________________________________________________________________________ |
| B. Social Security #: | ___________________________________ Date of Birth: ___________________________ |
| C. College/University: | ___________________________________ Graduation Date: ___________________________ |

I am applying for licensure as a clinical psychotherapist in the State of Kansas and I am required to provide information to support that application. This form, bearing my signature, gives my consent and authorization to release any and all information and/or documents that may be material to an evaluation of the practicum I completed as part of the requirements for my masters degree in psychology.

Please complete Section 2 of this form on my behalf, and then mail the completed form directly to me in the self-addressed stamped envelope enclosed herein. Please be certain to seal the envelope and sign over the seal. I am responsible for submitting to the Behavioral Sciences Regulatory Board (BSRB) the completed form in its sealed envelope as part of my application packet.

Signature of Applicant: ___________________________ Date: _______________________

### II. SECTION 2: This section is to be completed by the Dean, Director or Chairperson of the Masters Degree Psychology Program completed by the applicant. The completed form should be sealed in an envelope, signed over the seal, and then returned to the applicant.

| A. Did the applicant’s practicum consist of at least 750 clock hours of supervised practicum training? | Yes____ No____ |
| B. Did the program provide at least 350 hours of face-to-face client contact conducting therapy and assessment with individuals, couples, families, and/or groups? | Yes____ No____ |
| C. Were the following supervised activities completed by the applicant during the master’s degree practicum experience: |
| 1. Diagnosis? | Yes____ No____ |
| 2. Remediation techniques? | Yes____ No____ |
| 3. Psychological testing? | Yes____ No____ |
| 4. Interdisciplinary consultation and collaboration? | Yes____ No____ |
| 5. Direct practice activities with a client population presenting a diverse set of problems and backgrounds? | Yes____ No____ |
| D. Was the applicant formally enrolled in the master’s psychology program at the time the practicum was completed? | Yes____ No____ |
| E. Had the applicant satisfactorily completed practicum prerequisite graduate coursework prior to the practicum? | Yes____ No____ |
| F. Did the practicum provide the applicant with a minimum of one hour of supervision for every 10 hours of direct client contact? | Yes____ No____ |
| G. Did the applicant receive on-site supervision? | Yes____ No____ |
| H. Was the on-site supervisor licensed, registered, or certified as a psychologist, or alternately, otherwise legally authorized to practice as a psychologist in the state where the practicum occurred? | Yes____ No____ |

If “yes”, please answer the following questions:

1. Name of on-site supervisor: ________________________________________________________________________
2. License type: __________________________________ License #: ____________________________
3. Issued: ___________________________________ Expiration Date: __________________________

| I. Did the practicum identify students as being in training and not as staff? | Yes____ No____ |
| J. Did the applicant satisfactorily complete the practicum requirements? | Yes____ No____ |
K. Additional Comments:

ATTESTATION: I attest that the forgoing information I have supplied is true and accurate to the best of my knowledge.

Signature: ___________________________ Date: ___________________________

Printed Name: ___________________________

Official Title/Position: ___________________________

College/University: ___________________________

Mailing Address: ___________________________

Phone Number: ___________________________ Fax Number: ___________________________

Date: ___________________________
APPLICATION FOR LICENSURE AS A LICENSED CLINICAL PSYCHOTHERAPIST: LCP

Academic Background Form

INSTRUCTIONS: This form is to be completed by the applicant and submitted at the time of application. To be considered toward the educational requirements, the applicant’s reported coursework must be graduate level academic coursework that has been taken for graduate level academic credit. Each course may be reported in only one category, where it most accurately fits by course content. If the course title does not clearly reflect the category where you are reporting a particular course, submit at the time of application copies of the course catalog description and syllabus for any such course(s). If you graduate on or after July 1, 2003, you will be required to have at least 60 hours of graduate coursework rather than just the specific 36 hours.

The following activities shall not be reported, substituted for or counted toward the 36 academic coursework requirements:
1. Independent studies;
2. thesis or independent research courses;
3. practicum, internship or residency courses;
4. academic coursework that was audited;
5. academic coursework that has a failing grade;
6. coursework taken for undergraduate credit;
7. nonacademic coursework or training;
8. continuing education, in-service, or on-the-job training.
Some of these can be counted towards the 60 if you are required to complete 60. See Category 5.

Name of Applicant (Print): ____________________________________________________________

Social Security #: __________________________________________________________ Date of Birth: __________________________

Colleges/Universities attended: ___________________________________________________________________

Please remember that fifteen (15) graduate credit hours supporting diagnosis or treatment of mental disorders is required for the LCP license. Please indicate in the far right column which hours you will be claiming to meet the 15 hour requirement if you intend to apply for the LCP license at a later date.

Please see K.S.A. 74-5363 and K.A.R. 102-4-3a for more detail

Note: If your college or university awarded quarter or trimester credit hours rather than semester hours, please indicate by putting a Q (for quarter hours) or a T (for trimester hours) adjacent to the reported number of credit hours throughout the form.

**Category 1: Psychotherapy Courses.** A minimum of 6 semester hours is required in this category. Psychotherapy courses include in-depth study of the major theories, principles and clinical methods and techniques of psychotherapy with individuals, groups or families.

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<th>Course Title</th>
<th>Credit Hrs</th>
<th>University</th>
<th>15 Hr Requirement</th>
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Note: Additional psychotherapy courses beyond the required minimum of 6 semester hours may be used toward the professional core coursework requirements in Category 4.

**Category 2 Psychological Testing Courses.** A minimum of 6 semester hours is required in this category. Psychological testing courses include studies in the selection, administration, scoring, and interpretation of objective and projective diagnostic tests as indicators of intelligence and scholastic abilities or as screening devices for organic pathology, learning disability, and personality disturbance.

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Note: Additional psychological testing courses beyond the required minimum of 6 semester hours may be used toward the professional core coursework requirements in Category 4.
**LCP Academic Background Form**

**Page 2 of 4**

**Category 3: Psychological Foundation Courses.** A minimum of 12 semester hours is required in this category. Psychological foundation courses include studies in the following subcategories:

**A. Philosophy of Psychology:** Includes studies that introduce the fundamental philosophic, conceptual, theoretical or applied processes of psychology, and the issues central to professional orientation, role development, ethical and legal standards, and professional responsibility.

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**B. Psychology of Perception:** Includes studies of memory, language, speech, sensory, motor, reasoning, decision making, problem solving and other cognitive processes.

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**C. Learning Theory:** Includes studies pertaining to the fundamental theoretical assumptions and applied principles of learning, conditioning, concept formation, and behavior.

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**D. History of Psychology:** Includes studies that trace and analyze the historical development and contemporary evolution of the concepts and theories in psychology.

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**E. Motivation:** Includes studies of the concepts, principles and empirical finds concerning the innate, biological and acquired factors which underlie and drive human motivation.

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**F. Statistics:** Includes studies in the theory, analysis, interpretation, and the manual or computer of statistical measures. (Do not include thesis or independent research courses.)

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**Category 4. Professional Core Courses.** A minimum of 12 additional semester hours is required in this category. Professional core courses include studies in the following subcategories:

**A. Psychopathology:** Includes studies that examine the theories, definitions, dynamics, and differentiations in diagnostic classifications. This subcategory may also include studies in abnormal psychology or studies that examine the etiological factors, clinical course, and the clinical and psychopharmacological approaches to the treatment of mental, behavioral, and personality disorder.

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**B. Personality Theories:** Includes studies that seek to explain or compare and contrast the major theories of normal and abnormal personality development, functioning, adaptation, and assessment.

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**C. Developmental Psychology:** Includes studies which may include psychological or biologically based studies that provide a comprehensive overview of the bio-psycho-social factors, determinants, and stages that pertain to human physical, emotional, intellectual, and social development and adaptation from infancy through senescence.

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**D. Research Methods:** Includes studies in the principles, techniques, and ethics of research, as well as the identification of research problems, selection of research designs, measurement strategies, sampling techniques, and methods of evaluating the results. (Do not include thesis or independent research courses.)

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**E. Social Psychology:** Includes studies of the interactive and influencing effects of social, cultural, and ecological factors upon the emotions, beliefs, attitudes, expectations, roles, behaviors, and interactional dynamics of individuals, families, groups, organizations, and the larger society.

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**F. Additional Coursework in Psychotherapy or Psychological Testing:** Includes additional studies in psychotherapy or psychological testing as defined above in Categories 1 or 2.

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If you graduated with your masters degree in psychology **AFTER July 1, 2003** than a total of 60 semester hours of graduate coursework is required.

Be sure you have already completed the required 36 hours in Category 1-4.

The following activities shall **NOT** be reported, substituted for or counted toward the coursework requirements:

1. coursework taken for undergraduate credit;
2. academic coursework that was audited;
3. academic coursework that has a failing grade or that is incomplete;
4. non academic or correspondence coursework or training;
5. continuing education, in-service, or on-the-job training;
6. coursework that the Board determines is not closely related to the field or practice of counseling;
7. no more than 6 graduate hours of independent study that is related to the field or practice;
8. no more than 10 graduate hours of thesis research and writing.

### Category 5. Additional Coursework:

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APPLICATION FOR LICENSURE AS A CLINICAL PSYCHOTHERAPIST: LCP

Professional Reference Form

**Instructions:** Section 1 is to be completed by the applicant and then sent to the referencing individuals for completion. Additional copies of this form may be made and used as needed by the applicant. Completed Professional Reference forms shall be submitted, at the time of application, in the unopened envelopes that have been signed across the seal by the reference. Section 2 is to be completed by the referencing individual, sealed in an envelope, signed over the seal and then returned to the applicant.

**SECTION 1: This section is to be completed by the applicant:**

To: (Name of Reference-please print):

From: (Name of Applicant-please print):

I am applying for licensure as a clinical psychotherapist in the State of Kansas and I am required to provide information to support that application. This form, bearing my signature, gives consent and authorization to release any and all information and/or documents that may be material to an evaluation of my merit of the public trust. I authorize the Behavioral Sciences Regulatory Board (BSRB) and its representatives to consult with you regarding my professional competence, character, ethical qualifications, health status, ability to work cooperatively with others and other qualifications for licensure.

I release from liability any and all individuals, institutions and organizations that provided information to the BSRB or its representatives, in substantial good faith and without malice, concerning my merit or the public trust and my qualifications for licensure. I consent to the inspection by the BSRB and its representatives of all documents that may be material to an evaluation of my qualifications and competence. I understand that this consent for release of information will be in effect for a period of one year from the date of consent.

Please mail this completed form directly to me in a sealed envelope with your signature across the seal. Please be certain to seal the envelope and sign over the seal. I am responsible for submitting to BSRB the completed form in its sealed envelope as part of my application packet.

Signature of Applicant: _________________________________________________ Date:___________________________________

**SECTION 2: The qualified referencing individual should answer all of the following questions to the best of their knowledge. The reference should then return this completed form to the applicant in a sealed envelope. The reference should sign his/her name over/across the seal on the envelope to insure confidentiality.**

To qualify to serve as a professional reference, the referencing individual must be:

1. unrelated to the applicant;
2. authorized by law to practice psychology or in a related field;
3. able to address the applicant’s professional conduct, competence and merit of the public trust;
4. one of the reference must be from the on-site practicum supervisor.

**Note:** If you do not qualify to serve as a professional reference, please alert the applicant. If you do qualify to serve as a professional reference, please complete the form and return it, at your earliest convenience, to the applicant as indicated above. Please be sure to sign over the seal on the back of the sealed envelope before returning it to the applicant.

Thank you.

I. Professional Reference’s Qualifications:

A. Professional Reference’s Name:

B. Do you hold a professional license? Yes____No____ If “yes”, please answer the following questions:

1. Professional Licenses held:__________________________ License #:__________________________

2. State of Issuance:__________________________ Issuance Date:__________________________ Expiration Date:__________________________

C. Agency:__________________________________________

D. Agency Address:_____________________________________

E. Phone:__________________________________________ Fax:______________________________________
LCP Professional Reference Form

Page 2 of 2

F. Professional Reference’s Educational Background: ________________________________________________

G. Professional title: __________________________________________________________________________

H. Were you the applicant’s graduate program on-site practicum supervisor?     Yes____No____

I. Are you related by blood or marriage to the applicant?   Yes____No____ If “yes”, state relationship:

__________________________________________________________________________________________

J. How long have you known the applicant? _________________________________________________________

K. What relationship (such as employer, supervisor, co-worker, practicum, instructor and the like) have you had with
the applicant which has aided you in forming any opinion of his/her character:

__________________________________________________________________________________________

II. Professional Reference’s Knowledge of the Applicant:

A. Please consider the candidate’s behavior in the following areas: good judgement, integrity, honesty, fairness,
credibility, reliability, respect for others, respect for the laws of the state and nation, self-discipline, self-evaluation,
initiative, and commitment to the profession of clinical psychotherapy and its values and ethics. Does the
candidate, in your opinion, possess the moral standards and fitness required for working as a clinical
psychotherapist?           Yes____No ____

If your answer is “no”, explain in detail in an attached statement.

B. Are you aware of any significant facts concerning the applicant’s background that would reflect unfavorably
on the applicant’s character and fitness to practice clinical psychotherapy?           Yes____No____

If “yes”, please state these facts in detail on an attached statement.

C. Do you recommend the applicant for licensure to practice clinical psychotherapy in Kansas?       Yes____No____

If not, please elaborate in detail in an attached statement.

D. If you desire, please expand upon any of the foregoing answers or add any comments or information that you
believe will aid the Behavioral Sciences Regulatory Board (BSRB) to evaluate the applicant’s merit of the public
trust for licensure as a clinical psychotherapist in Kansas. For such purpose you may supplement this
Professional Reference Form by typewritten letter addressed to the Board and attached hereto.

III. Reference’s Attestation:

I certify the foregoing answers and information furnished above are given in good faith with the understanding that it will
be utilized for purposes of determining the applicant’s merit of the public trust to be licensed and to practice as a clinical
psychotherapist in the State of Kansas. Any response or information I have provided is true and correct to the best of my
knowledge and belief. Where I have relied upon other sources of information, they are only those which I believe to be
accurate and reliable.

Printed Name:________________________________________________________________________________ _____

Signature:___________________________________________________________________Date:________________
APPLICATION FOR LICENSURE AS A LICENSED CLINICAL PSYCHOTHERAPIST: LCP
Out-of-State Clearance Form

Instructions:
Section 1 is to be completed by the applicant and then sent to the out-of-state board for completion. Additional copies of this form may be made and used as needed by the applicant.
Section 2 is to be completed by a representative of the out-of-state board, and then returned directly to us.

I. SECTION 1: This section is to be completed by the applicant:
   A. Name: ____________________________________________________________________________________
   B. Social Security #:____________________________________Date of Birth:_____________________________
   C. Maiden or other name in which license was issued:________________________________________________
   D. Type of Credential held in the other state:________________________________________________________
   E. Type or Field of Practice:_____________________________________________________________________
   F. License Number:_______________________________Level of Licensure:______________________________
   G. Date of Issuance:__________________________________Date of Expiration:___________________________

II. SECTION 2: This section is to be completed by the State Board. Upon completion, please return this form to: BSRB, 700 SW Harrison St., Ste. 420, Topeka, KS 66603-3929.
   A. Type of Credential (please circle applicable designation):  Licensure_____  Registration_____ Certification_____
   B. Type or Field of Practice: _____________________________________________________________________
   C. Lic/Reg/Cert Number: _______________________________________________________________________
   D. Date of Issuance:_______________________________Date of Expiration:______________________________
   E. Level of Lic/Reg/Cert (Baccalaureate, Masters, Doctorate): ________________________________
   F. Is Lic/Reg/Cert in Good Standing?   Yes_____  No _____ If “no”, please state reason(s):
                                          ___________________________________________________________________________________________
                                          __________________________________________________________ ___________________________
   G. Has the Lic/Reg/Cert ever been suspended or revoked? Yes____No____ If “yes”, please state reason(s):
                                          ___________________________________________________________________________________________
                                          ___________________________________________________________________________________________
   H. Did the applicant take the Examination for Professional Practice in Psychology (EPPP) developed by the
       Association of State Provincial Psychology Boards (ASPPB) to qualify for the Lic/Reg/Cert? Yes____No____ If “yes”, please complete the following:
       1. Date of Exam:_________________________________________________________Passed: ☐ Failed: ☐
       2. Exam Level:___________________________________________________________
       3. Exam Form #:_________________________________Applicant’s Exam ID#:________________________
       4. Applicant’s Score: Raw:__________________Scaled:_________________Percent:_________________
          Exam Mean:____________Standard Deviation:________________State Cutoff Score:________________
I. Additional Comments:

Signature of State Board Representative:_______________________________________________________________
Printed Name:_____________________________________________________________________________________
Official Title/Position:_______________________________________________________________________________
State/Jurisdiction __________________________________________________________________________________
Mailing Address:___________________________________________________________________________________

Phone Number:___________________________________Fax Number:_______________________________________
Date:____________________________________________________________________________________________

STATE SEAL
APPLICATION FOR LICENSURE AS A CLINICAL PSYCHOTHERAPIST: LCP

Post-graduate Supervised Clinical Work Experience Supervisor’s Attestation
Consent and Authorization to Release Information

Applicant’s Name (Please print):_______________________________________________________________________
Supervisor’s Name (Please print):______________________________________________________________________

To my supervisor:
I am applying for license as a clinical psychotherapist in the state of Kansas, and I am required to provide information in support of that application. This form bearing my signature, gives my consent and authorization to release any and all information and documents that may be material to an evaluation of my qualifications and competence.

I authorize the Behavioral Sciences Regulatory Board (BSRB) and its representatives to consult with you regarding my professional competence, character, ethical qualifications, ability to work with others, and any other qualifications for licensure.

I release from liability any and all individuals, institutions, and organizations that provided information to the BSRB or its representatives, in substantial good faith and without malice, concerning my professional conduct, ethics, character and other qualifications for licensure. I consent to the inspection by the BSRB of all documents that may be material to an evaluation of my qualifications and competence. I understand that this consent for release of information will be in effect for a period of one year from the date of consent.

Please return this completed attestation to me IN A SEALED ENVELOPE, WITH YOUR SIGNATURE OVER THE SEAL. I am responsible for submitting this completed reference, in its unopened, sealed envelope as part of my application packet.

___________________________________________________________________________________________________________
Signature of Applicant                                                                               Date

I. Post Graduate Clinical Supervisor’s Attestation:
A. Setting where supervised postgraduate experience occurred:
   1. Agency name:___________________________________________________________________________
   2. Agency Address:_________________________________________________________________________
B. Dates of supervision provide by you: From____________________ to __________________________________

II. Supervised hours while under your supervision:
A. Total number of post graduate clinical experience hours that involved direct, face to face clinical contact with clients providing psychotherapy and evaluation:____________________________________________________
B. Total number of post graduate clinical experience hours that applicant completed including those hours reported in “A”:____________________________________________________________________________________
C. Average number of hours that applicant worked per week:
D. Total number of supervision sessions provided to the applicant:
E. Total number of supervision hours provided to the applicant:
F. Total number of hours of clinical supervision provided individually to the applicant:
G. Total number of hours of clinical supervision provided in a group setting:

III. Supervisor’s Qualifications at the time supervision was provided:
A. Masters degree in:_________________________Year conferred:____________________________
B. License type and number:_____________________________________________________________________
C. Original date of issue:___________________________________________ State:_________________________
D. If licensed in another state at the time supervision was provided, was this license the independent, clinical level of licensure?                   Yes____No____
E. Were you under any disciplinary sanction, restriction or have any disciplinary action pending by a professional licensing or credentialing Board at the time you provided supervision?   Yes____No____
F. Did you have, at least in part, clinical responsibility for the supervisee’s practice of masters level psychology?  
Yes____No____

G. Did you have knowledge and experience with the supervisee’s client population?  
Yes____No____

H. Did you have knowledge and experience with the methods of practice that the supervisee employs?  
Yes____No____

I. Were you a member of the staff in the supervisee’s practice setting?  
Yes____No____

If “no”, please answer the following questions:

1. Did you have an understanding of the organization and administrative policies and procedures of the practice setting?  
Yes____No____

2. Did you have an understanding of the mission of the practice setting?  
Yes____No____

3. Was the extent of your responsibilities clearly defined with respect to the client cases to be supervised and your role, if any, in the personnel evaluation within the practice setting?  
Yes____No____

4. Was the responsibility for payment for supervision clearly defined?  
Yes____No____

5. If the supervisee paid you directly for supervision, did you maintain your responsibility to the client and the practice setting?  
Yes____No____

6. Were the parameters of client confidentiality defined and agreed to by the client?  
Yes____No____

IV. Supervisor’s requirements within the supervision process:

A. Did you meet in person with the supervisee to provide at least 1 hour of supervision session for every 15 hours of direct clinical client contact?  
Yes____No____

B. If you provided supervision in a group format, how many supervisees were in those groups?  
_________________

C. Did you provide oversight, guidance and direction of the supervisee’s practice by assessing and evaluating the supervisee’s performance?  
Yes____No____

D. Did you provide supervision in a process distinct from personal therapy, didactic instruction, or masters level psychology consultation?  
Yes____No____

E. Did you ensure that your scope of responsibility and authority in the supervisee’s practice setting was clearly defined?  
Yes____No____

F. Did you periodically evaluate the supervisee’s role and their use of a theoretical base, and their use of psychological principles?  
Yes____No____

G. Did you provide supervision consistent with the education, training, experience, and ability of the supervisee?  
Yes____No____

V. Evaluation of the Applicant’s supervised experience:

A. Please summarize the types of clients and client situations dealt with during the supervised experience:

B. Did the applicant complete all supervision goals and objectives?  
Yes____No____

C. Please assess the applicant’s performance in regard to the following components of clinical psychotherapy practice.  

NOTE: If you rate any of the following categories as “unacceptable”, please attach a statement outlining the basis for those ratings, or for your reservations concerning licensing this applicant for independent clinical psychotherapy.

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<td>3. Treatment (psychotherapy)</td>
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<td>4. Client centered advocacy</td>
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<td>5. Consultation</td>
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<td>6. Evaluation</td>
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D. Was the applicant’s performance throughout the period of supervision consistently acceptable?  
Yes____No____

E. Please evaluate the applicant’s merit of public trust in regard to the following qualities:

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<th>Quality</th>
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<tbody>
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<td>7. Respect for others:</td>
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<td>8. Respect for state and federal laws:</td>
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9. Self discipline:  ________  ___________
10. Self-evaluation:  ________  ___________
11. Initiative:  ________  ___________
12. Commitment to psychology values and ethics:  ________  ___________

**F. Do you recommend this applicant for licensure at the independent, clinical level of clinical psychotherapy?**
Yes____No____ If your answer is “no”, please attach a statement that describes the basis for your denial.

**VI. Attestation of the Supervisor:**

I have personally known the above applicant who has made application to the BSRB for licensure as a clinical psychotherapist, and attest that said applicant has been practicing in the clinical setting as indicated, and has been supervised by me in that specialty.

In signing this form, I understand that I am attesting that all the information provided in this attestation form is true, accurate, and submitted in good faith. I understand that in accordance with Kansas statutes, anyone knowingly making a false statement on any form of the BSRB shall be guilty of a Class B misdemeanor.

Printed Name:_____________________________________________________________Date:____________________

Signature:________________________________________________________________________________________
Credit Card Payment Form

Only complete when paying by credit card.

The credit cards accepted are American Express, Discover, MasterCard and Visa.

Amount of Purchase: $____________

Credit Card: American Express ______ Discover ______
             MasterCard ______ Visa ______

Credit Card Acct. # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Credit Card Expiration Date ___ ___ / ___ ___

Name as it appears on the card __________________________________________

Signature: _______________________________ Date_________________

For Office Use Only:

Approval Number ______________ Date ______________