

## INSTRUCTIONS FOR CLINICAL PSYCHOTHERAPY LICENSURE LCP

Please read all instructions and review the statutes and regulations, before beginning the application. The statutes and regulations can be found on our website, [www.ksbsrb.ks.gov](http://www.ksbsrb.ks.gov).

**1. If you are currently licensed as an LMLP in Kansas, submit the following:**

- The completed application form (four pages)
- The \$50.00 application fee (See Appendix A);
- Post-Graduate Supervisor Attestation(s).

**If you are not currently licensed as an LMLP in Kansas, you will also need to submit the following:**

- The three (3) completed Professional Reference Forms;
- The Verification of Master's 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 with the degree posted; submitted directly from the university to the board office. You don't have to submit a transcript again if you have already submitted it previously.

**2. Criminal Conviction/s-** You are required to report the following convictions:

- A.** Conviction of Any felony
- B.** Conviction of any misdemeanor crime against a person

Either of the above listed convictions will require you to complete the Conviction Packet. You may click on this link to download the: [Conviction Packet](#) or you may find this packet on our website, [www.ksbsrb.ks.gov](http://www.ksbsrb.ks.gov) under forms. You must return the required documentation with your application packet. **Your application will not be reviewed without this information.** Your application will require a determination from the full Board on eligibility for licensure. **Please allow extra time for a decision to be made on your application.**

**3.** Instructions for paying the \$50 application fee may be found on **Appendix A. FEES ARE NON-REFUNDABLE.**

**4.** 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. Have the school send the transcript (with the degree posted) directly to the Board office. **We cannot accept transcripts submitted by the applicant. Note: You don't have to send a transcript if you have sent it previously.**

**5. If you are currently an LMLP in Kansas, go to # 6. 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 of the form, 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. Include these reference forms with your application and any other required material to the BSRB. NOTE: The individuals completing the reference 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 on-site practicum supervisor of your graduate program clinical practicum. If this person is unavailable, the graduate program director or any person with knowledge of the applicant's practicum evaluations may submit a reference.

**6.** The Board cannot determine whether you are eligible to sit for the examination until the 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 held a professional license, registration, or certification, you will need to have the State board(s) complete the License Verification form. They should send the completed form directly to the BSRB.

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](http://www.ksbsrb.ks.gov), under "Services."



**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 convicted of a felony? Yes\_\_\_No\_\_\_  
**If yes, submit the [Conviction Packet](#).**
2. Have you ever been convicted of a misdemeanor crime against persons? Yes\_\_\_No\_\_\_  
**If yes, submit the [Conviction Packet](#).**
3. 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\_\_\_
4. 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:

INSTITUTION	DATES OF ATTENDANCE		MAJOR AND/OR CONCENTRATION	DEGREE RECEIVED	DATE DEGREE CONFERRED
	FROM	TO			

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 master's degree in psychology or a master's 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 master's level psychology practicum was served:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

C. Dates of Practicum: \_\_\_\_\_

D. Number of hours worked per week: \_\_\_\_\_

E. Total number of practicum hours completed: \_\_\_\_\_

F. Names of On-site Practicum Supervisors: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

G. 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 Master's Degree Psychology Practicum Form. Note: This form must be completed by the psychology program director from the college or university that academically supervised the master's 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:

Name of Supervisor	Current Address	Setting of Experience	Dates of Employment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**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 scaled score of at least 500, 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 passed the EPPP examination at 500 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, postal address or email address change that might occur during the application process.



**APPLICATION FOR LICENSURE AS A CLINICAL PSYCHOTHERAPIST: LCP  
Verification of Master's Degree Practicum Form**

**Instructions:** Section 1 is to be completed by the applicant and then sent to the Dean, Director or Chairperson of the Master's 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 Master's 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 Master's 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. Last Four Numbers of Social Security #: \_\_\_\_\_
- 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 master's 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 Master's Degree Psychology Program completed by the applicant. The completed form should be sealed in the enclosed 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 \_\_\_ **If "no", how many clock hours were completed:** \_\_\_\_\_
- 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 \_\_\_  
**If "no", how many hours were completed:** \_\_\_\_\_
- 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 supervisor: \_\_\_\_\_

2. License type: \_\_\_\_\_ License #: \_\_\_\_\_ Issued: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

I. Did the practicum identify students as being in training and not as staff? Yes\_\_\_No\_\_\_

J. Did the applicant satisfactory 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: \_\_\_\_\_ Email Address: \_\_\_\_\_



**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): \_\_\_\_\_

**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.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

**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.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

**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.



**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.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

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

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

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

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

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

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

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

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

**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.)

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

**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.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
				Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

**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.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
				Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

**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.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
				Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

**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.)

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
				Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

**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.

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
				Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

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

Course #	Course Title	Credit Hrs	University	15 Hr Requirement	
				Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No





**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 my 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: \_\_\_\_\_ Email: \_\_\_\_\_

- 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**  
**License Verification form**

**Instructions:**

**Section 1** is to be completed by the applicant and then sent to the put 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 the BSRB.

**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, Master's, 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: \_\_\_\_\_  
State city state zip

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

**Post Graduate Clinical Supervisor's Attestation:**

**I. Work site where supervised postgraduate hours were accrued:**

A. Agency/Practice Setting (worksite) name: \_\_\_\_\_

B. Address: \_\_\_\_\_

C. Phone: \_\_\_\_\_ Email: \_\_\_\_\_

D. Date range of supervision provided solely by you: From \_\_\_\_\_ to \_\_\_\_\_  
(Provide end date. Do not write current/present)

**II. Supervised hours while under your supervision:**

A. Average number of hours that applicant worked per week: \_\_\_\_\_

B. **Total** number of post graduate clinical experience hours that applicant completed \_\_\_\_\_

C. Total number of post graduate clinical experience hours that involved **direct, face to face clinical contact providing psychotherapy and evaluation** \_\_\_\_\_

D. Total number of supervision **hours** provided to the applicant: \_\_\_\_\_

E. Total number of hours of supervision provided **individually** to the applicant \_\_\_\_\_

- How many hours of **individual supervision were provided using real-time interactive televideo?** \_\_\_\_\_

F. Total number of hours of clinical supervision provided in a **group** setting with six or less supervisees: \_\_\_\_\_

- How many hours of **group supervision were provided using real-time interactive televideo?** \_\_\_\_\_



**III. Supervisor's Qualifications at the time supervision was provided:**

- A. Master's 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 master's 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 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 with the supervisee to provide at least 1 hour of individual supervision 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 master's 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.**

	Acceptable	Unacceptable
1. Assessment	_____	_____
2. Diagnosis	_____	_____
3. Treatment (psychotherapy)	_____	_____
4. Client centered advocacy	_____	_____
5. Consultation	_____	_____
6. Evaluation	_____	_____

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:

	Acceptable	Unacceptable
1. Good judgment:	_____	_____
2. Integrity:	_____	_____
3. Honesty:	_____	_____
4. Fairness:	_____	_____
5. Credibility:	_____	_____
6. Reliability:	_____	_____
7. Respect for others:	_____	_____
8. Respect for state and federal laws:	_____	_____
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. Supervisor's contact information:**

Address: \_\_\_\_\_

Email address: \_\_\_\_\_

Phone number: \_\_\_\_\_

**VII. 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: \_\_\_\_\_

## *Appendix A*

### *Payment Instructions*

**1.** Individuals wishing to submit payments to the BSRB using a credit card or electronic check:

- (1) visit the BSRB website at [ksbsrb.ks.gov](http://ksbsrb.ks.gov)
- (2) select the “SERVICES” drop-down tab from the top of the home screen, and
- (3) click on the “Make A Payment” link. From this page, you will be asked to provide information allowing us to identify the applicant, select the item you wish to pay for, and make a payment for that item.

For use of the secure payment platform, the state of Kansas charges a 2.5 percent processing fee for credit card payments or a \$1.50 flat fee for use of an electronic check. After completing payment, you will receive a confirmation e-mail to confirm your payment.

**2.** Individuals wishing to submit payment to the BSRB office by mail using a check, cash, or a money order may send the payment with their application to the Behavioral Sciences Regulatory Board, 700 SW Harrison St., Ste. 420, Topeka, KS 66603.

Please submit payment upon mailing your application if you are using the online payment portal.