District of Columbia Board of Psychology
Notification of Supervised Practice of Psychology
In The District of Columbia

Supervisor must ensure that this form is completed fully and filed with the Board at least one week before supervision is to begin. Its completion requires information about the supervisee, supervisor, supervised practices and the supervisory relationship. A separate form must be completed for each supervisor-supervisee relationship.

Supervisor may incur a fine for each of the following:

1. Supervision starts before a completed form is accepted
2. Form includes inaccurate information

Graduate students and post-graduates: Be sure to review DCMR Title 17, Chapter 69, Section 6911 for information concerning this training.

Each of the form’s three sections must be completed for the form to be accepted: Applicant: Section I; Supervisor: Sections II and III.

Questions/concerns about the form should be directed to the Board’s Health Licensing Specialist at 202-724-4939 (Phone) or e-mail to nakia.snider@dc.gov.

*Each field must be completed; If not applicable, cite N/A*

**SECTION I. SUPERVISEE INFORMATION**

**A. Identification and Contact**

1. Name of Applicant: _____________________________
2. Address: Street #___________________ City _________ State __________ Zip Code____________
3. Contact: Daytime Phone # ______________________ email _______________________
4. Training Status:  ____ Graduate Student            ____Post-Graduate    ____ License Applicant

**B. Training Requirement Being Fulfilled (Only Complete the Applicable Parts)**

1. If supervision fulfills a graduate student requirement:
   a. Name of Current Institution: _____________________________
   b. Name of Graduate Program: _____________________________
   c. Name of Program Director: _____________________________
      (Credit for successful completion of the supervised experience will be assigned to:)
   d. Course name: _____________________________ e. Course number: _______
f. Level of Training:  
- Practicum  
- Externship  
- Internship

2. If supervision fulfills a **post-graduate requirement**:
   
a. Name of Degree Granting Institution: ________________________________
   
b. Name of Graduate Program: _________________________________________
   
c. Type of Degree Conferred: ___________________________
   
d. Date Conferred: ______________
   
**Note:** The license requirement of 4,000 hours of supervised experience must be obtained within 2 years after the doctorate: one year can be pre-doctorate, and the other year must be post-doctorate.

3. If supervision fulfills **license applicant requirement** for practicing while initial license application pending:
   
a. Date of DC psychology license application: ____________
   
b. Do you hold a valid psychology license in another state: Yes ☐ No ☐
   
c. If Yes, State: ___________________ License #: _____________ Expiration Date: ______________
   
**Note:** This PS Form 04 is not a required supporting document for the Psychologist license application. However, for each supervised practice form you submit to the Board of Psychology prior to applying for licensure, you should complete a corresponding Verification of Supervised Employment Form (PS Form 02) and submit it with your new license application.

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**SECTION II. IMMEDIATE SUPERVISOR INFORMATION**

**A. Identification and Contact**

1. Name: __________________________________________
2. Institution/Organization: _______________________________________________________________
3. Address: ___________________City _________ State __________ Zip Code ____________
4. Contact: Daytime Phone #:______________________    email: ___________________________
5. License Type (Check):  
   - Psychologist  
   - Psychiatrist  
   - Independent Clinical Social Worker
6. DC License Number: __________________ Expiration Date: _______________

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**SECTION III. SUPERVISED PRACTICE INFORMATION**

**Definition:** Supervision includes observing, instructing, listening, evaluating, recommending and giving feedback to the supervisee. **Immediate Supervision** refers to supervision being provided to the supervisee in-person (face-to-face). **General supervision** refers to the supervisor being available to the supervisee, as needed, via any appropriate method (including communication devices such as telephones, text messaging).

The amount of immediate supervision provided to supervisees should be commensurate with what is needed to protect the welfare of the clients they serve, as well as to foster the supervisees’ professional
development. But at least 5% of the supervisee’s weekly practice hours must be under individual (not group) immediate supervision, and that supervision shall not be less than 1 hour/week.

**A. Supervised Practice Arrangements**

1. Date supervised practice to begin: 

2. Supervision arrangement expected to continue how long? weeks, months, year(s)

3. Supervision expected to end (approximate date)

4. Number of hours supervisee will practice under supervision: hours; per week or month

5. Supervisee will receive hour(s) of individual immediate supervision per (week)

6. Location(s) where immediate supervision will be provided:
   a. Name: __________________________________ b. Address: _________________________________

7. Location(s) where supervisee will conduct supervised practice:
   a. Name: __________________________________ b. Address: _________________________________

**B. Supervised Practice Activities/Responsibilities: Check each that applies (and provide description where requested)**

1. Assessment (i.e., Intake, Case Conference): Estimated # of Clients ___; Weekly Monthly
   - Children
   - Adolescents
   - Adults

2. Psychological Testing: Estimated # of Clients ___; Weekly Monthly
   - Children
   - Adolescents
   - Adults

3. Individual Counseling/Therapy: Estimated # of Clients ___; Weekly Monthly
   - Children
   - Adolescents
   - Adults

4. Group Counseling/Therapy: Estimated # of Clients/Grps ___; Weekly Monthly
   - Children
   - Adolescents
   - Adults

5. Research:
   Briefly describe (including typical goals, methods and frequency of activities):

   - Children
   - Adolescents
   - Adults
6. □ Other (e.g., Training)
   Briefly describe (including typical goals, methods, clients and frequency of activities):

   [Blank space for description]

7. Likely diagnostic classifications of clients/patients (check each that applies):

   □ Mental Retardation  □ Attention Deficit  □ Other Developmental
   □ Learning Disability  □ Substance-Related  □ Mood
   □ Eating  □ Delirium, Dementia, Amnesia  □ Other
   □ Identity  □ Psychotic
   □ Adjustment  □ Other: Specify: ________________________
   □ Personality

C. Professional Psychology Expertise

1. I consider myself an expert for each age/developmental group checked below:

   □ Children  □ Adolescents  □ Adults  □ Elderly

2. I consider myself an expert for each diagnostic classification/disorder checked below:

   □ Mental Retardation  □ Attention Deficit  □ Other Developmental
   □ Learning Disability  □ Substance-Related  □ Mood
   □ Eating  □ Delirium, Dementia, Amnesia  □ Other
   □ Identity  □ Psychotic
   □ Adjustment  □ Other: Specify: ________________________
   □ Personality

3. I consider myself an expert for each psychology service checked below:

   a- □ Assessment (i.e., Intake, Clinical Interview)

   b- □ Psychological Testing: □ Academic  □ Intellectual  □ Personality-Objective
      □ Personality-Projective  □ Neuropsychological  □ Psychophysiological

   c- □ Counseling: □ Individual  □ Group

   d- □ Therapy: □ Individual  □ Group

   e- □ Research

   f- □ Other (Specify): ________________________