GOVERNMENT OF THE DISTRICT OF COLUMBIA
Health Professional Licensing Administration
899 North Capitol Street, NE - First Floor
Washington, D.C. 20002
BOARD OF PSYCHOLOGY

PSYCHOLOGY ASSOCIATE SUPERVISON FORM

*****APPLICANTS: This form must be completed and signed by your Supervisor of record and submitted with your application.**

SUPERVISOR'S NAME (Please Print):

_____ _____
LAST NAME FIRST NAME MI LICENSE NUMBER

_____ _____
WORK PHONE NUMBER EMAIL ADDRESS

Highest Degree Earned	Educational Institution	Area of Specialty
		Practice:
		Program

APPLICANT'S NAME (Please Print):

_____ _____
LAST NAME FIRST NAME MI DEGREE EARNED DATE CONFERRED

At what location will the Supervision occur? _____

Address: _____
STREET CITY, STATE ZIP CODE

Describe duties to be performed by the Psychology Associate:

How many other Psychology Associates are currently practicing under your supervision? _____

I understand that as a supervisor:

- **I will be held accountable in the event that a professional, ethical or legal issue arises pertaining to psychological services being rendered by a Psychology Associate.**
- **I am required to provide direct supervision to psychology associates as specified in Psychology Associates regulations § 8611 of Title 17 of the D.C. Municipal Regulations.**
- **I am required to inform clients, when applicable, that they are being treated by a Psychology Associate whose work I supervise.**
- **I am required to inform the Board in writing when the Psychology Associate relationship is terminated.**

_____ _____ _____
SUPERVISOR SIGNATURE **NAME** **DATE**