



NEW LICENSE APPLICATION  
BOARD OF PSYCHOLOGY

Please read instructions before completing this form. If you have any questions, call HRLA's Customer Service at 1-877-540-5827, Monday through Friday, 8AM to 5PM EST. A charge of \$65.00 will be imposed for dishonored checks (Public Law 89-208).

SECTION 1. REQUESTED LICENSE TYPE/FEEs (includes non-refundable application fee – see instructions)											
<input type="checkbox"/> PSY – Psychologist by Examination	\$322.00	Make check or money order payable to: DC Treasurer. MAIL TO: P.O. Box 37802 Washington, D.C. 20013									
<input type="checkbox"/> PSY – Psychologist by Re-Examination	\$119.00										
<input type="checkbox"/> PSY – Psychologist by Endorsement	\$322.00										
<input type="checkbox"/> PSY – Psychologist by Re-Endorsement	\$322.00										
<input type="checkbox"/> Duplicate License Print (limit 5) ___X \$34.00 =	\$ ____ .00										
<b>Total Enclosed</b>	<b>\$ ____ .00</b>	<table border="1"> <thead> <tr> <th colspan="3">HRLA ONLY</th> </tr> <tr> <th>Check \$</th> <th>Check #</th> <th>Staff</th> </tr> </thead> <tbody> <tr> <td>\$ ____ .00</td> <td></td> <td></td> </tr> </tbody> </table>	HRLA ONLY			Check \$	Check #	Staff	\$ ____ .00		
HRLA ONLY											
Check \$	Check #	Staff									
\$ ____ .00											

SECTION 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION																																	
Enter your name exactly as it should appear on the license. If your name has changed at any point since you first attended college or university, please complete Section 4 on page 2. You must also provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.																																	
<table border="1"> <tr> <td>_____</td> <td>MI</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>FIRST NAME</td> <td></td> <td>LAST NAME</td> <td>SUFFIX (Jr, Sr, etc.)</td> </tr> </table>	_____	MI	_____	_____	FIRST NAME		LAST NAME	SUFFIX (Jr, Sr, etc.)	<table border="1"> <tr> <td>____</td> <td>____</td> <td>____</td> <td>____</td> <td>____</td> <td>____</td> </tr> <tr> <td>M</td> <td>M</td> <td>D</td> <td>D</td> <td>Y</td> <td>Y</td> </tr> <tr> <td>____</td> <td>____</td> <td>____</td> <td>____</td> <td>____</td> <td>____</td> </tr> <tr> <td colspan="6">DATE OF BIRTH</td> </tr> </table>	____	____	____	____	____	____	M	M	D	D	Y	Y	____	____	____	____	____	____	DATE OF BIRTH					
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SECTION 3. SUPPORTING DOCUMENTS REQUIRED			HRLA ONLY
Please indicate the supporting documents you have included with this package or requested to be sent to the Board of Psychology. Keep a photocopy of all supporting documents for your records.			
A.	Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name printed on the back. The photos must be original photos and cannot be computer-generated copies or paper copies.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
B.	Character Reference List – On a separate sheet of paper list the names and addresses of three (3) responsible people (other than relatives, instructors, or employers) who have known you for at least one year and can attest to your character.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
C.	Official transcript (with seal) from the applicant's college or university. May be sent directly from the school, but is preferred that it accompany the application in a sealed envelope. Please see Section 6A.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
D.	If one of the following is submitted, an official transcript or test score is not needed. Please check one: ABPP Diploma ____ National Register Listing ____ CPQ ____	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
E.	Passing national exam at recommended score of 500 for the Examination of Professional Practice in Psychology (EPPP) examination, sponsored by the American Association of State and Provincial Psychology Boards (ASPPB).	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
F.	If you are or have ever been licensed in another state/jurisdiction: Verification of State Licensure from EACH state/jurisdiction (PS Form 03).	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
G.	If licensed in other jurisdictions: Nature of Practice Statement for more than two years of full-time practice or PS Form 02 for less than two years of practice.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
H.	Copies of legal documents supporting all name changes.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
I.	A completed and signed Clean Hands Form.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
 DEPARTMENT OF HEALTH – HEALTH REGULATION LICENSING ADMINISTRATION  
**NEW LICENSE APPLICATION**

**SECTION 4. PREVIOUS NAMES**

If your name has changed at any point since you first attended college or university, you must provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by:  Marriage  Divorce  Court Order  Spouse Death Certificate

FIRST NAME	MI	LAST NAME	SUFFIX (Jr, Sr, etc.)
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Changed to current name by:  Marriage  Divorce  Court Order  Spouse Death Certificate

FIRST NAME	MI	LAST NAME	SUFFIX (Jr, Sr, etc.)
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FIRST NAME	MI	LAST NAME	SUFFIX (Jr, Sr, etc.)
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**SECTION 5A. HOME ADDRESS**

Even if you have a PO Box, a street address should also be provided, if applicable.

APARTMENT  SUITE  FLOOR  PO BOX NUMBER

HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY

STATE  ZIP CODE + 4  -

HOME PHONE NUMBER  -   -   HOME FAX NUMBER  -   -   E-MAIL ADDRESS

**SECTION 5B. BUSINESS ADDRESS**

Please note: This information will be made available to the public.

COMPANY NAME

APARTMENT  SUITE  FLOOR  PO BOX NUMBER

BUSINESS STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise use this line to indicate STREET NUMBER and STREET NAME)

BUSINESS STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY

STATE  ZIP CODE + 4  -

BUSINESS PHONE NUMBER  -   -   BUSINESS FAX NUMBER  -   -   E-MAIL ADDRESS

**SECTION 5C. PREFERRED MAILING ADDRESS**

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed. The address that will appear on your license will be your business address.

HOME  BUSINESS

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
 DEPARTMENT OF HEALTH – HEALTH REGULATION LICENSING ADMINISTRATION  
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**SECTION 6A. PROFESSIONAL SCHOOLS ATTENDED**

List all colleges and universities attended prior to and including medical/professional schools. List in reverse chronological order, beginning with the most recent at the top.

School Name, City, State, Country	Number of Hours Completed	Date of Graduation	Type of Degree/Certificate

**SECTION 6B. POSTGRADUATE EXPERIENCE**

List all experience since graduation from medical/professional school, in reverse chronological order, beginning with the most recent. For "Type of Position," use the letter from the key below.

Organization/Institution	Location	Start Date	End Date	Type of Position (Use Key Below)*	Full Time	Part Time

**\* TYPE OF POSITION KEY**

- A. Employment
- B. Private Practice
- C. Instructor
- D. Clinical Rotations
- E. Other (specify on separate sheet of paper)

**SECTION 6C. PROFESSIONAL LICENSES IN OTHER STATES/JURISDICTIONS**

List all states and jurisdictions in which you have ever held a similar professional license. You must request and provide verification of licensure for all of these licenses, past and/or present.

Jurisdiction	Date License Was First Obtained	License Number

**SECTION 6D. DOCTORAL PROGRAM OR PREDOCTORAL INTERNSHIP/APA APPROVED**

Please answer the questions that correspond to you:

A. Was your doctoral program APA, CPA, or National Register approved?      \_\_\_ YES      \_\_\_ NO

B. Was your predoctoral internship APA, CPA, or APPIC approved?      \_\_\_ YES      \_\_\_ NO

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**SECTION 7. QUESTIONS – Applicants MUST answer all of the following questions.**

Please answer all of the following questions by placing an “X” in the appropriate boxes. If you answer “Yes” to questions B through J below, you must provide full information and complete details on a separate sheet of paper, including copies of relevant court documents, and attach to this application.

**HLRA ONLY**

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.

Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER “YES” TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR RENEWAL APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:

Yes    No  
   

- A.
1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
  2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
  3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
  4. Past due taxes;
  5. Past due District of Columbia Water and Sewer Authority service fees; or
  6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

YES    NO  
   

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the Clean Hands Before Receiving a License or Permit Act of 1996, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

B.	Have you ever been convicted or investigated of a crime (other than minor traffic violations) not previously reported to the Board?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
C.	Are you now or have you ever been licensed in DC or any other state/jurisdiction? (If "Yes," be sure to complete Section 6C of this form.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
D.	Have you ever been party to a malpractice action or had a malpractice action brought against you?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
E.	Have you ever voluntarily surrendered a license after formal charges have been filed against you or while under investigation?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
F.	Have you ever been terminated from or resigned from a clinical or professional training program?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
G.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
H.	Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
I.	(1) Have you withdrawn an application (in D.C. or any other state/jurisdiction) to practice your profession? (2) Has any authority or peer review board taken adverse action against your license or privileges? (3) Are you currently under investigation or were you investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority or peer review board informed you of any pending charges(s) or investigation not previously reported to this Board?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
J.	Have you ever been terminated or asked to resign from employment since obtaining your (professional) license?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>

**SECTION 8. LICENSEE APPLICATION ATTESTATION AND SIGNATURE**

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

**HLRA ONLY**

\_\_\_\_\_  
LICENSEE SIGNATURE

\_\_\_\_\_  
NAME (Please Print)

\_\_\_\_\_  
DATE