LICENSURE/CERTIFICATION VERIFICATION
OFFICE OF SCHOOL PSYCHOLOGY

THIS SECTION TO BE COMPLETED BY THE APPLICANT

Complete this part and submit a copy to each state where you hold or have ever held a license or certificate to practice school psychology or any health-related profession, making copies of this form as necessary. If you do not know your license or certificate number, you may leave this response blank.

Applicant Name _____

Address _____

License/Certification Number _____State of _____

I hereby authorize release of any information regarding my licensure status to the State of Florida, Department of Health, School Psychology office.

Applicant Signature_____ Date _____

THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE LICENSURE/CERTIFICATION BOARD

Please complete the following information and return this form to the address listed below.

LICENSEE NAME: _____ PROFESSION: _____

LICENSE/CERTIFICATION NUMBER:_____ ISSUE DATE: _____

LICENSE/CERTIFICATION STATUS: _____ EXPIRATION DATE: _____

ISSUANCE BASED ON: STATE EXAM _____ NATIONAL EXAM _____

RECIPROCITY WITH _____ ENDORSEMENT _____

EDUCATION _____ EXPERIENCE _____

IS LICENSE/CERTIFICATION IN GOOD STANDING? _____

HAS THE LICENSE/CERTIFICATION EVER BEEN REVOKED OR SUSPENDED? _____

DO YOU HAVE ANY DISCIPLINARY ACTION INFORMATION ON FILE REGARDING THE LICENSEE? _____

REMARKS: _____

_____

_____
Signature of Official

BOARD SEAL

_____
Printed Name and Title

STATE: _____ _____
Date Signed

Department of Health
School Psychology Licensure
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