Florida HEALTH

Application for School Psychlogy Licensure by Examination

Office of School Psychology Licensure
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: FloridaHealth.gov/Licensing-and-Regulation/School-Psychology/
Email: MQA.SchoolPsychology@FLHealth.gov
Phone: 850-245-4373
Fax: 850-414-6860

DH-MQA 1067, Revised 5/2025, Rule 64B21-500.002, F.A.C.

Are you an active-duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered “Yes” to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health’s commitment to serving members and veterans of the United States Armed Forces and their families online at FLHealthSource.gov/VALOR.

DH-MQA 1067, Revised 5/2025, Rule 64B21-500.002, F.A.C.

Florida HEALTH

Eligibility Information

This method means you are applying for licensure based on education, experience, and examination in compliance with the laws and rules of Florida. This application should not be submitted until the education, experience, and a passing score on the examination have already been completed.

Applicants must hold a doctorate, specialist, or master's degree in school psychology from an accredited institution. Applicants seeking to demonstrate an equivalent degree may submit the Department of Health's "School Psychology Education Coursework" form, reflecting completion of a program(s) primarily psychological in nature consisting of 60 semester or 90 quarter hours of graduate study in areas related to school psychology. These requirements are further outlined in Rule 64B21-500.009, Florida Administrative Code (F.A.C.). Applicants must also have completed the specialty area examination in school psychology, which is the Praxis II administered by Educational Testing Services (ETS). The applicant must also provide proof of completion of a minimum of three years (4,500 hours) of school psychology experience, at least two years (3,000 hours) of which must have been under the supervision of a licensed school psychologist, certified school psychologist or licensed psychologist. Each week of the supervised experience must have included at least 1.5 hours of face-to-face interactive supervision. A doctoral level internship may be applied toward the supervision requirement.

Address Changes: Notify the Office of School Psychology immediately of any address change for either practice location or mailing address. If you do not currently have a practice location, inform the office as soon as you obtain employment. Licenses are issued with the practice location address. The internet will display your practice location address only. If no practice location is provided, your home/mailing address will be displayed.

Application for School Psychology Licensure by Examination

Office of School Psychology
P.O. Box 6330
Tallahassee, FL 32314-6330
Fax: (850) 414-6860
Email: MQA.SchoolPsychology@flhealth.gov

Do Not Write in this Space
For Revenue Receipting Only

School Psychologist by Examination (1020) **$355.00**

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a $180.00 (Licensure Fee and Unlicensed Activity Fee) refund. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

Total fee of $355.00 includes the following:

Application Fee	$175.00
Licensure Fee	$175.00
Unlicensed Activity Fee	$5.00

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone

Practice Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)

_____ _____ _____
Street Suite No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the Office of School Psychology.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Specific licensure requirements can be found in s. 490.005, Florida Statutes, and Rule chapter 64B21-500, F.A.C., copies of which may be found at: http://www.floridahealth.gov/licensing-and-regulation/school-psychology/resources/index.html.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the Department of Health is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, s. 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

U.S. Social Security Number: _____

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

You may apply for licensure before obtaining a Social Security number. However, you will not be issued a license until proof of a U.S. Social Security number is received.

Name: _____

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

B. Have you ever applied for school psychology licensure in the state of Florida? ☐ Yes ☐ No

If "Yes," indicate the date you previously applied: _____
MM/DD/YYYY

C. Do you hold, or have you ever held licensure or certification to practice school psychology or any health-related profession in any state, including Florida, U.S. territory, or foreign country? School psychology certification from the Florida Department of Education is included. ☐ Yes ☐ No

D. List all health-related licenses (active, inactive, or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

☐ **Verifications are required for each license ever held.** Office staff will attempt to complete verifications online. If unavailable online or if the online verification lacks sufficient detail, you will be required to request an official verification from the licensing agency. License verifications must be received directly from the licensing authority regardless of the status of the license. **A copy of your license will not be accepted** in lieu of official verification from the licensing agency.

E. Do you hold diplomate status with the American Board of Professional Psychology (ABPP)?
☐ Yes ☐ No

If "Yes," provide the following:

Diploma Number	Diploma Date MM/DD/YYYY	Area of Specialty

F. Do you have a licensure or certification application pending in any jurisdiction, including Florida?
☐ Yes ☐ No

G. Have you ever withdrawn an application for licensure or certification? ☐ Yes ☐ No

H. Have you ever allowed an application for licensure or certification to lapse? ☐ Yes ☐ No

I. Have you ever been denied licensure or certification to practice school psychology or any health-related profession in any licensing jurisdiction? ☐ Yes ☐ No

☐ **If you responded "Yes" to F, G, H, or I,** provide a written explanation on a separate sheet.

4. AVAILABILITY FOR DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☐ No

If you respond "Yes," your name will be added to a listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

Name: _____

5. EDUCATION HISTORY

To qualify for licensure, all applicants must have completed a doctorate, specialist, or equivalent degree from a program primarily psychological in nature with 60 semester or 90 quarter hours of graduate study in areas related to school psychology, as defined by the Department of Health; a master's degree in school psychology is acceptable.

☐ **Applicants who have not obtained the minimum of a master's degree in school psychology must complete the "School Psychology Education Coursework" form found at the back of the application.**

A. List the graduate education being used to comply with licensure requirements.

School Name/Location	Major(s)	Graduation Date (MM/DD/YYYY)	Degree Awarded

☐ **All applicants** must have an **official transcript** forwarded directly to the office from your educational program. Diplomas and student copies are not acceptable.

☐ **Transcripts should be electronically transmitted by your school to MQA.SchoolPsychology@flhealth.gov or mailed to:**

Office of School Psychology
4052 Bald Cypress Way, Bin C-05
Tallahassee, FL 32399-3255

B. What name(s) did you use when you received your education?

_____

Name: _____

6. EXAMINATION HISTORY

Have you taken and passed the specialty examination in school psychology developed and administered by Educational Testing Service (ETS)? ☐ Yes ☐ No

If "Yes," provide the date the examination was passed: _____
MM/DD/YYYY

☐ **All applicants** must request their Praxis II examination scores be electronically transmitted to the Florida Office of School Psychology. When requesting scores, note that the destination code is **R7114**. The contact number for the Praxis exam vendor, ETS, is (609) 771-7395.

School Psychology Praxis II examination scores are not available from ETS more than 10 years from the date the examination was taken. In this instance, you may have the score report provided to this office by the licensing agency of another state or territory of the U.S. that received your original score report, or, if applicable, request a score confirmation letter from the National Association of School Psychologists (NASP) be provided directly to this office.

7. EXPERIENCE

All applicants must successfully complete three years (4,500 hours) of school psychology experience. Experience must meet the criteria listed below.

- One year of experience consists of 1,500 hours within 12 consecutive months.
- Two years (3,000 hours) of the three-year requirement must consist of supervised experience.
- All supervised experience must be performed by a certified or licensed school psychologist in any jurisdiction or a licensed psychologist.
- The third year may consist of general experience up to a maximum of 1,500 hours.
- Doctoral internships may be applied toward the supervision requirement.
- Non-doctoral internships, which are part of the education requirement, do **not** count toward the supervised **or** general experience requirement.

All applicants must complete and submit to the Office of School Psychology:

☐ **The "School Psychology Experience Verification" form** (found at the end of the application) - This form must be used to document the required two years of post-graduate supervised experience under a licensed psychologist, licensed school psychologist, or certified school psychologist. A doctorate-level internship in this field may be applied toward the supervision requirement. If you completed three years of supervised school psychology experience in compliance with the rule, you may use this form to document that all required experience was completed under supervision, in which case you will not need to complete the general experience form referenced below.

And, if applicable

☐ **The "General Experience Verification" form,** (found at the end of the application) - This form is used to document one year of school psychology experience that did not require supervision. Only necessary if less than three, but more than two years of supervision has been obtained.

This information is exempt from public records disclosure.

8. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice?
☐ Yes ☐ No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? ☐ Yes ☐ No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? ☐ Yes ☐ No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

☐ **A letter from a Licensed Health Care Practitioner,** who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

☐ **A written self-explanation,** identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

9. DISCIPLINE HISTORY

A. Have you ever had a license to practice any profession revoked, suspended, or otherwise acted against in a disciplinary proceeding in any state, including Florida, U.S. territory, or foreign country? ☐ Yes ☐ No

B. Have you ever been denied licensure to practice school psychology or any health-related profession in any licensing jurisdiction, including Florida, or been granted such under restrictions (e.g., probation, other obligations imposed, etc.) of any kind? ☐ Yes ☐ No

C. Are you now under investigation in any jurisdiction, including Florida, for an offense which would be a violation of chapter (ch.) 490, Florida Statutes? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of the **Administrative Complaint** and **Final Order**.

10. CRIMINAL HISTORY

*For the question below, you **must include** all misdemeanors and felonies, even if adjudication was withheld. Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are **not** minor traffic offenses for purposes of this question.*

*Pursuant to s. 943.0585(6)(b), Florida Statutes, and s. 943.059(6)(b), Florida Statutes, an applicant seeking to be licensed by the Department of Health **must disclose** expunged and sealed criminal history records.*

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? ☐ Yes ☐ No

If you responded "Yes" in this section, you must provide the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding each offense; including dates, city and state, charges, and final results.

☐ **Final Dispositions** and **Arrest Records** for all offenses. The Clerk of Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of Court.

☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

11. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), Florida Statutes.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under ch. 409, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), Florida Statutes)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? ☐ Yes ☐ No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, Florida Statutes? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 4.

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? ☐ Yes ☐ No

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 5.

   a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No

   b. Did termination occur at least 20 years before the date of this application? ☐ Yes ☐ No

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? ☐ Yes ☐ No

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

☐ **Supporting documentation** that includes court dispositions or agency orders where applicable.

Documentation for sections 8 and 9 must be sent to the office at MQA.SchoolPsychology@flhealth.gov or mailed to:

Office of School Psychology
4052 Bald Cypress Way, Bin C-05
Tallahassee, FL 32399-3255

Documentation for sections 10 and 11 must be sent to the Background Screening Unit at MQA.BackgroundScreen@flhealth.gov or mailed to:

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

12. LIVESCAN PRIVACY STATEMENT

☐ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation (found in the forms following this application).

The office will not receive your Livescan results if you do not confirm the above statement by checking the box.

☐ **Electronic Fingerprinting**: **(Required for ALL applicants)**

All applicants, including out-of-state applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan service providers that are approved by the Florida Department of Law Enforcement. For a list of approved vendors, visit our website at: http://www.flhealthsource.gov/background-screening/.

Typically background results submitted by Livescan are received by the office within 24-72 hours of being processed. The office's ORI number is **EDOH4730Z**. The office cannot accept hard fingerprint cards or results. All results must be submitted electronically by the Livescan service provider.

The Florida Department of Health retains fingerprints on any applicant in the Care Provider Clearinghouse. One of the requirements for your Livescan to be retained in the Care Provider Clearinghouse is a photograph must be taken by the Livescan service provider at the time of fingerprinting. Your background screening results will be retained for five years. Licensees will be notified when their retention date is approaching and will be provided instructions on how to retain their fingerprints to avoid having to submit a new background screening.

Name: _____

13. APPLICANT SIGNATURE

I, the undersigned, state that I am the person identified in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, Florida Statutes.

Florida law requires me to immediately inform the Office of School Psychology of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

I hereby acknowledge that I have read the regulations in ch. 490, Florida Statutes, pertaining to psychological services and Rule ch. 64B21, F.A.C., pertaining to school psychology.

I further state that I will comply with all requirements for licensure renewal, including continuing education credits.

Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after the initial filing with the Department of Health.

Applicant Signature _____ Date _____

You may print this application and sign it or sign digitally. MM/DD/YYYY

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR ALL APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORDS RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record to be employed, licensed, work under contract, or serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Person with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same or similar to yours.
Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of your record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, Florida Statutes, and Rule 11C-8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.
Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice
Federal Bureau of Investigation
Criminal Justice Information Services Division

PRIVACY STATEMENT

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub. L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN): Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosure to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional information: The requesting agency and/or the agency conducting the application investigation will provide additional information to the specific circumstances of this application, which may include identification of other authorities, purposes, uses and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

Office of School Psychology
Electronic Fingerprinting

Take this form with you to the Livescan service provider. Check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting a fingerprint scan using the Livescan method.
- You can find Livescan service providers at: http://www.flhealthsource.gov/background-screening/.
- Failure to submit background screening will delay your application.
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department.
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider, the office will not receive your background screening results.
- The ORI number for the Office of School Psychology is **EDOH4730Z**.
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, **including your Social Security number (SSN)**.
- Typically background screening results submitted through a Livescan service provider are received by the office within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: _____ SSN#: _____
Last First Middle

Aliases: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ ZIP: _____

Date of Birth: _____ Place of Birth: _____
MM/DD/YYYY

Weight: _____ Height: _____ Eye Color: _____ Hair Color: _____

Race: -_____ Sex: -_____
(W-White/Latino(a); B-Black; A- Asian; NA-Native American; U-Unknown) (M= Male; F=Female)

Citizenship: _____

Transaction Control Number (TCN#): _____
(This will be provided to you by the Livescan service provider.)

Keep this form for your records.

Office of School Psychology
4052 Bald Cypress Way, Bin C-05
Tallahassee, FL 32399-3255

Florida HEALTH

School Psychology Education Coursework

This form is only required if your masters, specialist, or doctorate degree was not in school psychology. Complete this form, providing the courses taken in each area listed. List only one course number per subject and indicate whether the hours taken were in quarter (Qtr.) or semester (Sem.) hours, list the hours in the appropriate column. See Rule 64B21-500.009, F.A.C., for information.

Name: _____

A. **Psychological Foundations** (12 Qtr./ 9 Sem. hours from the following concentrations):

Course	School	Course	# Sem. Hours	# Qtr. Hours
1. Human Development				
2. Human Learning				
3. Psychology of Personality				
4. Child or Adolescent Psychology				
5. Educational Psychology				
6. Human Exceptionality				
7. Abnormal Psychology				

B. **Educational Foundations** (9 Qtr./6 Sem. hours from the following concentrations):

Course	School	Course	# Sem. Hours	# Qtr. Hours
1. The Role & Function of School Psychologists				
2. Curriculum in the Schools				
3. Purposes & Organization of Schools				
4. Educational Administration				
5. Remedial Instruction				
6. Special Education				
7. Social Foundations of Education				
8. Social Psychology				

C. **Psycho-Educational Evaluation Methods** (12 Qtr./9 Sem. hours from the following concentrations, with at least 1 course in Individual Intellectual Assessment):

Course	School	Course	# Sem. Hours	# Qtr. Hours
1. Individual Intellectual Assessment				
2. Psycho-educational Assessment				
3. Statistics and Research Design				
4. Test and Measurement				

D. **Psycho-Educational Interventions** (12 Qtr./9 Sem. hours from the following concentrations):

Course	School	Course	# Sem. Hours	# Qtr. Hours
1. Consultations				
2. Behavior Modification				
3. Counseling & Interviewing Techniques				
4. Organizational & Administration of Pupil Services				

E. **Required Supervised Training Received in a Counseling Setting** (indicate coursework below):

Course	School	Course	# Sem. Hours	# Qtr. Hours
1. Practicum, Internship, or Fieldwork				

Complete verifications must be mailed directly to:

Office of School Psychology
4052 Bald Cypress Way, Bin C-05
Tallahassee, FL 32399-3255

School Psychology Supervised Experience Verification

If the total experience required was completed as supervised experience, **only** submit the **"School Psychology Supervised Experience Verification" form** for all 4,500 hours. Submit the **"School Psychology General Experience Verification" form** if you **completed the minimum** supervised experience (3,000) hours **and still need** to document the remaining 1,500 hours of total experience required.

Experience Definitions and Requirements

- **Total Experience Required** is three years (4,500 hours) of School Psychology experience.
- **One Year of Experience** is equivalent to 1,500 hours within 12 consecutive months.
- **Supervised Experience** is required to be a minimum of two years (3,000 hours) of supervised experience under a certified or licensed school psychologist in any jurisdiction or a licensed psychologist. The supervisor must provide 1 ½ hours weekly face-to-face interactive supervision over the entirety of the 3,000-hour supervisory period.
- **Doctoral Internships** may be applied toward the supervision requirement. Non-doctoral internships that are part of the education requirement, **do not** count toward the supervised or general experience requirement.

1. Applicant Information

Name: _____

Address: _____

2. Supervisor Information

A. Provide the following information:

Supervisor Name: _____

Address: _____

Phone: _____ Employer: _____

School: _____ Graduation Date: _____
MM/DD/YYYY

Degree: _____ Major: _____

B. How many years of experience had you completed as a school psychologist prior to supervising the applicant? _____

C. How many of those years were you supervised? _____

D. Choose your profession, at the onset of supervising the applicant, from the selection below. Select all that apply.

☐ Licensed School Psychologist	State:	License #:
☐ Certified School Psychologist	State:	License #:
☐ Licensed Psychologist	State:	License #:

If the applicant completed the 3,000 hours of supervision under more than one supervisor in more than one location, each supervisor must submit and sign a separate verification form attesting only to the supervision they provided.

 Name: _____

3. Applicant Supervised Experience

A. Provide the following information regarding the applicant's experience while under your supervision (attach additional sheets if necessary).

Facility Name	Facility Address	Supervised Experience Dates (MM/DD/YYYY)
		to
		to
		to

B. Did the applicant complete three years (4,500 hours) of school psychology experience under your supervision? ☐ Yes ☐ No

If "No," complete the following: Total number of years: _____ Total number of hours: _____

C. Did you provide the minimum required 1.5 contact hours per week of face-to-face interactive supervision during this period? ☐ Yes ☐ No

If "No," complete the following: Total number of hours: _____

D. Did your supervision focus on raw data from the applicant's clinical work, which was made available to you through such means as written clinical materials, direct observation, and video and audio recordings? ☐ Yes ☐ No

E. Was your supervision of the applicant a process clearly distinguishable from personal psychotherapy or didactic instruction? ☐ Yes ☐ No

F. List the percentage of the applicant's work hours spent in the following duties:

Duties	% of Work Hours
Evaluation, measurement, and assessment of intellectual ability, aptitudes, or achievement that directly relates to learning or behavioral problems in an educational setting in order to determine appropriate recommendations.	
Psycho-educational or vocational consultation or direct psycho-educational service to schools, agencies, organizations, or psychological professionals, which is directly related to learning problems.	
Development of programs to facilitate learning process of clients.	
Specify other duties, if applicable, and percentage of time spent in those areas:	

G. Have you ever received any complaints about this applicant or have any reason to suspect that the applicant is less than fully ethical, professional or qualified for licensure? ☐ Yes ☐ No

If "Yes," provide details on a separate sheet of paper.

4. Recommendation

Based upon your supervision and knowledge of the applicant's character, education, training and experience, are you of the opinion that the applicant, if licensed, will practice the profession of school psychology in an ethical and professional manner? ☐ Yes ☐ No

If "No," explain on a separate sheet of paper.

5. Applicant/Supervisor Statement

We hereby certify that the above information is true and correct to the best of our knowledge.

Supervisor Signature: _____ Date: _____
MM/DD/YYYY

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Office of School Psychology
4052 Bald Cypress Way, Bin C-05
Tallahassee, FL 32399-3255

School Psychology General Experience Verification

Do not submit this form if all required school psychology experience (three years = 4,500 hours) was fulfilled and is documented as supervised experience on the **"School Psychology Supervised Experience Verification" form**.

Important: The dates of general school psychology experience must have been completed after meeting the minimum required education for this license and the dates of experience recorded cannot be the same as nor overlap the hours of reported supervised experience.

1. Applicant Information

Name: _____

Address: _____

2. Verifying Party Information

Choose all the options that describe your relationship to the applicant:

☐ Employer	☐ Co-worker	☐ Supervisor
☐ Personnel Office Representative	☐ Other: _____	

Name: _____

Address: _____

Business Phone: _____ Home/Cell Phone: _____

3. Applicant Experience Data

List the name and address of the entity where experience took place:

Facility Name	Facility Address

A. Dates of Experience: From: _____ (MM/DD/YYYY) To: _____ (MM/DD/YYYY)

B. How many **hours per week** did the applicant practice? _____

C. How many **weeks of experience** did the applicant practice? _____

D. What was the **total number of hours of experience** the applicant practiced for the time period listed above? _____ *(generally calculated as the product of 3B and 3C)*

E. What position did the applicant hold? _____

Name: _____

F. List the percentage of the applicant's work hours spent in the following duties:

Duties	% of Work Hours
Evaluation, measurement, and assessment of intellectual ability, aptitudes, or achievement that directly relates to learning or behavioral problems in an educational setting in order to determine appropriate recommendations.	
Psycho-educational or vocational consultation or direct psycho-educational service to schools, agencies, organizations, or psychological professionals, which is directly related to learning problems.	
Development of programs to facilitate learning process of clients.	
Specify other duties, if applicable, and percentage of time spent in those areas:	

4. Recommendation

Based upon your supervision and knowledge of the applicant's character, education, training and experience, are you of the opinion that the applicant, if licensed, will practice the profession of school psychology in an ethical and professional manner? ☐ Yes ☐ No

5. Applicant/Supervisor Statement

We hereby certify that the above information is true and correct to the best of our knowledge.

Supervisor Signature: _____ Date: _____
MM/DD/YYYY

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Complete verifications must be mailed directly from the licensing agency to:

Office of School Psychology
4052 Bald Cypress Way, Bin C-05
Tallahassee, FL 32399-3255

School Psychology License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Office of School Psychology.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board seal
* Signature and title of state board official

The following information must be included in all verifications:

* Licensee name
* License number
* State or jurisdiction of licensure
* Licensure status
* Is license in good standing?
* Date of issuance and expiration
* Licensure method (examination, grandfathering, reciprocity/endorsement) If exam, provide exam name, exam level, exam date, and score achieved.
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.