APPLICATION FOR CONDITIONAL PRESCRIPTION CERTIFICATE
All information provided is public information except as provided by the New Mexico Inspection of Public Records Act.

You are responsible for insuring that all needed information on your application has been forwarded to the Board Office under separate cover or with this application form.

- $150.00 non-refundable application fee required at time of application. When you provide a check as payment, you authorize the State of New Mexico to either use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction
- Copy of Master’s transcript or Certificate of work in psychopharmacology
- Verification of malpractice insurance coverage
- Copy of New Mexico Psychologist License
- Verification of Experience by Training Program
- Supervisor verification of 80-Hour Practicum in Primary Health Care
- Supervisor verification of 400-Hour Practicum Treating a Minimum of 100 Patients with Pharmacotherapy.
- Copy of 80-Hour Evaluation by Supervisor in Primary Health Care Setting
- Midterm and final evaluation forms completed by supervisor of 400-hour practicum
- Proposed Supervisory Plan for Conditional Prescribing Psychologist

The Board may, at its discretion, require additional information or documentation.

APPLICATION INFORMATION

LEGAL NAME:

Last   First   M.            Any Other Name Used

Date of Birth:_________________________  E-mail address:_________________________

Telephone Number: W: (     )  Social Security Number_________________________

Mailing Address:

Number and Street  City,  State  Zip

Business Address:

Number and Street  City,  State  Zip

Staple one (1) passport-type photograph on white background taken within the last six months.

Revision date: 03/2018
**Licensure**

Do you have an active, unrestricted license to practice psychology in New Mexico?  

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<th>Yes</th>
<th>No</th>
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If Yes: Date issued: _____________  License No.: _____________

Do you hold other professional licenses?  

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Please list

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**Psychopharmacology Exam for Psychologists**

Have you taken the Psychopharmacology Exam for Psychologists (PEP)?

If yes, your scores must be sent to the Board office.

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<th>Yes</th>
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If you have not taken the PEP, indicate the date you plan to take it: _____________

**Postdoctoral Training in Psychopharmacology**

Institution you attended: _____________

Location & Address: _____________

Date Completed: _____________  Name of Program Director: _____________

Was your program an organized program of education consisting of didactic instruction of no fewer than 450 hours?  

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<th>Yes</th>
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**Check the type of institution attended:**

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<th>Type of Institution</th>
<th>Details</th>
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<tr>
<td>An institution of higher education that has a postdoctoral program of psychopharmacological education for psychologists and is accredited by a regional body recognized by the U.S. Department of Education or the Council for Higher Education Accreditation.</td>
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<tr>
<td>A continuing education provider approved by the American Psychological Association that offers a program of psychopharmacology education for psychologists.</td>
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</tr>
<tr>
<td>A continuing education program of professional development in psychopharmacology for psychologists that is administered in collaboration with a school if the applicant successfully completed 450 classroom hours of didactic study referred to in Subsection E of 16.22.23.8 NMAC prior to January 1, 2004.</td>
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Eighty-hour practicum (Attach supervisor verification)

Where completed: ___________________________ Date completed: ______________

Name of Supervisor: ___________________________

Was this program monitored by the program you attended?  Yes  No

400-hour/100 patient practicum (Attach supervisor verification)

Where completed: ___________________________ Date completed: ______________

Name of Supervisor: ___________________________

Was this program monitored by the program you attended?  Yes  No

MALPRACTICE INSURANCE

Do you have malpractice insurance that will cover your prescribing as well as psychotherapy?  Yes  No

List any limits of coverage and the name of the carrier.
______________________________________________

______________________________________________

QUESTIONS RELATED TO ETHICAL STANDARDS

Have you ever been called before the Committee on Ethics of any professional organization or State Licensing Board?  Yes  No

Has any action been taken against you by:

   a. another licensing jurisdiction?  Yes  No
   b. a professional psychologist association of which you are or have been a member?  Yes  No
   c. a government agency?  Yes  No

Have you ever failed to report to the board the surrender of a license or other authorization to practice psychology in another jurisdiction or the surrender of membership on a health care staff or in a professional association following, in lieu of, or while under a disciplinary investigation by any of those authorities for acts or conduct that would constitute grounds for action?  Yes  No
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<th>Question</th>
<th>Yes</th>
<th>No</th>
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<td>Have you voluntarily surrendered your license in another jurisdiction?</td>
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<td>Have you ever been convicted of, or pled guilty or <em>nolo contendere</em> to a violation of any federal or state statute, any city or county ordinance, or law of a foreign country?</td>
<td>Yes</td>
<td>No</td>
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<td>Are you now or have you ever engaged in any activities that misrepresent your professional qualifications, affiliation, or purposes, or those of institutions, organizations, products and/or services with which you are associated?</td>
<td>Yes</td>
<td>No</td>
</tr>
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<td>Have you ever been denied a license or certificate as a psychologist in any jurisdiction or country, or been denied the right to take an examination?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Have you ever had any license or certificate as a psychologist or psychologist associate suspended or revoked?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are you now under investigation by any other licensing board?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are there any complaints pending against you in another licensing jurisdiction?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are you currently more than thirty (30) days in arrears in payment of amounts required to be paid pursuant to an outstanding judgment and order for child support in New Mexico?</td>
<td>Yes</td>
<td>No</td>
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*If you answered ‘yes’ to any of the above, use a separate sheet, and provide a detailed explanation.*
AFFIDAVIT AND NOTARIZATION

The undersigned, being duly sworn, upon his/her oath deposes and says that he/she is the person making the foregoing statements and that they are made in good faith and are true in every respect. By executing this application, the undersigned also acknowledges that he/she has read the Code of Ethics for Psychologists and, if issued a license, agrees to conform with and support the Code of Professional Ethics, Rules and Regulation of the New Mexico State Board of Psychologist Examiners, and the Professional Psychologist Act. **I certify that all the statements made in this application are true, complete, and correct to the best of my knowledge and belief and are made in good faith.**

________________________________________________________________________
Signature of Applicant Date

I __________________________ a Notary Public in and for said County, in the State of ________________________
DO HEREBY CERTIFY THAT:

________________________________________________________________________personally known to be the same person whose name is subscribed in the foregoing instrument, appeared before me this day in person, and acknowledged that he/she signed, said document for the uses and purposes therein set forth.

GIVEN UNDER MY HAND AND NOTARIAL SEAL THIS

______________DAY OF__________________, 200__

________________________________________
Notary Public

My Commission Expires ______________________
VERIFICATION BY SUPERVISOR OF 80-HOUR PRACTICUM IN PRIMARY HEALTH CARE

The Board of Psychologist Examiners has received an application for a conditional prescription certificate as a prescribing psychologist from the applicant named below. (To be filled out by Applicant and forwarded on to the Director of the training program)

**Applicant:**

**Address:**

**City & State:**

**Telephone No.:**

Please provide requested information and return this form directly to the Board office as indicated on the bottom of the next page.

**SUPERVISOR**

**Name:**

**Address:**

**City & State:**

**Telephone No.:**

Supervisor, please describe the area of practice in which you are formally trained, certified, or licensed:

**NEW MEXICO LICENSURE**

Is your medical license current and unrestricted?  Yes ☐  No ☐

Date New Mexico medical license was issued:

License Number and Type of License:
Do you hold any other professional licenses in this or any other jurisdiction? Yes □ No □

If you answered ‘yes’ please list:

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<th>License No.</th>
<th>Type</th>
<th>State</th>
<th>Status (Active/Inactive)</th>
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Name and Address of Applicant’s Training Director:

Date Practicum Began: _____________ Date Practicum Ended: _____________

1. Have you sent an evaluation form about this applicant to the Director of Training discussing the student’s adequate development of skills in:
   a. Assessing a diverse and significantly ill medical population? Yes □ No □
   b. Observing the progression of illness and continuity of care of individual patients? Yes □ No □
   c. Adequately assessing vital signs? Yes □ No □
   d. Demonstrating competent laboratory assessment? Yes □ No □
   e. Demonstrating competence in physical and health assessment techniques? Yes □ No □

2. Has the student successfully completed the eighty-hours of supervised experience with you as specified in the Prescribing Psychologist Act? Yes □ No □

Please provide any comments you might have regarding this applicant’s practicum. Include any information you consider relevant regarding this applicant.

As the Clinical Supervisor of the 80-Hour Practicum, I certify that all of the statements made in this document are true, complete, and correct to the best of my knowledge and belief and are made in good faith.

Date _____________ Signature of Clinical Supervisor _____________

Please mail completed form directly to the Board Office at:
New Mexico Board of Psychologist Examiners
P. O. Box 25101
Santa Fe, New Mexico 87504
VERIFICATION BY SUPERVISOR OF 400-HOUR PRACTICUM TREATING A MINIMUM OF 100 PATIENTS WITH PHARMACOTHERAPY

PLEASE NOTE: To be completed by the supervisor

PRIMARY SUPERVISOR 400-HOUR/100-PATIENT PRACTICUM

The Board of Psychologist Examiners has received an application for a conditional certificate as a prescribing psychologist from the applicant named below. (To be filled out by Applicant and forwarded on to the Director of the training program)

Applicant: __________________________
Address: __________________________
City & State: ________________________
Telephone No. ______________________

Please provide requested information and return this form directly to the Board office as indicated on the bottom of the next page.

SUPERVISOR

Name: ______________________________
Address: __________________________
City & State: ________________________
Telephone No. ______________________

Supervisor, please describe the area of practice in which you are formally trained, certified or licensed. If you are not a psychiatrist, please indicate your experience and training in prescribing psychotropic medications: ____________________________

NEW MEXICO LICENSURE

Is your medical license current and unrestricted?       Yes ☐   No ☐
Date New Mexico medical license was issued: ______________
License Number and Type of License: ____________________

__________________________________________________________
New Mexico Regulation and Licensing Department
BOARDS AND COMMISSION DIVISION
Do you hold any other professional licenses in this or any other jurisdiction? Yes □ No □

If you answered ‘yes’ so, please list:

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Name and Address of Applicant’s Training Director:

SECONDARY SUPERVISOR, if applicable:

Name: ________________________________
Address: ________________________________
City & State: ________________________________
Telephone No.: ________________________________

Is your license current and unrestricted? Yes □ No □

Date New Mexico license was issued: ________________________________

Do you hold any other professional licenses in this or any other jurisdiction? Yes □ No □

If you answered ‘yes’ please list:

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Please describe the practice area in which you are formally trained, certified and/or licensed.

________________________________________________________________________

________________________________________________________________________

1. Was the 400-Hour Practicum part of the psychopharmacology training program from which the applicant obtained his/her certification or degree? Yes □ No □

2. Did the practicum meet the following requirements?
   a. A minimum of 100 separate patients? Yes □ No □
   b. A range of disorders listed in the DSM? Yes □ No □
   c. Both acute and chronic conditions? Yes □ No □
   d. Did the 400 hours include only time spent with patients to provide evaluation and psychopharmacotherapy and time spent in collaboration with treating healthcare providers? Yes □ No □
11. Did the applicant maintain a log, without patient ID, which included basic identifying data?  
   Yes ☐ No ☐

12. Did you, as a supervisor, write at least two formal evaluations of the applicant, preferably at the midpoint and at the end of the practicum, assessing progress, competence, and describing any deficiencies where competency had not been achieved?  
   Yes ☐ No ☐

13. Did you, as supervisor, submit copies of these evaluations to the applicant & Training Director?  
   Yes ☐ No ☐

14. Were you and any secondary supervisors in consultation regarding the applicant’s progress, competence, and deficiencies, if any?  
   Yes ☐ No ☐

15. Do you, as primary supervisor, certify that the applicant has successfully completed the 400-Hour/100-Patient practicum, as specified in the Prescribing Psychologist Act and is competent to obtain a conditional prescription certificate, all other requirements being satisfactorily completed?  
   Yes ☐ No ☐
As the primary clinical supervisor of the 400-Hour/100-Patient practicum, I certify that all of the statements made in this document are true, complete, and correct to the best of my knowledge.

________________________________________  ______________________________
Date     Printed Name and Signature of Clinical Supervisor

Please mail completed form to the Board Office at:
New Mexico State Board of Psychologist Examiners
P.O. Box 25101
Santa Fe, NM 87504
Applicant: Please fill out your name and submit the Form to be completed by your Supervisor(s) who will send it directly to the Board Office.

NAME OF APPLICANT:_____________________________________

To be completed by: Primary Supervisor

Primary Supervisor Name:_____________________________________
Address:___________________________________________________
City & State:_______________________________________________
Telephone No.:____________________________________________

Please describe the area of practice in which you are formally trained, certified and/or licensed. If you are not a psychiatrist, please indicate your experience and training in prescribing psychotropic medications.

License No._________ State:_______ Date of Initial License:_______

Is your license current and unrestricted?  
Yes  No

Do you have any other license in this or any other jurisdiction?  If yes, explain below.

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<th>State</th>
<th>Status Active/Inactive</th>
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New Mexico Regulation and Licensing Department
BOARDS AND COMMISSION DIVISION
To be completed by: Secondary Supervisor, if applicable.

Secondary Supervisor Name: ____________________________
Address: ____________________________________________
City & State: ________________________________________
Telephone No.: ________________________________

Please describe the area of practice in which you are formally trained, certified and/or licensed. If you are not a psychiatrist, please indicate your experience and training in prescribing psychotropic medications.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

License No.__________ State:_______ Date of Initial License:_____

Is your license current and unrestricted?  
Yes  No

Do you have any other license in this or any other jurisdiction?  
If yes, explain below.  
Yes  No

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To be completed by: Primary Supervisor

List the beginning and end dates of the two-year supervised practice covered by the plan.  
Approximate beginning date:_______________ Ending date:____________________

List the setting(s) in which the conditional prescribing psychologist will practice and the hours per week worked at each setting. 
__________________________________________________________________________
__________________________________________________________________________

List duties and clinical responsibilities of the conditional prescribing psychologist.__________
__________________________________________________________________________
List the location(s) where the supervision will occur and with whom.

____________________________

____________________________

List the areas in which the primary and secondary supervisor(s), if any, have specialized skills to render competent supervision.

____________________________

____________________________

List the License number and name of all the psychologists with conditional prescription certificates that you will be supervising during this time period: __________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Describe the manner in which the conditional prescribing psychologist will be represented to the public, including all written communications and public announcements. (Please enclose copies of any printed materials.)

____________________________________________________________________________

____________________________________________________________________________

Is there any direct or indirect financial agreement between or among the conditional prescribing psychologist and the primary and secondary supervisor(s)?

[ ] Yes  [ ] No

Describe any other information necessary to clarify the nature and scope of the supervision.

____________________________________________________________________________

Provide a statement specifying the manner in which supervision and clinical and professional responsibility will be provided during the named supervisor’s absence (for instance, during vacations or unexpected events that require said supervisor to be absent for any period of time).

____________________________________________________________________________

As the primary supervisor, will you provide supervision on a one-to-one basis for at least 4 hours per month for a total of at least 46 hours of one-to-one supervision per year?

[ ] Yes  [ ] No
As the supervising physician, will you have access to and will you review records relating to the treatment of patients under your supervision?

As the primary supervisor will you contact any secondary supervisor(s) at least once (?) every six months to obtain written or verbal progress reports concerning the performance of the prescribing psychologist?

Will the supervision be provided either face-to-face, telephonically, or by live tele-video communication?

Will you, as primary supervisor, inform any secondary supervisor(s) of any concerns about the performance of the conditional prescribing psychologist?

Will you maintain a supervision log containing dates, duration, and place/method of supervision, the same identification code for patients as used by the psychologist with a conditional prescribing certificate, and a brief description of the content of supervision?

Will you, as primary supervisor, maintain a log of contacts with the secondary supervisor(s)?

Will you review the results of laboratory tests as appropriate?

**PRIMARY SUPERVISOR AGREEMENT**

I, the undersigned, as a New Mexico licensed physician, knowledgeable in the administration of psychotropic medications, agree to supervise Dr. ________________________ who holds a conditional certificate as a prescribing psychologist.

I have read the above document and agree to comply with the terms and conditions described above. I understand that the supervisory plan may be modified if I deem appropriate by submitting to the application committee for its approval, a modified plan agreed to be me, any secondary supervisors, and the conditional prescribing psychologist. The intent of my modified plan would be to best reflect the psychologist’s needs for supervision.

____________________________  ________________________
Printed Name and Signature of Supervisor   Date

____________________________  ________________________
Printed Name and Signature of Psychologist Supervisee Date
SECONDARY SUPERVISOR AGREEMENT

Please complete this form for each Secondary Supervisor. Make as many copies of this form as needed.

Secondary Supervisor

Will you, as secondary supervisor, inform the primary supervisor of any concerns about the conditional prescribing psychologist you are supervising?  

[ ] Yes  [ ] No

Will you maintain a supervision log containing dates, duration, place and method of supervision, the same identification code for patients as used by the conditional prescribing psychologist and a brief description of the content of supervision?  

[ ] Yes  [ ] No

Will you review the results of laboratory tests as appropriate?  

[ ] Yes  [ ] No

I, _____________________________, a New Mexico licensed physician and secondary supervisor, agree to supervise Dr. ______________________________, who holds a conditional certificate as a prescribing psychologist. I have read the above document and agree to comply with the terms and conditions described above.

_____________________________________  ________________________
Printed Name and Signature     Date

_____________________________________  ________________________
Printed Name and Signature of Applicant/ Psychologist Supervisee     Date

Supervisor: Please mail completed form to:
New Mexico State Board of Psychologist Examiners
P.O. Box 25101
Santa Fe, NM 87504
TRAINING PROGRAM VERIFICATION OF EXPERIENCE

Board of Psychologist Examiners
P. O. Box 25101 • Santa Fe, New Mexico • 87504
(505) 476-4622

To the Training Director of a program of psychopharmacology

A. REQUEST FOR INFORMATION

The Board of Psychologist Examiners has received an application for a conditional certificate as a prescribing psychologist from the applicant named below. (To be filled out by Applicant and forwarded on to the Director of the training program)

Applicant:
Address:
City & State:
Telephone No.

Your name has been submitted by the applicant as a Director of the Training of that program. The Board has not received applicants from your program before. Therefore, we will need to complete an extensive review of the program to determine if it fulfills requirements of the New Mexico Prescribing Psychologist Act.

Please provide the Board with the information requested below and return this form directly to the Board office at the above listed address.

B. INFORMATION ABOUT THE TRAINING DIRECTOR

Training Director’s Name: ____________________________________________
Title and position of employment: _______________________________________
Institution of employment: _____________________________________________
Address: ____________________________________________________________
City & State: _________________________________________________________
Telephone No.: _______________________________________________________
Please describe your training in psychopharmacology:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Do you hold a license as a psychologist?      Yes No
State: ___________ Year license awarded: ___________

Do you hold a license to prescribe psychotropics?     Yes No
State: ___________ Year license awarded: ___________

Do you hold any other professional licenses in this or other jurisdictions?  Yes No
If you answered ‘yes’ please list:

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<th>State</th>
<th>License Type</th>
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C. INFORMATION ABOUT THE PROGRAM

Please circle the appropriate answer:

1. The program was an integrated program of study.    Yes No

2. The program had an identifiable body of students at different levels of matriculation.         Yes No

3. The program was clearly identified and labeled as a psychopharmacology program and specified its intent to educate and train psychologists to prescribe psychotropic medications.      Yes No

4. The program had a formally designated program director who was a psychiatrist or a doctoral psychologist trained in the area of psychopharmacology and licensed to practice in the jurisdiction
where the program is offered.

5. The training director was primarily responsible for directing the training program and had administrative authority commensurate with those responsibilities.

6. The training director’s credentials and expertise were consistent with the program’s mission and goal to train psychologists to prescribe psychotropic medications.

7. The program provided information regarding the minimum level of achievement required for postdoctoral trainees to satisfactorily progress through and complete the training program, as well as evidence that it adhered to the minimum.

8. The program had formally designated instructors and supervisors in a sufficient number to accomplish the program’s education and training.

9. Supervisors held an active, unrestricted license in their field of practice in the jurisdiction in which the program resides or where the supervision was being provided.

10. The program’s supervisors and instructors had sufficient expertise, competence, and credentials in the areas in which they taught or supervised.

11. The program’s instructors and supervisors participated actively in the program planning, implementation, and evaluation.

12. The program, with appropriate involvement from its training supervisors, instructors, and trainees, engaged in a self-study process that addressed:

   A. Expectations for the quality and quantity of the trainees’ preparation and performance in the program;
   B. Training goals and objectives for the trainees and the trainees’ views regarding the quality of the training experience and the program;
   C. Procedures to maintain current achievements or to make changes as necessary;
   D. Goals, objectives, and outcomes in relation to local, regional, and national changes in the knowledge base of psychopharmacology training.

13. The program followed the guidelines for psychopharmacology training
of postdoctoral psychologists established by the American Psychological Association.

14. Does the program include didactic instruction of no fewer than 450 class-room hours in at least the following core areas:
   - Neuroscience,
   - Pharmacology,
   - Psychopharmacology,
   - Physiology,
   - Pathophysiology
   - Appropriate and relevant physical assessment Clinical pharmacotherapeutics.

15. The training program assures that every student completes necessary training in the basic sciences (physiology, chemistry, biochemistry, the biological bases of behavior and psychopharmacology).

16. The program provides on-line access to a library of sufficient diversity and of a level to support the advanced study of the psychopharmacological treatment of mental disorders to students not in residence, wherever they may reside. Access remains available throughout all didactic and clinical phases of the training program.

17. Frequent face-to-face evaluation and discussion are included in the didactic training.

18. The program provided formal, written, measurement of the mastery of the course content.

19. The program demonstrated in its written materials or course syllabi integration of the following areas into the training: socio-cultural issues in psychopharmacological treatment, ethno-pharmacology, use of translators, the cultural context of compliance and non-compliance with prescribed medications, creating a culturally appropriate environment to meet patient care treatment and language needs, and working collaboratively with traditional healers.
D. SUBSTANTIATION

1. Please provide documentation that your program addresses the requirements stated above by providing as much of the following material and inserting checkmarks next to the documentation forwarded to the Board.

- Program curriculum
- University Catalog Description
- Relevant Policy Manual
- Relevant Student Handbook
- Resume of Director
- Resumes of Faculty
- Evaluation of program by external experts or associations

2. Does the program maintain a website?  Yes  No
   If so, please give url: __________________________________________

E. EVALUATION OF THE APPLICANT

1. Do you, as training director, certify that the applicant successfully completed didactic training as outlined above?  Yes  No

2. Eighty-Hour Practicum

   SUPERVISOR
   Name:
   Address:
   City & State:
   Telephone No.
Describe the supervisor’s area of practice in which he or she is formally trained, certified or licensed?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

License #___________ State:__________ Date of Initial License____________

Was the 80-hour practicum part of the psychopharmacology training program from which the applicant obtained the certification or degree?        Yes  No

Did your program receive an evaluation form about this applicant from this supervisor, which discusses the student’s adequate skill development in:

- Assessing a diverse and significantly medically ill population  Yes  No
- Observing the progression of illness and continuity of care of individual patients        Yes  No
- Adequately assessing vital signs        Yes  No
- Demonstrating competent laboratory assessment        Yes  No

Was the 80-hour practicum completed from full-time to over thirty weeks? Yes  No

3. 400 Hour Practicum in Psychopharmacology

PRIMARY SUPERVISOR
Name:

Address:

City & State:

Telephone No.
Describe the supervisor’s area of practice in which he or she is formally trained, certified or licensed.

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

License #___________ State:__________ Date of Initial License____________

SECONDARY SUPERVISOR 1
Name: 

Address: 

City & State: 

Telephone No.

Describe the supervisor’s area of practice in which he or she is formally trained, certified or licensed.

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

License #___________ State:__________ Date of Initial License____________
SECONDARY SUPERVISOR 2
Name:
Address:
City & State:
Telephone No.

Describe the supervisor’s area of practice in which he or she is formally trained, certified or licensed.
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
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License #___________ State:__________ Date of Initial License__________

SECONDARY SUPERVISOR 3
Name:
Address:
City & State:
Telephone No.

Describe the supervisor’s area of practice in which he or she is formally trained, certified or licensed.
____________________________________________________________________
____________________________________________________________________
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____________________________________________________________________

License #___________ State:__________ Date of Initial License__________
- Was the 400-hour practicum part of the psychopharmacology training program from which the applicant obtained his/her certification or degree?  

- Did the applicant submit a 400-hour practicum plan to the Practicum Director?  

- Did the practicum meet the following requirements?  

  A. A minimum of 100 separate patients?  
  B. A range of disorders listed in the most recent DSM?  
  C. Both acute and chronic conditions?  
  D. 400 hours included time spent with patients to provide evaluation and pharmacotherapy, and time spent in collaboration with treating healthcare practitioners?  
  E. Was there diversity, including gender, ages throughout the life cycle, various ethnicities, socio-cultural background, various economic backgrounds as much as possible within the psychologist’s area of practice?  
  F. Was the primary or secondary supervisor on-site?  
  G. Did the primary/secondary supervisor(s) review charts and records?  
  H. Was there at least one hour of supervision for every eight hours of direct service?  
  I. Did the applicant keep a log of dates & times of supervision?  
  J. Was the practicum completed in no less than 6 months and no more than three years?  
  K. Was the practicum completed within the 5 years preceding this application?  
  L. Is there evidence that during the initial contact with patients or guardians, the status of applicant as a licensed psychologist receiving specialized training in psychopharmacology and who is under supervision was fully explained?
- Did the applicant and the training program keep records of time spent during the practicum?  
  Yes  No

- Does the program have a coded log, without patient ID, submitted by the applicant, which includes for each of the 100 patients: age, gender, diagnosis, and time spent in treatment  
  Yes  No

- Does the program have at least two formal written evaluations of the applicant, completed by the primary supervisor, for the practicum experience assessing progress, competence, and deficiencies?  
  Yes  No

- Did the supervisor(s) certify in writing that the applicant’s performance was satisfactory for the practicum?  
  Yes  No

- Do you, as training director, certify that the applicant has adequately completed a 400-hour/100-patient practicum  
  Yes  No

4. Overall evaluation

1. I would rate this student’s performance under my training as:  
   (Please circle one)
   Excellent  Acceptable  Not Acceptable  Unable to Evaluate

2. REMARKS: The Board would appreciate any information regarding your evaluation in Item 1 above. Please include any information you consider to be relevant regarding the applicant.
________________________________________________________________________
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________________________________________________________________________
As Director of Training, I ________________________ certify that all of the statements made in this document are true, complete, and correct to the best of my knowledge and belief and are made in good faith.

__________________________     ______________________________
Date       Signature of Training Director/Supervisor

Please mail completed form directly to the Board Office at:

New Mexico Board of Psychologist Examiners
P. O. Box 25101
Santa Fe, New Mexico 87504