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STATE OF DELAWARE  
DEPARTMENT OF STATE  
DIVISION OF PROFESSIONAL REGULATION

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**DELAWARE BOARD OF EXAMINERS OF PSYCHOLOGISTS  
REGISTRATION FORM FOR PSYCHOLOGICAL ASSISTANTS**

Before a psychological assistant begins providing psychological services to clientele in the State of Delaware, the following must be on file with the Board of Examiners of Psychologists:

- 1) This completed registration form submitted with the pro-rated fee made payable to the State of Delaware.
- 2) Official college/university transcripts of graduate program(s)
- 3) Signed acceptance of responsibility statement by licensed psychologist (see page 2 of application)
- 4) Signed job description (see page 4 of application); and
- 5) Letter(s) from supervising psychologist(s) documenting a minimum of 450 hours of supervised internship, externship or practica completed as part of a program of studies.

All materials must be mailed to the address above.

**TO BE COMPLETED BY THE DELAWARE LICENSED PSYCHOLOGIST:**

Name: \_\_\_\_\_

Work Address: \_\_\_\_\_

Delaware License # \_\_\_\_\_ Date of Initial Licensure: \_\_\_\_\_

Work Phone # \_\_\_\_\_ Email \_\_\_\_\_

Please provide the Board with the names of the psychological assistants currently working for you. Include the number of clinical hours they are providing under your supervision and the amount of face-to-face supervision hours received per week. Indicate in the last space provided the name of the new psychological assistant.

NAME OF PSYCHOLOGICAL ASSISTANT(S)	Clinical Hours Per Week	Supervision Hours Per Week
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(NEW APPLICANT)

**Psychological Assistant's Job Description**

**1. Supervisory Arrangements:**

A. Work location of the Psychologist \_\_\_\_\_

\_\_\_\_\_

B. Work location of the Assistant \_\_\_\_\_

\_\_\_\_\_

C. At what location will weekly supervision occur? \_\_\_\_\_

\_\_\_\_\_

D. How much supervision will you provide and how will the supervision be provided?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that I am legally required to provide one (1) hour of face-to-face supervision for every ten (10) hours of clinical work provided by my psychological assistant, and that I am required to inform all clients that they are being treated by a psychological assistant. I am also aware that the psychological assistant is permitted to provide supervised psychological services under the authority of my license. I accept the direct responsibility of supervising this individual and realize that I am fully accountable for the services provided under the authority of my license.

LICENSED PSYCHOLOGIST \_\_\_\_\_ (Sign and Date)

**TO BE COMPLETED BY THE PSYCHOLOGICAL ASSISTANT:**

Name \_\_\_\_\_ Highest Degree \_\_\_\_\_

College \_\_\_\_\_

Work Address: \_\_\_\_\_

Social Security # \_\_\_\_\_ Phone # \_\_\_\_\_ Email \_\_\_\_\_

Have you received any previous psychological assistant experience in Delaware? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, with whom \_\_\_\_\_

Date(s) of Employment \_\_\_\_\_ Location \_\_\_\_\_

Employment History

Please list your most current employment first, the location and the dates of employment:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction? Yes  No  **If yes, submit a certified copy of your criminal history record.**

**To assure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:**

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

**Applications that are not complete within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.**

Pursuant to Section 7 of the Privacy Act of 1974, you are hereby given notice that the disclosure of your social security number on this application is required by 29 *Del. C.* §8807(m). It may be used to enforce child support obligations pursuant to 13 *Del. C.* §2216 and for other lawful purposes.

**TO BE COMPLETED BY THE LICENSED PSYCHOLOGIST AND PSYCHOLOGICAL ASSISTANT:**

I hereby acknowledge that I have read the Delaware psychology law and the rules and regulations pertaining to psychological assistants, and agree to the job description as stated.

LICENSED PSYCHOLOGIST \_\_\_\_\_ (Sign and Date)

PSYCHOLOGICAL ASSISTANT \_\_\_\_\_ (Sign and Date)

**Attach the psychological assistant's specific job description to the application and include the following:**

The job description must specifically define the role the psychological assistant will play in the practice of the licensed psychologist. The job description must:

- describe the range and type of duties assigned as well as the limits of independent action and decision making.
- describe the strategy for, and format of supervision, including the ratio of clinical to supervisory hours.
- include a detailed emergency and contingency plan, describing the assistant's plan of action in time of clinical crisis, including prearranged emergency consultations and the mechanism for obtaining these consultations.
- include backup planning for the anticipated or unanticipated unavailability of the licensed psychologist, who remains clinically and legally accountable for the actions of their assistants, and should arrange for competent and continuous clinical coverage. A current version of this job description remains on file with the Board.

If the psychological assistant's job description changes, or if the psychological assistant no longer provides services under my direct supervision, it will be my responsibility as the licensed psychologist, to update the registration form by filing an amendment with the Board office.

**TO BE COMPLETED BY THE LICENSED PSYCHOLOGIST:**

LICENSED PSYCHOLOGIST \_\_\_\_\_ (Sign and Date)

STATE OF \_\_\_\_\_ )

COUNTY OF \_\_\_\_\_ )

The above licensed psychologist, being sworn, deposes and says that he or she is attesting that all statements contained in his or her application are true and correct in every respect, and that he or she has not suppressed any information that might affect this application.

Sworn to me before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_ My commission expires on \_\_\_\_\_ .

Notary Signature