IOWA BOARD OF PSYCHOLOGY
IOWA DEPARTMENT OF PUBLIC HEALTH
LUCAS STATE OFFICE BLDG, 5TH FLOOR
DES MOINES, IOWA 50319-0075

TRAINING DIRECTOR CERTIFICATION
FOR THE CONDITIONAL PRESCRIPTION CERTIFICATE

Iowa Licensed Psychologist / Applicant _____

The above named Psychologist has applied for a Conditional Prescription Certificate. You are identified by the applicant as the training director for the postdoctoral Master of Science degree in clinical psychopharmacology program completed by the applicant. The educational, clinical and practicum requirements are found in the Board rules at 645—244.3. https://idph.iowa.gov/Licensure/Iowa-Board-of-Psychology/Laws-and-Rules

Please complete this form to certify the Psychologist's completion of the clinical and practicum requirements, and email the form to plpublic@idph.iowa.gov. Thank you for your assistance.

Training Director Name _____

EMAIL _____

Name of University /College / Program _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Training Director Certification of Applicant's Completion of Clinical Experience and Practicum

I certify that the training physician(s) identified below meet the qualifications for a training physician as defined in Board rule 645—244.1 and were approved by the training program. (Please list)

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Clinical experience: I certify that the Applicant successfully completed the minimum number of required clinical experience patient encounters and has demonstrated competence in clinical assessment techniques through completion of all milestones defined in Board rules.

Practicum: I certify that the Applicant successfully completed a minimum of 400 practicum hours and treated a minimum of 100 individual patients. I certify that the Applicant completed at least 100 practicum hours in a psychiatric setting and completed at least 100 hours in a primary care or community mental health setting. I certify the Applicant demonstrated competence in the evaluation and treatment of patients with mental disorders through pharmacological intervention through completion of the milestones defined in Board rules.

Applicant's practicum dates:

From: _____ to _____
(Month/day/year) (Month/day/year)

I hereby certify that all of the above information is true and correct to the best of my knowledge.

Training Director Signature _____

Title: _____

Date: _____