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

TRAINING PHYSICIAN CERTIFICATION FORM
FOR THE CONDITIONAL PRESCRIPTION CERTIFICATE
https://idph.iowa.gov/Licensure/Iowa-Board-of-Psychology/Laws-and-Rules.
https://idph.iowa.gov/Licensure/Iowa-Board-of-Psychology/Licensure

Iowa Licensed Psychologist / Applicant _____

The above named psychologist has applied for a Conditional Prescription Certificate. You are identified by the applicant as the training physician for a portion of the required clinical experience and/or practicum. Training physicians must be approved by the psychopharmacology training program to provide this training. The training requirements are found in Board rule at 645—IAC 244.3(2) and 244.3(3). Your signature at the bottom of this form verifies the applicant's successful completion of the training you provided. Please complete this form and email the form to plpublic@idph.iowa.gov. Thank you for your assistance.

Clinical Experience The training director and the training physician(s) shall certify that the psychologist has successfully completed the required minimum number of 600 clinical experience patient encounters and has demonstrated competence in clinical assessment techniques and pathophysiology through completion of the milestones defined in the Board rules at 645—244.3(2)"d."

Practicum The training director and the training physician(s) shall certify that the psychologist has successfully completed the minimum number of practicum hours, treated the minimum number of patients, and demonstrated competence in the evaluation and treatment of patients with mental disorders through pharmacological intervention by completion of the milestones defined in the Board rules at 244.3(3)"f." The complete practicum requirements are found in Board rule at 645—244.3(3).

TRAINING PHYSICIAN INFORMATION

Name: _____

Address _____City_____ State _____ Zip Code _____

EMAIL _____ Phone _____

State(s) Licensed /License number(s) _____

Board Certifications: Family Medicine _____ Internal Medicine _____ Neurology _____

Pediatrics _____ Psychiatry _____ Other _____/Type _____

Dates of my supervision of the above-named applicant for certification (complete as applicable):

1. Clinical Training: Dates: _____ Number of patient encounters: _____

2. Practicum training: Dates: _____ No. of hours: _____ No. of patients: _____

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

Signature: _____

Date: _____