

## CONDITIONAL PRESCRIBING PSYCHOLOGIST PROPOSED SUPERVISORY PLAN

LAST NAME     FIRST NAME     MIDLE NAME     SUFFIX       MAILING ADDRESS     STATE     ZIP CODE     PERSONAL PHONE     BUSINESS PHONE       EMAIL     Image: Demonstration of the second and	CONDITIONAL PRESCRIBING PSYCHOLOGIST APPLICANT INFORMATION							
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EMAIL	CITY			STATE	ZIP CODE			
DATE OF BIRTH  PRIMARY SUPERVISOR INFORMATION NAME OF PRIMARY SUPERVISOR  ADDRESS  CITY STATE ZIP CODE  TELEPHONE NUMBER  DESCRIBE YOUR TRAINING IN PSYCHOPHARMACOLOGY  DO YOU HOLD A CURRENT AND UNRESTRICTED PSYCHOLOGIST LICENSE? YES NO  LICENSE NUMBER LICENSE STATUS YEAR AWARDED STATE OR JURISDICTION OF LICENSURE  OTHER PROFESSION LICENSES HELD BY PRIMARY SUPERVISOR NVA  LICENSE PROFESSION LICENSE NUMBER LICENSE STATUS STATE OR JURISDICTION OF LICENSURE  ILICENSE PROFESSION LICENSE NUMBER LICENSE STATUS STATE OR JURISDICTION OF LICENSURE  SECONDARY 1 SUPERVISOR INFORMATION NVA  ADDRESS	PERSONAL PHONE	BUSINESS PHONE						
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DES	CRIBE YOUR TRAIN	NING IN PSYCHOPHAR	MAC	OLOGY								
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DAT	E 2-YEAR SUPERVI	SION BEGAN		DATE 2-YEA	R SUPERVISION ENDED							
_												
1.	1. List the setting(s) in which the conditional prescribing psychologist will practice and the hours per week worked at each setting.											
2.	List duties and clinical responsibilities of the conditional prescribing psychologist.											
3.	List location(s) where the supervision will occur and with whom.											
4.	4. List areas in which the primary and secondary supervisor(s), if any, have specialized skills to render competent supervision.											
L												
5.	List the number and name of the psychologists with conditional prescription certificates that you will be supervising during this time period:											
6.					t will be represented to the public, including a copies of any printed materials.)							



7.	YES NO						
	prescribing psychologist and the primary and secondary supervisor(s)? If yes, please describe the agreement:						
	Describe any other information necessary to clarify the nature and scope of the supervision.						
8.	Provide a statement specifying the manner in which supervision and clinical and professional re						
	provided during the supervisor's absence (during vacations or unexpected events that require th	at supervisor to be					
	absent for any period of time).						
9.	As the primary supervisor, will you provide supervision on a one-to-one basis for at least 4						
).	hours per month and a total of at least 46 hours of one-to-one supervision per year?	YES NO					
10.							
11.	As the primary supervisor will you contact any secondary supervisor(s) at least every six						
	months to obtain written or verbal progress reports concerning how the prescribing	🗌 YES 🗌 NO					
10	psychologist is performing?						
12.	Will the supervision be provided either face-to-face, telephonically, or by tele-video live communication?	□ YES □ NO					
13.	Will you, as primary supervisor, inform any secondary supervisor(s) of any concerns about the conditional prescribing psychologist's performing?	☐ YES ☐ NO					
14.	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	YES NO					
1.5	conditional prescribing certificate, and a brief description of the content of supervision?						
15.	Will you, as primary supervisor, maintain a log of contacts with the secondary supervisor(s)?	YES NO					
16.	Will you review the results of laboratory tests as appropriate?      MARY SUPERVISOR AGREEMENT	YES NO					
PKL	VIART SUPERVISOR AGREENIENT N/A						
I	, as a licensed physician and primary supervisor, knowl	edgeable of the					
admi	nistration of psychotropic medications, agree to supervise Dr H	e/she will hold a					
	itional certificate as a prescribing psychologist.						
	e read the above document and agree to comply with the terms and conditions as described above						
	upervisory plan may be modified if I deem appropriate by submitting to the application committe dified plan agreed to be me, any secondary supervisors, and the conditional prescribing psycholo						
	nodified plan would be to best reflect the psychologist's needs for supervision.	gist. The intent of					
ing i							
Sign	ature of Supervisor Date						
Sign							
Signature of Psychologist Supervisee       Date         SECONDARY 1 SUPERVISOR AGREEMENT							
1.	Will you, as secondary supervisor, inform the primary supervisor of any concerns about the	YES NO					
	conditional prescribing psychologist you are supervising?						
2.	Will you maintain a supervision log containing dates, duration, place/method of supervision,	YES NO					
	the same identification code for patients as used by the conditional prescribing psychologist and a brief description of the content of supervision?						
3.	Will you review the results of laboratory tests as appropriate?	YES NO					
I as a licensed physician and secondary supervisor knowledgeship of the							
administration of psychotropic medications agree to supervise Dr							
admi	, as a licensed physician and secondary supervisor, kno nistration of psychotropic medications, agree to supervise Dr H	wledgeable of the e/she will hold a					



conditional certificate as a prescribing psychologist. I have read the above document and agree to comply with the terms and conditions as described above.							
Signatu	Signature of Supervisor Date						
Signatu	Signature of Psychologist Supervisee Date						
SUPEF	RVISOR'S ADDRES	S					
TELEF	PHONE		F	EMAIL			
LICEN	ISE PROFESSION	LICENSE NUMBER	LICENSE	STATUS	STATE OR JURISD LICENSURE	ICTION OF	
		'S AREA OF PRACTIC	E IN WHICI	H SUPERVIS	OR IS FORMALLY T	RAINED	
AND/O	OR LICENSED/CER	TIFIED					
		SOR 2 AGREEMENT					
	conditional prescribin	ry supervisor, inform the ng psychologist you are s	supervising?	-		YES NO	
		supervision log containin				YES NO	
	the same identification code for patients as used by the conditional prescribing psychologist and a brief description of the content of supervision?						
	Will you review the results of laboratory tests as appropriate?   YES NO						
I, as a licensed physician and secondary supervisor, knowledgeable of the administration of psychotropic medications, agree to supervise Dr He/she will hold a conditional certificate as a prescribing psychologist. I have read the above document and agree to comply with the terms and conditions as described above.							
Signatu	ure of Supervisor			Date			
Signatu	Signature of Psychologist Supervisee    Date						

\*Please e-mail to the Board Office at <a href="mailto:psychologist.examiners@state.nm.us">psychologist.examiners@state.nm.us</a>

