



NMRLD

NEW MEXICO
REGULATION &
LICENSING DEPARTMENT

TRAINING PROGRAM VERIFICATION OF EXPERIENCE

SECTION A – CONDITIONAL PRESCRIBING PSYCHOLOGIST APPLICANT INFORMATION			
LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX
MAILING ADDRESS			
CITY	STATE	ZIP CODE	
PERSONAL PHONE		BUSINESS PHONE	
EMAIL		<input type="checkbox"/> PERSONAL OR <input type="checkbox"/> BUSINESS	
DATE OF BIRTH			
SECTION B – TRAINING DIRECTOR INFORMATION			
NAME OF TRAINING DIRECTOR			
TRAINING DIRECTOR’S TITLE AND POSITION OF EMPLOYMENT			
NAME OF INSTITUTION OF EMPLOYMENT			
INSTITUTION ADDRESS			
CITY	STATE	ZIP CODE	
BUSINESS PHONE			
DESCRIBE YOUR TRAINING IN PSYCHOPHARMACOLOGY			
DO YOU HOLD A LICENSE AS A PSYCHOLOGIST? <input type="checkbox"/> YES <input type="checkbox"/> NO			
LICENSE NUMBER	LICENSE STATUS	YEAR AWARDED	STATE OR JURISDICTION OF LICENSURE
DO YOU HOLD A LICENSE TO PRESCRIBE PSYCHOTROPICS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
LICENSE NUMBER	LICENSE STATUS	YEAR AWARDED	STATE OR JURISDICTION OF LICENSURE
OTHER PROFESSIONAL LICENSES HELD BY TRAINING DIRECTOR <input type="checkbox"/> N/A			
LICENSE PROFESSION	LICENSE NUMBER	LICENSE STATUS	STATE OR JURISDICTION OF LICENSURE
LICENSE PROFESSION	LICENSE NUMBER	LICENSE STATUS	STATE OR JURISDICTION OF LICENSURE



SECTION C – INFORMATION ABOUT THE PROGRAM		
Does the applicant’s psychopharmacology training meet the following criteria?		
1.	The program was an integrated program of study.	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.	The program had an identifiable body of students at different levels of matriculation.	<input type="checkbox"/> YES <input type="checkbox"/> 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.	<input type="checkbox"/> YES <input type="checkbox"/> 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 in which the program resides.	<input type="checkbox"/> YES <input type="checkbox"/> NO
5.	The training director was primarily responsible for directing the training program and had administrative authority commensurate with those responsibilities.	<input type="checkbox"/> YES <input type="checkbox"/> NO
6.	The training director’s credentials and expertise were consistent with the program’s mission and goals to train psychologists to prescribe psychotropic medications.	<input type="checkbox"/> YES <input type="checkbox"/> NO
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.	<input type="checkbox"/> YES <input type="checkbox"/> NO
8.	The program had formally designated instructors and supervisors in sufficient number to accomplish the program’s education and training.	<input type="checkbox"/> YES <input type="checkbox"/> NO
9.	Supervisors held an active, unrestricted license in their field of practice in the jurisdiction in which the program resides or where the supervisor was being provided.	<input type="checkbox"/> YES <input type="checkbox"/> NO
10.	The program’s supervisors and instructors had sufficient expertise, competence, and credentials in the areas in which they taught or supervised.	<input type="checkbox"/> YES <input type="checkbox"/> NO
11.	The program’s instructors and supervisors participated actively in the program planning, implementation, and evaluation.	<input type="checkbox"/> YES <input type="checkbox"/> NO
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; and D. Goals, objectives, and outcomes in relation to local, regional, and national changes in the knowledge base of psychopharmacology training.	<input type="checkbox"/> YES <input type="checkbox"/> NO
13.	The program followed the guidelines for psychopharmacology training of postdoctoral psychologists established by the American Psychological Association.	<input type="checkbox"/> YES <input type="checkbox"/> NO
14.	Does the program include didactic instruction of no fewer than 450 classroom hours in at least the following core areas: <ul style="list-style-type: none"> • Neuroscience, • Pharmacology, • Psychopharmacology, • Physiology, • Pathophysiology, • Appropriate and relevant physical assessment, • Clinical Pharmacotherapeutics 	<input type="checkbox"/> YES <input type="checkbox"/> NO
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).	<input type="checkbox"/> YES <input type="checkbox"/> NO
16.	When students are not in residence, the program provides on-line access to a library of sufficient diversity and level to support the advanced study of the psychopharmacological treatment of mental disorders from wherever the student resides. Access remains available throughout all didactic and clinical phases of the training program.	<input type="checkbox"/> YES <input type="checkbox"/> NO



17.	Frequent face-to-face evaluation and discussion are included in the didactic training.	<input type="checkbox"/> YES <input type="checkbox"/> NO
18.	The program provided formal, written, measurement of the mastery of the course content.	<input type="checkbox"/> YES <input type="checkbox"/> NO
19.	The program demonstrated in its written materials or course syllabi that integrates into the training the following areas: socio-cultural issues in psychopharmacological treatment, ethnopharmacology, 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.	<input type="checkbox"/> YES <input type="checkbox"/> NO

SECTION D – SUBSTANTIATION

1.	Please provide documentation that your program addresses the above requirements by providing as much of the following material as possible and checking below documentation forwarded to the Board. Program curriculum <input type="checkbox"/> University Catalog Description <input type="checkbox"/> Relevant Policy Manual <input type="checkbox"/> Relevant Student Handbook <input type="checkbox"/> Resume of Director <input type="checkbox"/> Resumes of Faculty <input type="checkbox"/> Evaluation of program by external experts or associations	
2.	Does the program maintain a website? If so, please give URL:	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.	Do you, as training director, certify that the applicant successfully completed didactic training as outlined above?	<input type="checkbox"/> YES <input type="checkbox"/> NO

SECTION E – EVALUATION OF APPLICANT

80-HOUR PRACTICUM

SUPERVISOR INFORMATION

NAME OF SUPERVISOR

SUPERVISOR’S ADDRESS

TELEPHONE

EMAIL

LICENSE PROFESSION

LICENSE NUMBER

LICENSE STATUS

STATE OR JURISDICTION OF LICENSURE

DESCRIBE SUPERVISOR’S AREA OF PRACTICE IN WHICH SUPERVISOR IS FORMALLY TRAINED AND/OR LICENSED/CERTIFIED

1.	Was the 80-hour practicum part of the Psychopharmacology Training Program from which the applicant obtained His/her certification or degree?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.	Did your program receive an evaluation form about this applicant from this supervisor, which discusses the student’s adequate development of skills in:	
	a. Assessing a diverse and significantly medically ill population?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	b. Observing the progression of illness and continuity of care of individual patients?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	c. Adequately assessing vital signs?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	d. Demonstrating competent laboratory assessment?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.	Was the 80-hour practicum completed from full-time to over thirty weeks?	<input type="checkbox"/> YES <input type="checkbox"/> NO

400-HOUR PRACTICUM IN PSYCHOPHARMACOLOGY

PRIMARY SUPERVISOR INFORMATION

NAME OF SUPERVISOR

SUPERVISOR’S ADDRESS



TELEPHONE			EMAIL		
LICENSE PROFESSION		LICENSE NUMBER	LICENSE STATUS		STATE OR JURISDICTION OF LICENSURE
DESCRIBE SUPERVISOR'S AREA OF PRACTICE IN WHICH SUPERVISOR IS FORMALLY TRAINED AND/OR LICENSED/CERTIFIED					
SECONDARY SUPERVISOR 1 INFORMATION <input type="checkbox"/> N/A					
NAME OF SUPERVISOR					
SUPERVISOR'S ADDRESS					
TELEPHONE			EMAIL		
LICENSE PROFESSION		LICENSE NUMBER	LICENSE STATUS		STATE OR JURISDICTION OF LICENSURE
DESCRIBE SUPERVISOR'S AREA OF PRACTICE IN WHICH SUPERVISOR IS FORMALLY TRAINED AND/OR LICENSED/CERTIFIED					
SECONDARY SUPERVISOR 2 INFORMATION <input type="checkbox"/> N/A					
NAME OF SUPERVISOR					
SUPERVISOR'S ADDRESS					
TELEPHONE			EMAIL		
LICENSE PROFESSION		LICENSE NUMBER	LICENSE STATUS		STATE OR JURISDICTION OF LICENSURE
DESCRIBE SUPERVISOR'S AREA OF PRACTICE IN WHICH SUPERVISOR IS FORMALLY TRAINED AND/OR LICENSED/CERTIFIED					
SECONDARY SUPERVISOR 3 INFORMATION <input type="checkbox"/> N/A					
NAME OF SUPERVISOR					
SUPERVISOR'S ADDRESS					
TELEPHONE			EMAIL		
LICENSE PROFESSION		LICENSE NUMBER	LICENSE STATUS		STATE OR JURISDICTION OF LICENSURE
DESCRIBE SUPERVISOR'S AREA OF PRACTICE IN WHICH SUPERVISOR IS FORMALLY TRAINED AND/OR LICENSED/CERTIFIED					
1.	Was the 400-hour practicum part of the Psychopharmacology Training Program from which the applicant obtained his/her certification or degree?				<input type="checkbox"/> YES <input type="checkbox"/> NO
2.	Did the applicant submit a 400-hour practicum plan to the Practicum Director?				<input type="checkbox"/> YES <input type="checkbox"/> NO
3.	Did the practicum meet the following requirements:				
	a. A minimum of 100 separate patients?				<input type="checkbox"/> YES <input type="checkbox"/> NO
	b. A range of disorders listed in the most recent DSM?				<input type="checkbox"/> YES <input type="checkbox"/> NO
	c. Both acute and chronic conditions?				<input type="checkbox"/> YES <input type="checkbox"/> NO



	d. 400 hours included time spent with patients to provide evaluation and pharmacotherapy, and time spent in collaboration with treating healthcare practitioners?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	f. Was the primary or secondary supervisor on-site?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	g. Did the primary/secondary supervisor(s) review charts and records?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	h. Was there at least one hour of supervision for every eight hours of direct service?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	i. Did the applicant keep a log of dates & times of supervision?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	j. Was the practicum completed in no less than 6 months and no more than three years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	k. Was the practicum completed within the 5 years preceding this application?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4.	Did the applicant and the training program keep records of time spent during the practicum?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5.	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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
6.	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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
7.	Did the supervisor(s) certify in writing that the applicant's performance was satisfactory for the practicum?	<input type="checkbox"/> YES <input type="checkbox"/> NO
8.	Do you, as training director, certify that the applicant has adequately completed a 400-hour/100-patient practicum?	<input type="checkbox"/> YES <input type="checkbox"/> NO
OVERALL EVALUATION		
1.	I would rate this student's performance under my training: (Please check one.) <input type="checkbox"/> Excellent <input type="checkbox"/> Acceptable <input type="checkbox"/> Not Acceptable <input type="checkbox"/> 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.	
PRIMARY SUPERVISOR CERTIFICATION		
I _____, the Training Director, certify that all of the statements made in this document are true, complete, and correct to the best of my knowledge and made in good faith.		
Clinical Signature _____ Date _____		

***Please e-mail to the Board Office at psychologist.examiners@state.nm.us**

