NMRLD
NEW MEXICO
REGULATION &
LICENSING DEPARTMENT

CONDITIONAL PRESCRIBING PSYCHOLOGIST
PROPOSED SUPERVISORY PLAN

CONDITIONAL PRESCRIBING PSYCHOLOGIST APPLICANT INFORMATION			
LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX
MAILING ADDRESS			
CITY	STATE	ZIP CODE	
PERSONAL PHONE	BUSINESS PHONE		
EMAIL	☐ PERSONAL OR ☐ BUSINESS		
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 PROFESSIONAL LICENSES HELD BY PRIMARY SUPERVISOR ☐ **N/A**			
LICENSE PROFESSION	LICENSE NUMBER	LICENSE STATUS	STATE OR JURISDICTION OF LICENSURE
LICENSE PROFESSION	LICENSE NUMBER	LICENSE STATUS	STATE OR JURISDICTION OF LICENSURE

SECONDARY 1 SUPERVISOR INFORMATION ☐ **N/A**		
NAME OF SECONDARY 1 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 PROFESSIONAL LICENSES HELD BY SECONDARY 1 SUPERVISOR ☐ N/A			
LICENSE PROFESSION	LICENSE NUMBER	LICENSE STATUS	STATE OR JURISDICTION OF LICENSURE
LICENSE PROFESSION	LICENSE NUMBER	LICENSE STATUS	STATE OR JURISDICTION OF LICENSURE
SECONDARY 2 SUPERVISOR INFORMATION ☐ N/A			
NAME OF SECONDARY 2 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 PROFESSIONAL LICENSES HELD BY SECONDARY 2 SUPERVISOR ☐ N/A			
LICENSE PROFESSION	LICENSE NUMBER	LICENSE STATUS	STATE OR JURISDICTION OF LICENSURE
LICENSE PROFESSION	LICENSE NUMBER	LICENSE STATUS	STATE OR JURISDICTION OF LICENSURE
INFORMATION ABOUT THE SUPERVISION			
DATE 2-YEAR SUPERVISION BEGAN	DATE 2-YEAR SUPERVISION ENDED		

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.	List areas in which the primary and secondary supervisor(s), if any, have specialized skills to render competent supervision.
5.	List the number and name of the psychologists with conditional prescription certificates that you will be supervising during this time period:
6.	Describe the manner in which the conditional prescribing psychologist will be represented to the public, including all written communications and public announcements. (Please attach copies of any printed materials.)

7.	Is there any direct or indirect financial agreement between or among the conditional 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.	☐ YES ☐ NO
8.	Provide a statement specifying the manner in which supervision and clinical and professional responsibility will be provided during the supervisor's absence (during vacations or unexpected events that require that 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.	As the supervising physician, will you have access to and review records relating to the treatment of patients under his/her supervision?	☐ YES ☐ NO
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 psychologist is performing?	☐ YES ☐ NO
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 conditional prescribing certificate, and a brief description of the content of supervision?	☐ YES ☐ NO
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?	☐ YES ☐ NO

PRIMARY SUPERVISOR AGREEMENT ☐ **N/A**

I ____, as a licensed physician and primary 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. I understand that the supervisory plan may be modified if I deem appropriate by submitting to the application committee for its approval, a modified plan agreed to be me, any secondary supervisors, and the conditional prescribing psychologist. The intent of my modified plan would be to best reflect the psychologist's needs for supervision.

Signature of Supervisor ____ Date________________________________

Signature of Psychologist Supervisee _____________________________ Date________________________________

SECONDARY 1 SUPERVISOR AGREEMENT

1.	Will you, as secondary supervisor, inform the primary supervisor of any concerns about the conditional prescribing psychologist you are supervising?	☐ YES ☐ NO
2.	Will you maintain a supervision log containing dates, duration, place/method of supervision, the same identification code for patients as used by the conditional prescribing psychologist and a brief description of the content of supervision?	☐ YES ☐ NO
3.	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.

Signature of Supervisor ______________________________________ Date_____________________________

Signature of Psychologist Supervisee _____________________________ Date_____________________________

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 AGREEMENT ☐ **N/A**		
1.	Will you, as secondary supervisor, inform the primary supervisor of any concerns about the conditional prescribing psychologist you are supervising?	☐ YES ☐ NO
2.	Will you maintain a supervision log containing dates, duration, place/method of supervision, the same identification code for patients as used by the conditional prescribing psychologist and a brief description of the content of supervision?	☐ YES ☐ NO
3.	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.

Signature of Supervisor ______________________________________ Date_____________________________

Signature of Psychologist Supervisee _____________________________ Date_____________________________

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