

**STATE BOARD OF PSYCHOLOGY OF OHIO
2014-2016 PSYCHOLOGIST REINSTATEMENT REQUEST**
Please print clearly

① IDENTIFYING INFORMATION

NAME: _____
DEGREE: _____ LICENSE NUMBER: _____
EMAIL: _____

② CHANGES TO PREFERRED MAILING ADDRESS ONLY

- NO CHANGE. The address on my mailing continues to be my preferred address for Board correspondence.
 UPDATE my preferred address for Board correspondence:

Number and Street Address _____
City State ZIP County _____
() () _____
Telephone Fax

③ SECONDARY ADDRESS [LIST YOUR PRIMARY BUSINESS ADDRESS IF YOUR HOME IS YOUR PREFERRED MAILING ADDRESS].

Number and Street Address _____
City State ZIP County _____
() () _____
Telephone Fax

④ PAYMENT DUE

- \$400 (\$350 Renewal fee PLUS \$50 penalty enclosed)
 Active duty in U.S. Armed Forces [Fee and MCE waiver per OAC 4732-1-06]. Please attach documentation of active duty/deployment orders.

⑤ MANDATORY CONTINUING EDUCATION

I acknowledge the requirement (ORC 4732.14) to cause the Board to receive a report from OPA-MCE or OSPA-MCE of compliance with approved MCE completed **after 8/31/12** (includes 3 hours in ethics and professional conduct):

- 23 MCE hours (license issued before 10/1/12)
 13 MCE hours (license issued between 10/1/12 and 9/30/13)
 No MCE required (license issued after 9/30/13 or waiver granted)

⑥ COMPETENCE AREAS I claim competence as follows:

- | | |
|--|---|
| <input type="checkbox"/> Applied Behavior Analysis | <input type="checkbox"/> Civil Forensic Services |
| <input type="checkbox"/> Family Psychotherapy | <input type="checkbox"/> Criminal Forensic Services |
| <input type="checkbox"/> Group Psychotherapy | <input type="checkbox"/> Telepsychology |
| <input type="checkbox"/> Individual Psychotherapy | <input type="checkbox"/> Health Psychology |
| <input type="checkbox"/> Marital/Couples Therapy | <input type="checkbox"/> Neuropsychology |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> School Psychology |

Others: _____

I claim competence to provide services to the following populations:

- Infants Children Adolescents Adults Elderly

⑦ RECORDS

Identify a psychologist, school psychologist, or other appropriate person who in the event of your absence, emergency or death has knowledge of **your written plan** for responsibility for your records.

Name _____
Mailing Address _____
City State ZIP _____
() _____
Telephone _____

⑧ LEGAL/ETHICAL REGULATIONS

a) During the past five years have you been the subject of any formal regulatory or disciplinary action, whether by agreement or adjudication (other than by this Board), regarding your suitability to be licensed, certified, or registered or have you been denied professional licensure, certification or registration by any other credentialing body? NO YES

b) Are criminal charges currently pending or, during the past five years, have you been convicted of, or pled guilty or no contest to, violating any municipal, state or federal law other than minor traffic offenses? NO YES

If "YES" on either of the above two questions, attach details on separate page, including identities of any court and state/province and address/telephone number of the appropriate Clerk of Court.

⑨ PSYCHOLOGICAL SUPERVISION

- I have no supervisees registered on my license
 I am Board-authorized to exceed 4 supervisees (Do not list)
 I provide psychological supervision to the following persons:

1) _____ 2) _____
3) _____ 4) _____

⑩ SIGNATURE/SOCIAL SECURITY NUMBER

By signature hereon, I affirm that all information on this form is true to the best of my knowledge. I also authorize all professionals, government entities, educational institutions, professional associations, and past or present business or professional employers or associates to release to the State Board of Psychology of Ohio any information necessary to verify the information set forth on this registration or which is related to any questions in Section 8 answered "Yes." I also consent to the release of my Social Security Number (SSN), which must be collected by the Board pursuant to 42 U.S.C. sec. 1320a-7e(b), 5 U.S.C. sec 552a, and 45 C.F.R. pt. 61 for potential disclosure to the Federal Department of Health and Human Services' Healthcare Integrity and Protection Data Bank. I further understand that the provision of my SSN is mandatory for child support enforcement purposes, pursuant to R.C. 3123.5.

SIGNATURE _____

SSN (LAST FOUR) _____

DATE _____

STATE BOARD OF PSYCHOLOGY OF OHIO
LICENSE REINSTATEMENT REQUEST INSTRUCTIONS 2014-16

MAIL YOUR FORM AND \$400 FEE PAYABLE TO "STATE TREASURER" TO:
STATE BOARD OF PSYCHOLOGY 77 S. HIGH ST., SUITE 1830 COLUMBUS, OH 43215

INSTRUCTIONS FOR COMPLETING REINSTATEMENT FORM ON REVERSE
PURSUANT TO ORC 149.43 REINSTATEMENT FORMS ARE DEFINED AS PUBLIC RECORDS

- ① **IDENTIFYING INFORMATION.** Please be certain to provide your license number. Email address is requested but optional.
- ② **CHANGES TO MAILING ADDRESS ONLY [ORC 4732.14].**
- ③ **SECONDARY ADDRESS.** If a home address is your primary mailing address for Board correspondence, you are required to list your primary business address for Board records. Remember that listing a home address is always voluntary, but the Board must have your primary business address in section ② or ③.
- ④ **REGISTRATION FEE AND REINSTATEMENT PENALTY [ORC 4732.14].** Remit \$400 payable to State Treasurer. **Remit only the \$50 penalty if the \$350 license registration fee has been paid.**
- ⑤ **MCE REQUIREMENTS [ORC 4732.141].** Check the appropriate box indicating the number of MCE hours that you were required to have reported to the Board for the most recent MCE deadline (August 31, 2014).
- ⑥ **COMPETENCE AREAS [OAC 4732-1-06].** Indicate your areas of competence established by education, training, and experience.
- ⑦ **RECORDS [OAC 4732-17-01 (B) (6)].** Provide the name and contact information of a person who knows of your arrangements regarding transfer of and accountability for your records in the event of your absence from practice, emergency, or death.
- ⑧ **LEGAL/ETHICAL REGULATIONS [OAC 4732-1-06].** Please complete both items, and provide any details on a separate page. Staple any correspondence to the renewal form.
- ⑨ **PSYCHOLOGICAL SUPERVISION [4732-13-04].** *No Supervisees* if you do not have supervisees under your license or if you provide supervision in a university or training setting, where supervisees are registered with the Board under a designee such as a Director of Training. *Board-authorized to exceed 4 supervisees* if permission received. Do not list names. *The third box if you have FOUR OR FEWER supervisees registered with the Board*, and identify each by name. Please remember that Mental Health Worker Supervision is not psychological work, and should not be registered.
- ⑩ **SIGNATURE/SOCIAL SECURITY NUMBER.** SSN is required by state and federal law. Sign and date the form.

The license reinstatement process is governed under the following statute and rule:

ORC 4732.14 Biennial registration
OAC 4732-1-06 Biennial registration

Please note the following: The State Board was granted authority by the Ohio General Assembly, effective March 20, 2014, to take action against any license holder practicing on an expired license:

ORC 4732.17 Actions against applicants or license holders.

(14) Offering or rendering psychological services after a license issued under this chapter has expired due to a failure to timely register under section 4732.14 of the Revised Code or complete continuing education requirements;