CONNECTICUT VALLEY HOSPITAL
PSYCHOLOGY SERVICES
Application for Clinical Credentialing

[ ] Addiction Division [ ] Forensic Division [ ] General Psychiatry

Name: _____

Job title: _____

Year doctorate awarded: _____ University: _____

Specialty area: [ ] General clinical [ ] Forensic psychology [ ] Substance abuse

[ ] Neuropsychology [ ] Geriatrics [ ] Other (specify): _____

CT Psychology license #: _____ or Post-doctoral fellow [ ]

License verified by: _____ date verified? _____

Psychological Assessment	**Psychotherapy**	**Forensic expertise**
____ Cognitive	____ Individual	____ PSRB
____ Personality: Objective	____ Group	____ Competency
____ Personality: Projective	____ Family	____ Pre-sentence
____ Neuropsychology	____ Behavioral	____ Probate
____ Psychodiagnostic		

Administration

____ Supervision *ENTER PRACTICE STATUS:*

____ Program management US (Under Supervision), I (Independent) *OR* S (Supervisory)

By submitting this application for clinical credentialing, I intend to abide by all standards and ethical principles of the profession of psychology as defined by the American Psychological Association, and to practice in accordance with state law.

I confirm that all information on this form is true and give permission to DMHAS and its representatives to verify the facts as I have presented them.

I confirm that I have not been convicted of a felony and that I do not suffer from a medical or psychiatric disorder that would prevent me from serving in the areas in which I seek credentialing.

_____ Date:_____

(Psychologist signature)

Approved: Date_____ _____

Chair, Credentialing Committee

Approved: Date_____ _____

Chair, Discipline of Psychology or designee