



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 Mainstream Drive
NASHVILLE, TENNESSEE 37243
www.tennessee.gov

**TENNESSEE BOARD OF EXAMINERS IN PSYCHOLOGY
PSYCHOLOGIST
(Local) (615) 741-5735 or (Toll Free) (800) 778-4123 ext. 741-5735**

APPLICATION INSTRUCTIONS FOR SPECIAL VOLUNTEER LICENSE

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Special Volunteer License.

Information Required for Tennessee Licensees

- | | Done |
|--|-------------|
| 1. Complete and mail the application pages 1 through 4. | _____ |
| 2. Complete and mail attachment 1 to each state, country, or province in which you hold or have ever held a license to practice any profession. | _____ |
| 3. Request the site of the free health clinic in which you intend to practice submit directly to this office a letter informing us of the clinic's location where you will be working and a notarized copy of the IRS ruling that provides proof of the clinic's private, not-for-profit status. | _____ |

Information Required for Non-Tennessee Licensees

- | | |
|---|----------------|
| 1. Complete items 1, 2 and 3 above. | _____ |
| 2. Submit a clear and recognizable, recently taken, bust photograph which shows the full head, face forward from at least the top of the shoulders up. | _____ |
| 3. Provide two (2) letters attesting to the applicant's character, from medical professionals on the signatory's letterhead. The letters must be original and dated within the last year. | _____ |
| 4. Fill out the Declaration of Citizenship document found at:
https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-4183.pdf
Provide proof of citizenship or evidence of being legally entitled to live and work in the United States. Such evidence may include notarized copies of birth certificates, naturalization papers or current Visa status. | _____
_____ |
| 5. Complete and mail the Mandatory Practitioner Profile Questionnaire pages 1 through 6 found at:
https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-3585.pdf | _____ |

UNDERSTANDING THE APPLICATION PROCESS

1. All documents required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

**Tennessee Board of Examiners in Psychology
665 Mainstream Drive
Nashville, TN 37243 (37228 for courier service only)**

2. **Allow fourteen (14) working days** for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.
3. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you. The supporting documentation requested in the letter must be received in the Board office ninety (90) days from the date of the initial deficiency letter. **(Files not completed within ninety (90) days will be closed.)**
4. Absent any complicating factors, the average application processing time is eight (8) weeks. Once the application is completed, your file will be reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.
5. **If an address change occurs at any time during the application process, you must notify the Board office, in writing, immediately.**

Thank you for your cooperation. We will make every effort to expedite your application in a professional and efficient manner.



STATE OF TENNESSEE
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665 Mainstream Drive
Nashville, Tennessee 37243

APPLICATION FOR SPECIAL VOLUNTEER LICENSE

READ INSTRUCTIONS PRIOR TO COMPLETING APPLICATION. APPLICANTS MUST COMPLY WITH ALL INSTRUCTIONS. FILL IN ALL BLANKS; IF NOT APPLICABLE, STATE N/A

PERSONAL INFORMATION

NAME _____
(Last) (First) (Middle/Maiden)

CURRENT HOME MAILING ADDRESS:

CURRENT PRACTICE NAME & ADDRESS:

*If you have no practice address, notify the Board of your practice address within 30 days of obtaining a practice address. If you have multiple practice address, please attach an additional page listing all practice addresses.

HOME PHONE _____ PRACTICE PHONE _____

E-MAIL ADDRESS: _____

Do you wish to receive notifications, including renewal notification, from the Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. ___ Yes ___ No

Social Security No. _____ - _____ - _____ Birth Date: ____ / ____ / ____

Race: _____ Gender: Female ___ Male ___ U.S. Citizen: Yes ___ No ___
Out of state applicants must complete the Declaration of Citizenship form.

Entitled to Live and Work in the U.S. Yes ___ No ___ (MUST check one)

Name and address of not-for-profit organization.

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. ***IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION.***

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following meanings:
 - a. The cognitive capacity to make appropriate clinical diagnosis, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;
 - b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
 - c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of substances obtained illegally (e.g., heroin, or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.
6. **"Minor Traffic Offense"** generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

QUESTIONS:

YES NO

- | | | |
|--|---|---|
| 1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice? | — | — |
|--|---|---|

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]

COMPETENCY INFORMATION CONTINUED

QUESTIONS:	YES	NO
2. Do you currently use chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety? If so, please list: _____	_____	_____
3. At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	_____	_____
4. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal or controlled substances?	_____	_____
5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	_____	_____
6. Have ever held or applied for a license, privilege, registration or certificate to practice psychology in any state, country, or province, that has ben or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
7. Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	_____	_____
9. Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	_____	_____
10. Have you ever been rejected or censured by a professional association or society?	_____	_____
11. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered against you;	_____	_____
b. Have you ever entered into any settlement of any legal action; or	_____	_____
c. Are there any legal actions pending against you or to which you are a party?	_____	_____
12. Have you ever held a license, registration, privilege or certificate in any profession, that has been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	_____	_____
13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)	_____	_____

***Affirmative response requires final documents or orders from the issuing states, courts, and/or agencies.**

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT AND SIGN

AFFIDAVIT AND RELEASE

I, _____ of _____
(Applicant's Name) (City) (State)

being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a psychologist in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a psychologist.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE

DATE



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**TENNESSEE BOARD OF EXAMINERS IN PSYCHOLOGY
(Local) (615) 741-5735 or (Toll Free) (800) 778-4123 ext. 741-5735
CLEARANCE FROM OTHER STATE LICENSURE BOARDS**

APPLICANT: Please provide the information requested in the top box and then mail one form to the licensure board in EACH state where you hold OR HAVE EVER HELD a license to practice any profession. (You may copy this form.) **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

<p>_____ was granted a license to practice _____ <i>(Name of Applicant)</i> <i>(Profession)</i> with license number _____ on _____ in the State of _____ <i>(Date)</i></p> <p>The Tennessee Board of Examiners in Psychology requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:</p> <p style="text-align: center;">State of Tennessee Board of Examiners in Psychology 665 Mainstream Drive Nashville, TN 37243</p> <p>Date: _____</p> <p style="text-align: right;">_____ Applicant's Signature</p> <p style="text-align: right;">_____ Applicant's typed or printed name</p>

ADMINISTRATIVE OFFICE OF STATE LICENSURE BOARD, PLEASE COMPLETE:		
Name In Full As It Appears On License _____		
License Number _____	Profession _____	Date Issued _____
Basis of issuance: _____ Endorsement/Reciprocity with _____ (Check One) <i>(State)</i>		
_____ Written Examination _____ <i>(Name of Exam)</i>		
The License is currently active and registered? Yes _____ No _____		
Is there any derogatory information on file? Yes _____ No _____ If yes, an explanation must be attached.		
_____	_____	_____
Authorized Signature	Title	Date