

SECTION II: SUPERVISOR'S CERTIFICATION

A limited permit may be issued to an applicant who has met all requirements for licensure except the licensing examination and/or experience requirements. The permit is valid for one year and may be extended once, at the discretion of the Department, for one additional year.

The applicant named in Section I is seeking a limited permit to practice as a psychoanalyst in New York State. Complete the information below to certify that the applicant will be supervised at the setting named below. Supervision and practice under a limited permit must be consistent with the requirements for supervised experience in Appendix A.

Applicant's name: _____

A. I have reviewed Appendix A and I meet the qualifications as a supervisor.

I am a licensed _____ in _____
Professional Title State

License number *(Attach a copy of your license if other than New York)* _____ Date licensed _____

Or

I have applied for licensure as a psychoanalyst and am certified or registered by _____ which is a national certifying or registering body for psychoanalysts. (Attach a copy of your certification or registration.)

B. Setting where experience will take place:

Name of facility (if applicable)

Street City State Zip Code

The above facility is a (check one):

- Office of Mental Health (OMH) approved facility
- Office of Mental Retardation and Developmental Disabilities (OMRDD) approved facility
- Office of Alcoholism and Substance Abuse Services (OASAS) approved facility
- Department of Health (DOH) approved hospital or nursing home
- Office of Children & Family Services (OCFS) approved facility
- Public health agency or facility approved by the social services district
- Office of a licensed psychoanalyst (not owned by the applicant)
- Office of a licensed physician, clinical social worker, or psychologist
- Other facility: _____

ATTESTATION OF SUPERVISOR

I will supervise the permit holder in accordance with the requirements in Appendix A. I declare that the statements made in the foregoing certification are true, complete and correct. Any false or misleading information in or in connection with this certification may be the cause for denial of permit and licensure.

Supervisor's signature: _____ Date _____ / _____ / _____
mo. day yr.

Print full name: _____

Title: _____

Address: _____

Phone: _____ Fax: _____

E-mail: _____

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, PO Box 22063, Albany, NY 12201.