# Notification of Supervision Relationship Form

**Notification of Supervision Relationship**

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**SUPERVISOR INFORMATION:**

<table>
<thead>
<tr>
<th>Full Name</th>
<th>First</th>
<th>Middle</th>
<th>Last</th>
<th>ND License#:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Highest Degree:**

- PhD [ ]
- PsyD [ ]
- EdD [ ]
- MA [ ]
- MS [ ]
- Other: [ ]

**ABA Certification:**

- BCBA-D [ ]
- BCBA [ ]
- Other: [ ]

**EMAIL:**

**Date License Granted:**

**Date License Expiration:**

**Business Name:**

**Business Phone:**

**Business Street Address:**

**Business City:**

**Business State:**

**Business Zip:**

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**SUPERVISEE/APPLICANT DATA:**

<table>
<thead>
<tr>
<th>Full Name</th>
<th>First</th>
<th>Middle</th>
<th>Last</th>
<th>CPQ [ ]</th>
<th>BCBA-D [ ]</th>
<th>BCBA [ ]</th>
<th>NDABA Cert [ ]</th>
</tr>
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</tbody>
</table>

**Highest Degree:**

- PhD [ ]
- PsyD [ ]
- EdD [ ]
- MA [ ]
- MS [ ]
- BA [ ]
- BS [ ]
- Other: [ ]

**Date Highest Degree Granted:**

**U.S. Citizen:**

- Yes [ ]
- No [ ]

**Birth Name (if applicable):**

**Previous Names or Aliases:**

**Date of Birth:**

**Place of Birth:**

**Gender:**

**EMAIL:**

**Required Supervised Experience Information:**

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th>Business Email:</th>
<th>Office Phone:</th>
</tr>
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<tbody>
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</table>

**Facility Street Address:**

**Facility City:**

**Facility State:**

**Facility Zip:**

**Job Title:**

**Starting Date:**

**Hours per week:**

**Primary Supervisor:**

**Supervision Hours per week:**

**Secondary Supervisor:**

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**While practicing in ND, what services will you provide:**

<table>
<thead>
<tr>
<th>Clinical Assessment/Evaluation</th>
<th>Yes [ ]</th>
<th>No [ ]</th>
<th>Applied Behavior Analysis Services</th>
<th>Yes [ ]</th>
<th>No [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>Yes [ ]</td>
<td>No [ ]</td>
<td>Industrial Organizational Services</td>
<td>Yes [ ]</td>
<td>No [ ]</td>
</tr>
<tr>
<td>Treatment Services</td>
<td>Yes [ ]</td>
<td>No [ ]</td>
<td>Forensic Services</td>
<td>Yes [ ]</td>
<td>No [ ]</td>
</tr>
<tr>
<td>Remote Services</td>
<td>Yes [ ]</td>
<td>No [ ]</td>
<td>Other (Please list):</td>
<td>Yes [ ]</td>
<td>No [ ]</td>
</tr>
</tbody>
</table>

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This form MUST be completed and submitted by the supervising licensee when a supervision agreement has been established with the applicant in accordance with NDCC: 43-32-20.2 (Postdoctoral supervised psychological employment), NDAC: 66-02-01-13 (Psychology residents and industrial-organizational psychology residents), and 66-02-01-15 Subsection 2 (c) (Requirements for licensing and registering applied behavior analysts). This form is one of several requirements that must be in place prior to ANY supervised practice. An applicant is not able to practice until a letter is received from the Board Office confirming the receipt of requirements and status of applicant. In addition, the signatures below indicate acknowledgement that communications between the supervisor listed above and the Board may occur and be initiated by either. All data on this page is subject to public disclosure NDCC 43-32-16.

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**Supervisor Signature:**

**Date:**

**Applicant Signature:**

**Date:**

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Mail, Email, or Fax to:

ND State Board of Psychologist Examiners

PO Box 1338

Bismarck, ND 58502-1338

Phone: 701.214.5580  Fax: 701-224-9824

Email: BoardOffice@ndsbpe.org