OPTIMA BEHAVIORAL HEALTH
APPLICATION FOR PSYCHOLOGICAL TESTING PRIVILEGES

Optima Behavioral Health
Application for Psychological Testing Privileges
Licensed Professional Counselors

Practitioner Name: _____

License Type: _____

License Number and Expiration Date: _____

Primary Practice Name: _____

Office Address: _____

_____

_____

Please list all formal course work (completed and passed) that you believe qualifies you for testing privileges. For all schools listed, please request that an official transcript be sent toOBH Credentialing Department. Transcripts must show evidence of specific training in each type of testing for which you request privileges.

Course Name	School (include complete address)	Date Completed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List other testing supervision:

Discipline	Name and Address of Supervisor	Dates of Supervision
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Indicate age groups to be tested:

☐ Children ☐ Adolescents ☐ Adults

Peer References:
Please have at least two peers knowledgeable in psychological testing provide letters of reference attesting to your qualifications and recent (within the last two years) experience. OBH would prefer letters from testing supervisors, another Licensed Professional Counselor, and/or at least one provider not directly affiliated with your clinical practice. At least one letter must be from a Licensed Clinical Psychologist.

Ethical Standards:
OBH requires that all professionals providing psychological testing services adhere to the code of Ethics and Stands of Practice adopted by their licensing board. As a Licensed Professional Counselor, I understand and agree to follow the ethical standards of my licensing board.
Attestation and consent:
By completing and signing this form, I hereby attest to the accuracy of all information provided, agree to notify OBH of any change in my license or clinical status affecting my ability to provide testing services, and verify my intent to adhere to OBH endorsed ethical principles. I also give OBH permission to request primary verification information from schools, facilities, other professionals, etc. regarding my qualifications to perform these services; a copy of this form shall be as valid as the original.

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_____
Practitioner Signature

_____
Practitioner Printed Name

_____
Date Signed

Please return this form, along with official transcripts and reference letters to:

Optima Behavioral Health Credentialing
Attention: Testing Privileges
4417 Corporation Lane
Virginia Beach, VA 23462
Fax: (757) 275-9719 or (757) 275-9716
Phone: (757) 552-7561

Please ensure that you call within 24 hours to confirm that your complete application has been received in the department.