



**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 to OBH Credentialing Department. Transcripts must show evidence of specific training in each type of testing for which you request privileges.

<u>Course Name</u>	<u>School (include complete address)</u>	<u>Date Completed</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List other testing supervision:

<u>Discipline</u>	<u>Name and Address of Supervisor</u>	<u>Dates of Supervision</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____



**OPTIMA BEHAVIORAL HEALTH
APPLICATION FOR PSYCHOLOGICAL TESTING PRIVILEGES**

Page 2 – Practitioner Name: _____

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 Standards 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.



**OPTIMA BEHAVIORAL HEALTH
APPLICATION FOR PSYCHOLOGICAL TESTING PRIVILEGES**

Page 3 – Practitioner Name: _____

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.

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.