

MONTANA BOARD OF PSYCHOLOGISTS
PO Box 200513 (301 S Park, 4th Floor)
Helena, MT 59620-0513
LICENSING PHONE: (406) 444-5773
EMAIL: dlibspsy@mt.gov WEBSITE: www.psy.mt.gov

INSTRUCTIONS FOR BEHAVIOR ANALYST SUPERVISED EXPERIENCE:

VERIFICATION OF SUPERVISED EXPERIENCE:

- Use the attached form to provide proof demonstrating the Documentation of 100 hours of clinical supervised experience beyond the hours set forth in the current version of the “BACB Experience Standards” required by the BACB for the current certificate level of the applicant.

-- NOTE: Each behavior analyst applicant certified by the BACB on or before December 31, 2017, shall be granted one year following licensure in which to provide proof to the board demonstrating the applicant has met the experience requirements of ARM 24.189.910(1). Applicants who are certified by the BACB after December 31, 2017, must provide proof demonstrating the applicant has met the experience requirements of ARM 24,189.910(1) at the time of application. No exceptions.

IMPORTANT INFORMATION:

- All documents not in English must be accompanied by certified translations.
- It is critical to your continued licensure to not withhold any information regarding each question on the application.
- You will be notified of any deficiencies.
- It is your responsibility to keep the board office informed of any name changes, address changes, changes in licensure status, complaints or proposed disciplinary action against you in this or any other state. The change of address form is available at www.psy.mt.gov.
- The practice of behavior analysis in Montana is governed by the Board’s Statutes and Administrative Rules. These are found at www.psy.mt.gov, under the Regulations tab.
- Illegible and incomplete forms and/or supporting documents will be returned.

**BEHAVIOR ANALYST SUPERVISED
EXPERIENCE FORM FOLLOWS**

MONTANA BOARD OF PSYCHOLOGISTS
PO Box 200513 (301 S Park, 4th Floor)
Helena, MT 59620-0513
LICENSING PHONE: (406) 444-5773
EMAIL: dlibspsy@mt.gov WEBSITE: www.psy.mt.gov

Behavior Analyst Supervised Experience

Allow 30 business days from the date the Board office has received all required documentation for processing.

PLEASE PRINT OR TYPE

1. FULL NAME _____
Last First Middle

2. OTHER NAME(S) KNOWN BY _____

3. BUSINESS NAME _____

4. BUSINESS ADDRESS _____
Street or PO Box # City and State Zip

5. HOME ADDRESS _____
Street or PO Box # City and State Zip

PREFERRED MAILING ADDRESS

BUSINESS HOME EMAIL ADDRESS _____

6. BUSINESS PHONE _____ HOME PHONE _____ FAX _____

7. SOCIAL SECURITY NUMBER _____ FOREIGN ID NUMBER _____

8. DATE OF BIRTH _____ PLACE OF BIRTH _____ MALE
FEMALE

9. Post-BACB Certification Supervised Clinical Experience

Duties			
Name of principal supervisor and department			
Institution			
Current Address			
Dates: (From - To)		Actual Total Hours:	

Duties			
Name of principal supervisor and department			
Institution			
Current Address			
Dates: (From - To)		Actual Total Hours:	

DECLARATION

I authorize the release of information concerning my education, training record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Psychologists. I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds.

I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

Legal Signature of Applicant _____ Date _____