

FORM A

THE PROFESSIONS SUPPLEMENTARY TO MEDICINE ACT, 1965

APPLICATION FOR ADMISSION TO THE REGISTER OF PSYCHOLOGY AND COUNSELLING

*LICENSURE CATEGORY:

(Check the box(es) beside the professional level and specialization that apply to you).

PROFESSIONAL LEVEL	SPECIALIZATION			
	CLINICAL	COUNSELLING	APPLIED-SOCIAL	EDUCATIONAL/ SCHOOL (please indicate which)
<input type="checkbox"/> LICENSED PSYCHOLOGIST <i>(Doctoral level)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> LICENSED ASSOCIATE PSYCHOLOGIST <i>(Masters level)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> LICENSED PROFESSIONAL COUNSELLOR <i>(Doctoral level)</i>	NOT APPLICABLE			
<input type="checkbox"/> LICENSED ASSOCIATE PROFESSIONAL COUNSELLOR <i>(Masters level)</i>	NOT APPLICABLE			

*PSYCHOMETRIC COMPETENCE

(Check the box that corresponds to your level of psychometric competence).

<input type="checkbox"/> LEVEL A	<input type="checkbox"/> LEVEL B	<input type="checkbox"/> LEVEL C	<input type="checkbox"/> NOT APPLICABLE
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*see Scope of Practice at www.jampsych.com for an explanation of these areas

NAME OF APPLICANT: <i>(In block letters)</i>	SURNAME	CHRISTIAN & MIDDLE NAMES		
STATE WHETHER: <i>(Please check the relevant box)</i>	<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> DIVORCED	<input type="checkbox"/> WIDOWED
	<i>Married female applicants: Please state maiden name and furnish relevant documents.</i>			
DATE OF BIRTH: <i>(DD/MM/YYYY)</i>		PLACE OF BIRTH:		
NATIONALITY:		CONTACT NUMBER(S):		
EMAIL ADDRESS:				
CURRENT ADDRESS: <i>(This should be an address at which you are certain to receive communication sent</i>				

to you).	
PLACE AND PRACTICE ADDRESS: <i>(Address of place or institution in which Profession is practised)</i>	
QUALIFICATION(S):	
SPECIAL AWARD(S):	

MEMBERSHIP STATUS

I confirm that I am a member of the Jamaican Psychological Society in good standing.

FORWARDED HERewith ARE THE FOLLOWING:

1. CERTIFICATES <i>(or certified copies thereof):</i>	a)	
	b)	
	c)	
2. **EVIDENCE OF PSYCHOMETRIC COMPETENCE (transcript, certification)		3. **EVIDENCE OF SUPERVISORY HOURS (course outline, practicum/internship log, letter from supervisor)
4. CHARACTER REFERENCES FROM TWO REFEREES <i>(One must be from a person in good standing in the applicant's profession):</i>		5. ONE PASSPORT SIZE PHOTOGRAPH

**see Scope of Practice at www.jampsych.com for detailed information regarding documentation

PLEASE STATE:

1. ARE YOU FLUENT IN THE USE OF THE ENGLISH LANGUAGE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL OFFENCE? <i>(If "YES" give details)</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. HAVE YOU EVER BEEN FOUND GUILTY OF PROFESSIONAL MISCONDUCT? <i>(If "YES" give details)</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

I DECLARE THAT THE FOREGOING PARTICULARS ARE CORRECT TO THE BEST OF MY KNOWLEDGE. I HAVE NOT MADE A PREVIOUS APPLICATION AND I HAVE READ THE **COUNCIL'S GUIDELINE ON INFAMOUS CONDUCT**. I ENCLOSE THE FEE OF _____ DOLLARS AND I HEREBY APPLY FOR REGISTRATION IN THE REGISTER FOR _____ AND I PROMISE, IN THE EVENT OF MY BEING REGISTERED, AND IN THE CONSIDERATION THEREOF, TO BE BOUND BY AND TO CONFORM IN ALL RESPECTS TO THE REGULATIONS RELATING TO _____ FOR THE TIME BEING IN FORCE.

SIGNATURE OF APPLICANT

DATE

Return completed form to:
**The Registrar ▪ Professions Supplementary to Medicine ▪ 1st Floor, Kingston School of Nursing ▪
50 Half Way Tree Road, Kingston 5 ▪ JAMAICA, WEST INDIES ▪**

FOR OFFICE USE ONLY
DOCUMENTS RECEIVED
REGISTRATION FEE (\$ _____) CHEQUE <input type="checkbox"/> CASH <input type="checkbox"/>
REGISTRATION DATE
CERTIFICATE NO.
DATE COLLECTED/DISPACHED

VERIFIED	APPROVED	DEFERRED	REJECTED

N.B. ALL FEES ARE NON-REFUNDABLE