

Wisconsin Department of Safety and Professional Services

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MARRIAGE AND FAMILY THERAPY, PROFESSIONAL COUNSELING, AND SOCIAL WORK EXAMINING BOARD

AFFIDAVIT OF SUPERVISOR IN SUPPORT OF APPLICATION TO ENGAGE IN PSYCHOMETRIC TESTING

APPLICANT: Complete this section and submit directly to your supervisor for completion. Form must be returned directly from the supervisor to the Department.

Applicant Name: _____

Application Number: _____

ATTESTATION OF APPLICANT: I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations.

Applicant Signature (If unable to provide a digital signature print and sign form.) _____ **Date** _____

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SUPERVISOR: Complete this section for the above-named applicant and return directly to the Department using the License Third-Party Upload Portal at license.wi.gov. You will need the application number shown above. (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of credential application.)

Choose one of the following:

- I am a licensed psychologist under Wis. Stat. ch. 455 and I have the education, experience, and training to select, administer, score, and interpret the specific tests as listed below for which I provided supervision (Wis. Admin. Code § MPSW [1.11\(4\)](#)).
- I am a licensed marriage and family therapist, licensed professional counselor, or licensed clinical social worker who meets the requirements in MPSW [1.11\(5\)\(a\)](#) and [\(b\)](#) (Wis. Admin. Code § [MPSW 1.11\(6\)](#)).

I affirm that I supervised the applicant stated above and I attest that he/she has acquired specific qualifications for the responsible selection, administration, scoring and interpretation of the following psychometric tests in the particular settings listed below for the specific purposes listed below. (Attach additional sheets if necessary.)

Particular settings include an employment context, an educational context, a career and vocational counseling context, a health care context, or a forensic context. Specific purposes include classification, description, prediction, intervention planning, tracking, training, and supervision. (Attach additional sheets if necessary.)

Dates of Supervision From: □□□/□□□/□□□□□ To: □□□/□□□/□□□□□

| Test | Setting(s) | Purpose(s) | Number of Administrations |
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Wisconsin Department of Safety and Professional Services

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| <p>ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.</p> | | | |
| Supervisor's Printed Name | | Supervisor's Profession | |
| | | | |
| Supervisor's Title (if applicable) | | Supervisor's Credential Number | |
| | | | |
| Facility Name | | Facility Phone Number | |
| | | | |
| Facility Address (number/street) | | (city) | (state) (zip code) |
| | | | |
| Supervisor Signature (If unable to provide a digital signature print and sign form.) | | | Date |
| | | | <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |