



EMERGENCY TEMPORARY REGISTRATION

(LA R.S. 29:769)

**Louisiana State Board of Examiners of Psychologists
4334 S. Sherwood Forest Blvd., Suite C-150
Baton Rouge, LA 70816
225-295-8410**

ATTACH
PHOTO
HERE

I, _____, am submitting the information requested herein in order to obtain Emergency Temporary Registration (ETR) as a psychologist in Louisiana under the authority granted the LSBEP by R.S. 29:769(E) and pursuant to Executive Order 163-JBE-2021-Renewal of Emergency Declaration and/or 165-JBE-2021-State of Emergency Tropical Storm Ida effectuated on the 26TH day of August, 2021 expiring on the 27TH day of September, 2021. I understand that additional requirements may be imposed pursuant to LAC 46: LXIII. §1002.D. and will comply with those requirements if so requested.

I understand that registration under an Emergency Temporary Registration is intended for individuals providing volunteer gratuitous services in response to Hurricane Ida.

PART I: GENERAL INFORMATION (Please print or type)

Full Name: (Last, First, Middle, Suffix)		Social Security Number:	
Maiden/Alias:	Date and Place of Birth:	E-mail address:	
Home Phone:	Home Address:		
Cell Phone:	City, State Zip		
Business Phone:	Business Address:		
Fax Number:	City, State Zip		

PART II: LICENSE HISTORY

State of your residence:	Are you licensed for the independent practice of psychology at a doctoral level in this state? <input type="checkbox"/> YES <input type="checkbox"/> NO			
License Number:	Original Issue Date:	Expiration Date:	Area of Practice:	
<i>Provide information on other jurisdictions where you have held, or currently hold a professional license</i>				
Jurisdiction	Original Issue Date	License Number	Expiration Date	Area of Practice

PART III: DATES AND LOCATION OF PRACTICE IN LOUISIANA (Period may not exceed thirty (60) days.)

Start Date: (mm/dd/yyyy)	End Date: (mm/dd/yyyy)
Provide the name and address of the organization or association through which you will be providing emergency mental health services and attach documentation of your affiliation with this organization.	Organization Name:
	Street Address:
	City, State Zip:
	Telephone Number:
Provide the location of your temporary practice, and the local phone number for this location to the right of this box.	Temporary Practice Location:
	Street Address:
	City, State Zip:
	Telephone Number:
Describe specific psychological duties to be provided during your temporary practice in Louisiana:	
Will you be receiving payment for these services, or revenue of any kind, for psychological services performed in Louisiana? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PART IV: ATTESTATION, IDENTIFICATION AND AFFIDAVIT

If you answer "Yes" to any of the following questions, attach an explanation on a separate page.

Have you ever been disciplined, sanctioned, reprimanded, or subjected to any like action by the Committee on Ethics of any professional organization of which you were, or are, a member?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been convicted of, or pled guilty or nolo contendere to a violation of any federal, state or provincial statute, any city or country ordinance, or law of a foreign country (except for minor traffic violations?)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you now, or have you ever engaged in any activities that misrepresent your professional qualifications, affiliation, or purposes, or those of institutions, organizations, products and/or services with which you are associated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been denied any license or certificate as a psychologist in any state, province, or country, or denied the right to take an examination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been denied any license or certificate for any other profession?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any license or certificate as a psychologist ever been restricted, suspended, or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any license or certificate for any other profession ever been restricted, suspended, or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been found guilty of any unprofessional conduct under the Law or Rules of any jurisdiction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been found guilty of fraud or deceit in any services rendered as any licensed professional?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever aided or abetted any person who has misrepresented themselves as a psychologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever voluntarily surrendered or relinquished a license to practice psychology?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever taken and passed a psychology oral examination? If yes, date _____ Location _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

IDENTIFICATION AND DOCUMENTATION REQUIRED

1. Attach on the first page of this application, one current passport size picture of yourself.
2. Attach one copy of a valid driver’s license, or other state issued photo identification.
3. Attach a copy of your current and unrestricted license to practice psychology at a doctoral level from the state of your residence.

NOTARIZED AFFIDAVIT

I understand that I may choose to apply for licensure under applicable standard board licensing procedures rather than under this agreement. My signature indicates that I have chosen to register for emergency temporary practice, to provide gratuitous services in response to the declared emergency, not to exceed a period of 60 days in this calendar year, and that in doing so I agree to the conditions stated in LAC 46:LXIII. Chapter 10.

The undersigned, being duly sworn under penalty of perjury, deposes and says that the statements contained herein are true, complete, and correct to the best of his/her knowledge and belief; that he/she has not suppressed any information which might affect this registration; that he/she has not omitted any information relevant to his/her current fitness to practice; that he/she is of good moral character and will conform to the ethical standards and conduct of the profession; that he/she has no complaints pending, and has had no disciplinary action against him/her in any jurisdiction; that he/she has otherwise met all statutory requirements and believes him/herself eligible for licensure via reciprocity, and that he/she has read and understood this affidavit.

Signature of Registering Out-of-State Psychologist Date

NOTARY REQUIRED

STATE OF _____

PARISH OR COUNTY _____

SWORN TO BEFORE ME THIS _____ DAY OF _____ 20_____

SIGNATURE OF NOTARY _____

NOTARY
SEAL

Return completed registration form to the LSBEP via mail to the address on the first page of this application or via email to admin.lsbep@la.gov.

(Emergency Registrations will be expedited in accordance with LAC 46: LXIII. §1002.C.)