STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

BOARD OF VOCATIONAL NURSING & PSYCHIATRIC TECHNICIANS
2535 Capitol Oaks Drive, Suite 205, Sacramento, CA 95833-2945
Phone (916) 263-7800 Fax (916) 263-7855 Web www.bvnpt.ca.gov

CALIFORNIA PSYCHIATRIC TECHNICIAN LICENSURE EXAMINATION
Expert Examiner Application

Directions:
1. ***Please type or print all requested information.***
2. ***Please complete all sections of the application to ensure timely processing.***
3. ***Return the form with its attachments to the BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS, 2535 Capitol Oaks Drive, Sacramento, CA 95833.***

1. Full Name: _____

2. Home Address: _____

3. ***Telephone***:

   Home: (____)_____ Work: (____)_____

   FAX: (____)_____ FAX (____)_____

4. ***Licensure:***

   - Do you hold current licensure as a registered nurse or psychiatric technician? Yes ☐ No ☐
   - RN License Number: _____ Expiration: _____
   - PT License Number: _____ Expiration: _____

5. Are you currently employed in nursing or psychiatric technician practice giving direct client care **AND** working directly with psychiatric technicians who have entered practice during the last five years? Yes ☐ No ☐

6. Are you currently employed as an educator in a nursing or psychiatric technician program or a psychiatric clinical facility? Yes ☐ No ☐

7. ***Employment*:**

   - Present Employer: _____
   - Business Address: _____

     _____
   - Present Job Title: _____

8. Please indicate your area(s) of specialty practice or instruction. _____

9. Please indicate the average number of hours you practice per week?

□ 0 – 8 Hours	□ 17 – 24 Hours	□ 33– 40 Hours
□ 9 – 16 Hours	□ 25 – 32 Hours	□ Over 40 Hours

10. Please indicate the type of setting in which you practice.

□ Education	□ Psychiatric Facility	□ Developmental Center	□ Clinic
□ Emergency Psychiatry	□ Residential Care	□ Home Care	□ Corrections

11. If selected, are you able to travel for five - day item development conferences? Yes □ No □

12. ***Educational Preparation:*** Nursing or psychiatric technician education, graduate work, national certification, etc. List highest level of preparation first. Do not include high school. Attach a separate sheet, if necessary.

Educational Institution Area of Major Concentration Degree/Credits Completed

_____

_____

_____

13. ***Professional Experience***: Please list last five (5) years of employment, present employer first.

Employer Institution Position/Title Clinical Specialty Length of Time

_____

_____

_____

14. ***PLEASE ATTACH***:

a. A letter from your immediate supervisor: 1) verifying that you will be released from work for participation; and 2) verifying your clinical expertise in the identified area of clinical specialty.

b. A brief narrative statement, approximately one page, 1) explaining why you feel you are qualified to serve as an item writer; 2) describing your clinical expertise in your area of specialty; and 3) stating the contributions you would bring to the CAPTLE.

_____ _____

Signature ***Date***

PLEASE DO NOT WRITE BELOW THIS LINE.

For Official Board Use

Application Processing: Received: _____ Review _____ Evaluation _____

Date: Approval _____ Alternate _____ Rejection _____

Reviewed By:

_____

Revised: 06/17