Appendix A - Intern Weekly Report Template

PSYCHOLOGY INTERN WEEKLY REPORT

Please return no later than Monday of the following week.

Intern:	
Reviewing Supervisor:	
Week of:	
Vacation hours:	
Professional Leave hours:	
Floating Time Off hours:	
Sick hours:	
Holiday hours:	
Total Leave:	0

HOURS SPENT ENGAGED IN ALL INTERNSHIP ACTIVITIES:

Primary Track Total (Face-to-Face, Didactics & Support, Research)	0		
Baylor Psychiatry Clinic (Face-to-Face & Support)	0		
Research Rotation	0		
Core Program Didactics	0		
Supervision Individual	0		
Supervision Group	0		
Other	0		
Total Internship Hours	0	Supervision Total:	0

PRIMARY TRACK

Face-to Face Clinical Contact Hours

Type of Service	Number of Patients	Hours of Service Provision	Supervisor
Intake			
Individual Therapy			
Group Therapy			
Assessment			
Inpatient Consultation			
Other (Please Specify)			
Totals	0	0	

Appendix A - Intern Weekly Report Template

Primary Track Didactic & Support Hours

Didactic or Support Activity	Time spent
Total Hours	0

Primary Track Research Activities

Type of Activity	Time spent	Supervisor
Total Hours	0	

BAYLOR PSYCHIATRY CLINIC - OUTPATIENT PSYCHOTHERAPY

Type of Service	Hours of Service Provision	Supervisor
Intake		
Individual Therapy		
Couple Therapy		
Support Hours - Intake & Progress Note Writing		
Other Support Hours (Please Specify)		
Total Hours	0	

RESEARCH ROTATION

Type of Activity	Time spent	Supervisor
Total Hours	0	

Appendix A - Intern Weekly Report Template

CORE PROGRAM DIDACTICS

Activity	Time spent
Total Hours	0

SUPERVISION (OF ALL PROGRAM ACTIVITIES)

	Group Supervision		**Individual Supervision**	
Supervisor	Scheduled	Received	Scheduled	Received
Total Hours	0	0	0	0

OTHER PROGRAM ACTIVITIES

Activity	Time spent
Total Hours	0

Appendix B - Policies Regarding Vacation and Absences

The following policies are for vacation, professional leave, sick time, and/or other authorized absences. Any variation or exceptions to these standards must be discussed with an approved by your primary supervisor and the Training Director.

1. Interns are required to complete a minimum of 2000 hours during the internship year, which extends from the first working day in July to the last working day in June. Interns are expected to be at the internship site for the entire year.

2. Interns are allotted 10 days of vacation during the training year. Interns must obtain approval from all supervisors and from the Training Director as documented by the leave form at least two weeks before the anticipated leave start date. Any exceptions to the above must be discussed with and approved by the Training Director and will be considered on a case-by-case basis.

3. A maximum of 5 days can be taken during one primary rotation period unless there are extenuating circumstances.

4. For rotations with multiple interns, more than one intern cannot be absent from the same rotation at the same time except in rare circumstances as approved by the Training Director and the primary track supervisor(s).

5. As employees of Baylor College of Medicine, interns also accrue "floating time off." Eight hours of "floating time off" are accrued at the beginning of each quarter (July 1, October 1, January 1, and April 1). This time may be used much as vacation time, with the caveat that the time must be accrued prior to being used.

6. The internship program generally observes the holiday schedule of Baylor College of Medicine Baylor College of Medicine. However, if a primary site is closed on a MTRF, the intern may also observe that holiday even if it is not a Baylor College of Medicine holiday. This is a rare occurrence.

7. Absences from the internship site for structured educational purposes which contribute to the internship (e.g., local and national workshops and conventions) are considered authorized professional leave absences if approved by current supervisors and the Training Director. Interns may take a maximum of 10 days of professional leave absence during the year. Interns may also use professional leave for dissertation defense (but not work on dissertation) or for interviews for post-internship positions.

8. If a primary site is sponsoring or hosting a conference or training and primary supervisor(s) are in support of attendance by an intern currently at that primary site, interns may attend such activities on primary site days (MTWR) without requesting/using professional leave time. If such activities occur on Wednesdays during didactics or other core program activities, professional leave time is required.

9. Work on dissertation will not be counted as internship work hours. Any dissertation work (except defense, which may be taken as professional leave) must be taken as part of vacation time.

10. Interns will be granted 5 days for absences related to illness during the internship year. Exceptions to this must be approved by supervisors and the Training Director.

11. No vacation or professional leave may be taken during the last 2 weeks of the internship year except in rare circumstances and as approved by supervisors and the Training Director.

12. Any exceptions to the above policies will be made at the discretion of the Training Director.

Appendix B.1 - BCM Holiday Schedule - Policies and Procedures

https://intranet.bcm.edu/index.cfm?fuseaction=Policies.Display_Policy&Policy_Number=02.8.01

02.8.01 - Human Resources: Time-Off From Work

Holiday Schedule

Last Update: 02/11/2011

Applies to: Faculty, Staff

PURPOSE

To establish a policy for seven (7) paid holidays and four (4) floating time off (FTO) days at Baylor College of Medicine.

POLICY

(1) The College observes seven (7) official paid holidays and four (4) paid FTO days each calendar year. The College publishes on the BCM Intranet a list of the actual days to be observed for the seven (7) holidays. https://intranet.bcm.edu/?tmp=/hr/holiday

The seven official holidays recognized are:

New Year's Day (Jan. 1)
Martin Luther King's Birthday (3rd Monday in January)
Memorial Day (Last Monday in May)
Independence Day (July 4)
Labor Day (1st Monday in September)
Thanksgiving Day (4th Thursday in November)
Christmas Day

(2) Holidays which fall on Sunday are normally observed the following Monday. Holidays which fall on Saturday are normally observed the preceding Friday.

(3) Full-time salaried employees in active pay status receive seven paid holidays per year and four FTO days. Part-time salaried employees are entitled to holiday pay and FTO pay equal to their FTE percent at the time of the accrual or holiday. For example, a 60 percent employee receives 4.8 hours of holiday pay (8 x 60 percent = 4.8 hours).

(4) If a College holiday occurs during a period of paid sick or vacation time, the employee is not charged for sick or vacation time.

5) Holidays will not carry over to the next calendar year.

(6) In regard to the four FTO days:

- A new absence type called “Floating Time Off” (FTO) will be created in SAP.
- Employees will receive one FTO day per quarter based on FTE (e.g., 8 hours for FT employee).
- FTO time will accrue on the first day of each quarter – January 1, April 1, July 1, and October 1.
- FTO accruals will appear on employee pay stubs.
- Once accrued, FTO time can be used at any time during the calendar year upon approval of Supervisor.
- Unused FTO time will not carry forward to a new calendar year. Any unused FTO time will be lost on January 1 of the following year.
- Terminating employees will not be paid for unused FTO time.
- New hires will receive their first FTO accrual on the first day of the quarter, beginning on or after their hire date.

7) If you work for an affiliate hospital that does not recognize BCM holidays, you will continue to be able to use an alternative day off as agreed upon by your supervisor. For FTO, you will work with your supervisor at the affiliate organization for scheduling time off. You will designate FTO on your BCM timesheet. The amount of FTO is dependent on whether you are a full-time or a part-time employee.

8) The College encourages the free exercise of religious expression by permitting employees to observe religious holidays which are not included in the seven (7) paid holidays observed by the College. Employees need to request any time off for such holidays at least one week in advance of the date the holiday is observed. Employees must charge the observance of such holidays to FTO days, personal, vacation, or time off without pay, in that order

9) For “Frequently Asked Questions” about this policy

BCM Holiday Policy January 2011

Appendix B.2 – Intern Vacation Leave Form

PSYCHOLOGY INTERN
VACATION/PROFESSIONAL LEAVE FORM
(10 Vacation Days – 10 Professional Leave Days)
PLEASE SUBMIT 2 WEEKS IN ADVANCE

DATE SUBMITTED TO Dr. Nguyen: _____

Intern Name: _____

I am requesting to be absent the following dates: _____ through **_____**

Number of days requested: Vacation **_____** Professional Leave **_____**

Floating Time Off _____ (8 hours accrued per quarter of calendar year)

Emergency Contact Name: _____

Emergency Telephone Number(s): _____

Present Rotation: _____ Rotation Supervisor: _____

Rotation clients covered by & phone: _____

My BPC supervisor(s) & phone(s) (If more than one supervisor, specify patient initials for each):

_____

Intern covering BPC clients & phone: _____

BPC supervisor(s) for intern providing coverage & phone: _____

_____

If professional leave, please describe activity:

_____

_____

_____

Vacation Days taken prior to today: _____ Floating Time Off taken prior to today: _____

Leave Days taken prior to today: _____

_____ _____ _____ _____
Rotation Supervisor Signature **Date** **Training Director Signature** **Date**

Appendix C

2019-20120 Website Materials

The Menninger Department of Psychiatry & Behavioral Sciences at Baylor College of Medicine:
https://www.bcm.edu/departments/psychiatry-and-behavioral-sciences

Baylor College of Medicine Psychology Internship: www.bcm.edu/psychology-internship

BCM Obsessive Compulsive Disorder Program:
https://www.bcm.edu/healthcare/care-centers/psychiatry/services/obsessive-compulsive-disorder

Baylor Psychiatry Clinic – OCD and Related Disorders Track:
https://www.bcm.edu/departments/psychiatry-and-behavioral-sciences/education/psychology-internship/tracks/ocd-and-related-disorders-track

The Menninger Clinic: http://www.menningerclinic.com/

The Menninger Clinic – Adult Track: https://www.bcm.edu/departments/psychiatry-and-behavioral-sciences/education/psychology-internship/tracks/adult-track

Menninger Compass Program for Young Adults:
https://www.menningerclinic.com/patients/compass-program-for-young-adults

Menninger Hope Program for Adults: https://www.menningerclinic.com/patients/hope-program-for-adults

TIRR Memorial Hermann: http://tirr.memorialhermann.org/

TIRR Memorial Hermann – Rehabilitation Psychology and Neuropsychology Track:
https://www.bcm.edu/departments/psychiatry-and-behavioral-sciences/education/psychology-internship/tracks/rehab-psychology-neuropsychology-track

Veterans Affairs Health Services Research and Development Center of Innovation (COIN):
http://www.houston.hsrd.research.va.gov/

Veterans Affairs Hospital Behavioral Medicine and Geropsychology Research Track:
https://www.bcm.edu/departments/psychiatry-and-behavioral-sciences/education/psychology-internship/tracks/behavioral-medicine-geropsychology-research

Appendix D

BCM Menninger Department of Psychiatry & Behavioral Sciences Psychology Internship Program
Baylor Psychiatry Clinic Outpatient Psychotherapy Supervisor Options
2019-2020

Supervisor Name	Work Phone Number	Office Address	Email Address	Preferred contact method	Preferred supervision times	# interns	Self-Identified Theoretical Orientation	Self-Identified Areas of Expertise
Balick, Lisa	713-666-1354	3400 Bissonnet #282	lisabal@aol.com	Phone	Varies; 8:00-6:00	2	Eclectic, with basis in Psychodynamic Psychotherapy, Self Psychology, CBT, Mindfulness & Stress Management Techniques	eating disorders, chronic illness, loss/grief
Evans-Hudnall, Gina	713-794-8662		ginae@bcm.edu	Email	M-W 10-3	1-2	CBT & solution focused	Multicultural issues, depression, anxiety, adults, tx for co-existing mental & physical health problems & couples counseling
Hundt, Natalie	713-440-4450	VAMC 2002 Holcombe Blvd.	hundt@bcm.edu	Email	M-W 10-3	1	CBT, Motivational Interviewing	PTSD, Anxiety, Depression, Substance Abuse
Kopel, Kenneth	713-665-3100	6759 West Loop South, #1000	drkopel@gmail.com	Phone	Varies	1-2	CBT	medical psychology, panic disorder, marriage and family, hypnotherapy
Lindsay, Jan	713-798-4682	McGovern Campus VAMC (Office #223)	Jan.Lindsay2@va.gov jalindsa@bcm.edu	Email	Mon, Tues	1	CBT, Mindfulness-Based Relapse Prevention, MI	Substance use disorders, telehealth and mobile technologies, combining pharmacotherapy and behavioral therapy
Phelps, Suzi	713-779-0351	Frost Bank Building 6750 West Loop South, #1000 Bellaire, TX 77401	Suzi.Phelps@sbcglobal.net	Phone	8:00-5:00 M, T, Th, F	1	Eclectic, probably with a CBT bent	anxiety and mood d/o, physical trauma, PTSD, chronic pain, families/couples
Margaret Jordan, PhD	713-520-1121	3000 Weslayan, Suite 320 Houston, TX 77027	margjord@aol.com	Phone	Afternoons, but Tuesday morning may be available	1	Psychodynamic	Adult and couples psychotherapy, personality disorders, anxiety disorders

Appendix D - BPC Clinical Supervisor Options

BCM Menninger Department of Psychiatry & Behavioral Sciences Psychology Internship Program
Baylor Psychiatry Clinic Outpatient Psychotherapy Supervisor Options
2019-2020

Supervisor Name	Work Phone Number	Office Address	Email Address	Preferred contact method	Preferred supervision times	# interns	Self-Identified Theoretical Orientation	Self-Identified Areas of Expertise
Balick, Lisa	713-666-1354	3400 Bissonnet #282	lisabal@aol.com	Phone	Varies; 8:00-6:00	2	Eclectic, with basis in Psychodynamic Psychotherapy, Self Psychology, CBT, Mindfulness & Stress Management Techniques	eating disorders, chronic illness, loss/grief
Evans-Hudnall, Gina	713-794-8662		ginae@bcm.edu	Email	M-W 10-3	1-2	CBT & solution focused	Multicultural issues, depression, anxiety, adults, tx for co-existing mental & physical health problems & couples counseling
Hundt, Natalie	713-440-4450	VAMC 2002 Holcombe Blvd.	hundt@bcm.edu	Email	M-W 10-3	1	CBT, Motivational Interviewing	PTSD, Anxiety, Depression, Substance Abuse
Kopel, Kenneth	713-665-3100	6759 West Loop South, #1000	drkopel@gmail.com	Phone	Varies	1-2	CBT	medical psychology, panic disorder, marriage and family, hypnotherapy
Lindsay, Jan	713-798-4682	McGovern Campus VAMC (Office #223)	Jan.Lindsay2@va.gov jalindsa@bcm.edu	Email	Mon, Tues	1	CBT, Mindfulness-Based Relapse Prevention, MI	Substance use disorders, telehealth and mobile technologies, combining pharmacotherapy and behavioral therapy
Phelps, Suzi	713-779-0351	Frost Bank Building 6750 West Loop South, #1000 Bellaire, TX 77401	Suzi.Phelps@sbcglobal.net	Phone	8:00-5:00 M, T, Th, F	1	Eclectic, probably with a CBT bent	anxiety and mood d/o, physical trauma, PTSD, chronic pain, families/couples
Margaret Jordan, PhD	713-520-1121	3000 Weslayan, Suite 320 Houston, TX 77027	margjord@aol.com	Phone	Afternoons, but Tuesday morning may be available	1	Psychodynamic	Adult and couples psychotherapy, personality disorders, anxiety disorders

Appendix E.1. - Research Secondary Rotation Learning Plan

Intern: _____ Training Year: _____

Secondary Rotation Supervisor(s): _____

_____ 12-month rotation

_____ 6-month rotation (specify 1st or 2nd 6 months) _____

Brief Description Research Project(s):

Specific Intern Roles and Responsibilities (include any expectations for location/time of work):

Plan for Supervision:

Expected Research Product(s) Generated by Rotation End (e.g., manuscript, poster, symposium):

Authorship Plan for Research Product(s):

_____ _____

Intern Signature Secondary Rotation Supervisor Signature

_____ _____

Training Director Signature Date Approved

Appendix E.2 - Research Rotation 2019-2020 Options

Tom Baranowski, PhD, *Professor (Pediatrics, Children's Nutrition Research Center)* is interested in children's diet and physical activity especially in regard to adiposity/obesity. He has been PI on studies for innovative measures of diet and physical activity, how diet and physical activity relate to child adiposity, cross sectional studies of predictors of diet and physical activity (including parenting practices), innovative measures of predictors of children's diet and physical activity (including parenting practices), and interventions to change children's diet, physical activity and adiposity. He is currently funded to evaluate two video games to change children's diet and physical activity, develop and test a new video game to change vegetable parenting practices among parents of preschoolers, and develop an innovative measure of diet assessment that combines objective all day photographs of consumption with a computerized self report program. He is willing to involve interns in these projects, and also to discuss possible projects related to any of these funded activities, or on literature reviews or other interests of the interns. Contact Tom at tbaranow@bcm.edu.

Andrea Bradford, Ph.D., *Assistant Professor* (*Gynecologic Oncology and Reproductive Medicine*), is based at the University of Texas MD Anderson Cancer Center where she conducts research on long-term psychosocial adjustment and health behavior in women with cancer. Her current projects aim to better understand (1) the role of brief psychological intervention for young women who are considering fertility preservation prior to cancer treatment; (2) sexual health problems and needs in medically underserved gynecologic cancer survivors; and (3) health care seeking behaviors of long-term gynecologic cancer survivors. Depending on the intern's interests and skills, the rotation may include data collection through chart reviews or patient interviews, qualitative content analysis of interview transcripts, literature review, and/or data analysis. It may be possible to perform a portion of the work off-site. This rotation will provide an opportunity to develop a presentation or a publication. Contact her at ABradford@mdanderson.org.

Jeffrey Cully, Ph.D., *Associate Professor (Psychiatry Research),* has research interests in mental health services research, the application of cognitive-behavioral therapy in primary care and specialty medical settings, measuring and assessing psychotherapy quality, and psychotherapy training and supervision. Current projects include a multi-site trial of CBT for medically ill patients in the VA primary care setting and a study examining a behavioral intervention for rural Veterans with diabetes and depression. A third project is about begin looking at the application of brief CBT for rural and community based outpatient clinics within the VA. The current focus of this research seeks to improve the effectiveness and "uptake" of evidence-based mental health interventions in real world care settings (also known as implementation or dissemination). We are actively examining the use of non-traditional educational and implementation efforts to improve the outreach of mental health treatments as provided by frontline providers. Duties may include on or off-site work at the VA including assistance with grant writing, data collection with patient contact (e.g., telephone assessment calls), data collection and feedback to service providers (e.g. collecting data from primary care mental health clinicians and working with them to learn the CBT intervention), development of clinician online training materials, and manuscript preparation (including authorship potential). Contact him at jcully@bcm.edu.

Michael Davis, M.D., Ph.D., and Jan Lindsay, Ph.D., *Assistant Professors (Psychiatry and*

Behavioral Science) are interested in increasing access to and improving effectiveness of evidence-based treatments for schizophrenia. These include biological treatments such as intranasal oxytocin, pharmacologically-augmented cognitive therapies, and the use of technology to improve treatment delivery. A secondary focus includes understanding the presentation of schizophrenia in special populations, including transgender Veterans and those with comorbid obsessive compulsive disorder. Dr. Davis is developing a VA clinic for optimal treatment of veterans with psychotic disorders, including psychotherapy, and plans to have this clinic function as a platform for research studies. Dr. Lindsay specializes in developing and testing technology-based behavioral interventions and the implementation of evidence-based psychotherapy. Dr. Lindsay is currently Principal Investigator on 3 grant-funded projects focusing on the implementation of evidence-based psychotherapy and the use technology in behavioral interventions. She works closely with Dr. Davis on projects that involve serious mental illnesses. Drs. Davis and Lindsay are willing to involve interns on projects, including secondary analyses of existing datasets (special populations of transgender Veterans and individuals with obsessive compulsive disorder), literature reviews, and clinical trials. Please contact Dr. Davis at mcd1@bcm.edu<mailto:mcd1@bcm.edu> or Dr. Lindsay at jan.lindsay2@va.gov<mailto:jan.lindsay2@va.gov>.

Gina Evans-Hudnall, Ph.D., *Assistant Professor (Medicine-Health Services Research),* focuses on improving chronic disease self-care in underserved and vulnerable populations with co-existing mental illness using evidenced based behavioral RCT interventions. Prior studies and available data sets include: (1) cross sectional analysis of barriers to healthy eating among African American women, (2) pilot study examining the effects of depression and anxiety on stroke self-care among underserved hospital patients, and (3) an ancillary multi-site study that examined the effects of depression and community resource utilization on diabetes self-care among African Americans and Latino groups. We currently have a VA funded three phase research project that examines and decreases barriers to mental and physical health self-care among obese veterans. Participation in this rotation does not require the intern to be on-site. Potential duties will depend upon the intern's prior experience and needs but can include grant writing, data collection, intervention manual development, data analysis, manuscript writing, and provide supervision to bachelor's or master's level students. Contact her at ginae@bcm.tmc.edu.

Beth H. Garland, Ph.D. *Assistant Professor (Pediatrics)* is involved in research centered on eating disorders, obesity/weight management in adolescents, as well as issues surrounding transition-age youth and families in mental health care. Current databases in progress include the investigation of psychopathology across different weight presentations and weight histories, the instruction of medical trainees in motivational interviewing techniques for obesity management, the benefits of a weight management behavioral intervention group for adolescents, the assessment of adolescent motivation for change. The rotation does require at least some on-site time at Texas Children's Hospital, with variation in the amount of on-site time throughout the rotation. Some work would need to be completed on either Wednesdays, Thursdays, or Fridays; however, flexibility with dates and times could be considered. Potential duties include: literature review, data management, data analysis, preparation of posters and manuscripts. Dr. Garland can be contacted at garland@bcm.edu.

Sheryl O. Hughes, Ph.D, *Associate Professor (Pediatrics), Children's Nutrition Research Center*, Baylor College of Medicine, studies parent-child interactions around feeding with an emphasis on problematic interactions that lead to childhood obesity. She is the primary investigator on three federally funded research grants. The NICHD funded project examines general self-regulation and food-specific self-regulation in Hispanic Head Start families with

preschoolers. Of particular interest in this project is gaining a better understanding of how parents either foster or thwart innate self-regulatory abilities in children between the ages of 4 and 7 (in general and in food-specific arenas). A second study funded by USDA is an obesity prevention study targeting internal cues of hunger and fullness in Hispanic and Black low-income families with preschoolers. A third study also funded by USDA adds a parenting component to an existing EFNEP program. Potential duties include working with statisticians at the center and the development of manuscripts for publication. Contact her at shughes@bcm.edu.

Robin Kochel, Ph.D., *Assistant Professor (Pediatrics, Psychology Section)*, conducts research in autism spectrum disorder (ASD). She is the Principal Investigator for two multi-site studies that have collected genetic and clinical data from select families. One project, the Simons Simplex Collection (SSC; https://sfari.org/simons-simplex-collection), focused on families who have a single child with ASD among first- through third-degree relatives. The second project, the Simons Variation in Individuals Project (SVIP; http://simonsvipconnect.org/), conducted in-depth studies (psychological testing, MRI, genetic analysis) on families who have 16p11.2 or 1q21 genetic deletions or duplications. Current research opportunities include use of the SSC/SVIP data to examine (a) risk factors for developmental regression in children with ASD and (b) prevalence of regression in children with select copy number variants (16p, 1q, 15q13.3). All data for each project have already been collected; work would include literature review, possible data entry, dataset organization, statistical analysis, and abstract/manuscript development. Contact her at kochel@bcm.edu<mailto:kochel@bcm.edu>.

Sanjay J. Mathew, M.D, *Associate Professor (Psychiatry & Behavioral Sciences, directs the* Mood Disorders Program, a translational clinical research program aimed at identifying novel therapies for difficult-to-treat mood and anxiety disorders. We conduct early phase, proof-of-concept clinical trials of novel mechanism drugs and study mechanisms underlying therapeutic benefit using neuroimaging, EEG, and other biomarker techniques. We are particularly interested in helping patients achieve sustainable improvements in a more rapid manner than generally observed with current therapies (such as our work with IV ketamine). During 2014-15 academic year, we have ongoing or planned studies in anxious depression, treatment-resistant depression, and PTSD, with funding support from NIH, VA, foundations, and industrial partners. Several of these studies use neuropsychological batteries, and all use standardized assessment [SCID] and rating scales such as MADRS. After the completion of a research protocol, which generally range from 1 week to 6 months in duration, many patients elect to continue treatment, providing the possibility for psychology interns to treat patients in an "open" fashion, as clinically indicated. Groups are also created post-study, for support and/or for specific therapy (i.e., DBT). Work may be on- or off-site with potential duties including data analysis, data collection (SCID ratings, neuropsychological assessment, depression rating scales), and manuscript writing. Contact him at sjmathew@bcm.edu

Bob McLaughlin, PhD, *Dean, School of Allied Health Sciences* and**, Beth Garland, PhD,** *Assistant Professor (Pediatrics)*, specialize in both the clinical service and teaching of Motivational Interviewing (MI) to healthcare professionals across a wide array of disciplines (medicine, physician assistants, psychologists, orthotists and prosthetists). This rotation would require one day of training to be a standardized patient as well as participating as a standardized patient for two half days in the fall for current health care learners; these dates are set and we would work with your placement sites to arrange your attendance. As a standardized patient, a student would also provide structured feedback to learners on MI skills, in an MI format. The remaining time on this rotation is flexible, with some on-site meetings at Main Baylor or Texas Children's Hospital. An intern in this rotation could also become knowledgeable/proficient in the most update video coding system for MI (MITI 4.0). Responsibilities may include literature

searches, video coding, data analysis of quantitative and qualitative student responses, and manuscript preparation, no projects evaluating effectiveness of the training or application of MI skills in specific disciplines of practice. Dr. Garland is the point of contact for this rotation and can be reached for questions at garland@bcm.edu.

Aanand D. Naik, MD, *Associate Professor (Medicine-Health Services Research),* is a medical *geriatrician who studies the psychological burden of chronic morbidities in older adults. This* includes The Veterans Cancer Rehab Study, which enrolls and follows veterans diagnosed with cancer for the psychological, functional, and physical consequences of cancer 6 to 18 months post diagnosis. We are in the data analysis process and writing up our results for publication. Study data includes a wide range of functional, psychological, and social data. Another area of work is the Healthy Outcomes through Patient Empowerment (HOPE) intervention, which involves development and testing of telephone based interventions using psychological coaching methods to improve patient self-management for depression and diabetes. Work on the HOPE Intervention can be done both on and off-site (depending on the duties). Potential duties include screening and recruitment of subjects, collecting subject data and survey assessments, participating as a HOPE coach/interventionalist (requires training and fidelity assessment, communicating with study clinicians), participation in data interpretation, and preparing abstracts and manuscripts. Contact him at anaik@bcm.edu

Rhonda Robert, PhD, *Professor, Behavioral Pediatrics, Clinical Psychology, Children's Cancer Hospital, University of Texas MD Anderson Cancer Center.* The Psychology Section at MD Anderson Children's Cancer Hospital consists of 2 Clinical Psychologists, 2 Master's Clinicians, a Neuropsychologist, and trainees from the University of Houston Clear Lake and Texas A&M University. We are primarily a clinical service and simultaneously engage in scholarly activities and projects. We welcome collaboration with Baylor College of Medicine Pre-Doctoral Psychology Interns who are interested in pediatric psycho-oncology. Project options include 1) writing a review article; 2) collecting data; 3) participating in protocol development, and 4) assessing a performance improvement project. Contact Dr. Robert at rrobert@mdanderson.org

Katrina Rufino, Ph.D, *Assistant Professor, University of Houston - Downtown, Adjunct Assistant Professor (Psychiatry & Behavioral Sciences),* studies cognitive vulnerabilities for suicide and suicidal behaviors, development and testing of assessments designed specifically for patients at risk for suicide, self-report and implicit assessment of suicide risk, and the association between sleep disturbance (including nightmares) and psychopathology. She is primary investigator for study examining mechanisms of change and predictors of post-discharge suicide risk in suicidal psychiatric inpatients at the Menninger Clinic. A particular area of interest is cognitive bias towards suicide. A newer area of study concerns relationships between psychopathology and sleep disturbance, nightmares in particular. Collaboration around projects in which the intern is interested can take place via telephone and email, with occasional visits to the Clinic. Potential duties include analysis of current datasets to address specific hypotheses, compilation and organization of new datasets, background research (e.g., literature reviews) for writing projects, and collaborative writing of manuscripts. Contact her at krufino@menninger.edu.

Carla Sharp, Ph.D., *Professor* and Director of Clinical Training (University of Houston Department of Psychology), is BCM Adjunct Faculty and Principal Investigator on a research project at the Adolescent Treatment Program of the Menninger Clinic. Interns interested in participating in research that focus on the social-cognitive risk factors of psychopathology in adolescents and who rotate at the Menninger Clinic are particularly encouraged to participate.

This rotation requires attending research meetings on Friday mornings at Menninger, making it more practical for the Adult/Adolescent Psychology intern based at Menninger than for other interns. Additional experiences are also available at the University of Houston's Developmental Psychopathology Lab under the direction of Dr. Sharp. Several projects that focus on the interpersonal, attachment, emotion processing and social-cognitive correlates and causes of psychopathology in children and adolescents are available for intern participation. At both the Menninger Clinic and the University of Houston, interns can be involved in manuscript preparation or data management and collection, depending on their skill level and interest. Contact Dr. Sharp at csharp2@uh.edu.

Melinda Stanley, Ph.D., *Professor, Psychiatry and Behavioral Science*, **Ellen Teng, Ph.D.,** *Associate Professor, Psychiatry and Behavioral Science*, **Jan Lindsay, Ph.D.,** *Assistant Professor, Psychiatry and Behavioral Science*, and **Terri Barrera, Ph.D.**, *Assistant Professor, Psychiatry and Behavioral Science*.
This team of psychologists is conducting research to examine the nature of services currently being provided for Veterans with OCD and the resources available and/or needed for VA providers who see these individuals. One ongoing study uses data from the VA National Care Patient Database to examine the frequency of OCD, patterns of comorbidity, and nature of treatment provided to Veterans who are recognized as having OCD. Another study utilizes data from a national survey of VA mental health providers (psychologists, psychiatrists, social workers) that inquired about provider experience and confidence in treating OCD and perceptions of resources available and/or needed to improve care for Veterans with this disorder. Interns interested in participating with this project need to have or obtain 'Without Compensation' (WOC) status with the VA to allow access to project data. Interns could participate in ongoing projects and/or conduct secondary analysis of database or survey data under the supervision of this team. Drs. Stanley, Teng, and Barrera have experience in the assessment and treatment of OCD; Drs. Barrera and Lindsay have experience in the analysis of large datasets within VA. If interested, please contact Dr. Stanley at mstanley@bcm.edu

Lane Strathearn, M.B.B.S., Ph.D. , *Associate Professor of Pediatrics, Neuroscience,* and the Menninger Department of Psychiatry and Behavioral Sciences, and Director of the Attachment and Neurodevelopment Lab at Baylor College of Medicine. The Attachment and Neurodevelopment Lab focuses on understanding how early childhood experience shapes social and neural development, and the role of neurochemicals such as oxytocin in this developmental process. We are particularly interested in studying neurodevelopmental disorders such as autism. The work of the lab includes functional MRI studies of new mothers and infants, including mothers with addiction problems, and a randomized controlled trial of intranasal oxytocin as a possible preventative treatment for maternal neglect. We are also running fully automated eye-tracking experiments in children with autism. Students would be involved in the coordination and running of study visits, processing infant face images and cry audio clips and preprocessing of functional MRI and eye-tracking data. The lab is composed of 3 full-time research coordinators, and part-time undergraduate students. Dr Strathearn is also a developmental pediatrician practicing at The Meyer Center for Developmental Pediatrics, and the Autism Center at Texas Children's Hospital. Students may receive practical experience preparing for and running study visits, as well as preprocessing and analyzing fMRI and eye-tracking data. We hope that this will also result in a poster presentation. Dr. Strathearn can be reached at lanes@bcm.edu.

Adriana M. Strutt, Ph.D., ABPP-CN, *Assistant Professor (Neurology & Psychiatry)* is involved in research investigating cognitive changes following deep brain stimulation for the

treatment of Parkinson's disease, obsessive compulsive disorder and Tourette's syndrome, the cognitive and behavioral changes associated with dementia, frontal-lobe mediated behavioral changes in neurodegenerative disorders and the cross-cultural development and validation of neuropsychological measures for primarily Spanish-speaking adults. Potential duties include: literature review, data collection, data management, data analysis, preparation of posters and manuscripts. A student with some research experience is preferred. A separate writing opportunity (composition of educational articles) is available for a Spanish-speaking student who is able to write such material in Spanish. A strong writing background is preferred. Contact Dr. Strutt at adrianam@bcm.edu.

Ellen Teng, Ph.D., *Assistant Professor (Psychiatry & Behavioral Sciences)*, has research interests in developing innovative cognitive-behavioral treatments for Veterans with anxiety disorders and psychiatric comorbidity. Current projects include: evaluating intensive but brief treatments for anxiety delivered over the weekend; developing a Smartphone application to augment cognitive behavioral interventions for anxiety to promote treatment maintenance; treating comorbid posttraumatic stress disorder and panic simultaneously in a randomized controlled trial; and exploring religious/spiritual struggles returning Veterans experience in a longitudinal study. Training opportunities include conducting clinical assessments, participating in treatment delivery, and collaborating in the preparation of manuscripts and presentations at national conferences. Contact her at eteng@bcm.edu.

Deborah Thompson, PhD, *Associate Professor (Pediatrics)*, focuses on youth obesity prevention through the promotion of healthy diet and physical activity behaviors. Her work can be placed into one of three categories: theory and measurement, health message design, and intervention development and evaluation. Each of these categories utilizes qualitative research to identify and understand the perspective of youth in an effort to ensure that the resulting theoretical models, measurement scales, messages, and interventions are developmentally and culturally appropriate. Her intervention work investigates ways in which technology (e.g., video games, online programs, text messages) can be used to promote healthy diet and physical activity behaviors to youth. Current projects include a study assessing the feasibility of using theoretically-grounded text messages to help parents of 8-10 year old African American girls create a home environment that promotes and supports obesity prevention, a study examining the effect of self-representational avatars on youth physical activity, and a study to translate an efficacious in-person family communication program to an online format. Possible opportunities include analysis of existing datasets, research for grant applications (i.e., literature reviews), assistance in the development of a grant application, participation in team meetings, writing abstracts/manuscripts, or participation in a brief training introducing qualitative methods and techniques. Contact her at dit@bcm.edu

Rebecca Wagner, PhD, *Assistant Professor (Psychiatry & Behavioral Sciences)* is a faculty member at The Menninger Clinic. She is the Principal Investigator on a research project that examines eating disorders as it relates to attachment, suicide, self-harm, and other psychiatric conditions. Interns interested in participating in research focusing on eating disorders and who rotate at The Menninger Clinic are encouraged to participate. This rotation requires research meetings. However, collaboration can also take place by telephone and email. Potential duties include analysis of current datasets, compilation and organization of new datasets, literature reviews and writing portions of manuscripts currently in development. Contact her at rwagner@menninger.edu.

Michele York, Ph.D., ABPP-CN *Associate Professor (Neurology and Psychiatry)* is involved in research projects investigating cognitive rehabilitation for executive functioning in Parkinson's disease, cognitive changes following deep brain stimulation for the treatment of various

movement disorders, the underlying neural substrates of cognitive impairments in Parkinson's disease using neuroimaging, and the cognitive and behavioral changes associated with amyotrophic lateral sclerosis. The rotation requires on-site time at McNair 9th floor or the VA, with variation in the amount of on-site time throughout the rotation and meeting times flexible. Potential duties include literature review, data collection, data analysis, abstract and/or manuscript preparation and potential for presentation. Contact her at myork@bcm.edu.

Appendix F - BCM Affiliate Training Electives

2019-2020 BCM Affiliate Training Electives (subject to change based on availability)

Cross-track training electives are intended as a mechanism for sharing the rich training resources among the different tracks in our program and to offer interns the opportunity to gain exposure to a faculty member or area of interest otherwise not incorporated in routine training experiences. This opportunity is intended to be quite flexible with the goal of expanding the list of available opportunities as new experiences are requested and developed. Additional opportunities may be offered as they arise during the year, but interns are also encouraged to inquire about the potential for developing additional electives other than those listed below.

The Menninger Clinic

Self-Compassion Group - Interns will learn principles of self-compassion and how this translates to work within a group therapy setting. Interns will observe patients engaging in the "Three Chair" approach in a group setting. In the first chair, they describe their problem. In the second chair, they talk to themselves in their critical voices. Finally, in the third chair they try voicing empathy and self-compassion, which is often difficult for them to do and is often a powerful experiential process.

Eating Disorder Track Experience - Interns can observe clinicians assessing and treating patients who struggle with eating disorders. They may choose to learn about the Eating Disorders Inventory (EDI) or observe how the principles of Dialectic Behavior Therapy are tailored to meet the needs of eating disordered patients.

Autism Spectrum Disorder Assessment - Interns will have the opportunity to learn about assessing autism spectrum disorders (ASDs) in adolescents, either by observing administration of the Autism Diagnostic Interview-Revised (ADI-R) or by reviewing an ADI-R in order to gain familiarity with the types of questions that can be helpful to ask parents in the assessment of ASDs.

Therapeutic Assessment - Interns will learn about the basics of the Therapeutic Assessment model created by Stephen Finn, Ph.D. and how elements of the model are applied on the inpatient adolescent unit at the Menninger Clinic. In learning the basics of the model, the intern will be able to discuss a recent adolescent assessment case, review testing data, and discuss how the collaborative assessment informed treatment team conceptualization and the adolescent's care.

Electives Affiliated with Research Rotations or Clinical Supervisors

Behavioral Pediatric Obesity Intervention (Debbe Thompson, Ph.D.; dit@bcm.edu) - Interns will learn about an online behavioral intervention to reduce obesity risk in African American girls. The intern will review theories of behavior change, will participate in a discussion regarding the importance of partnering with the target audience to develop the intervention, and will engage in a discussion about key components of and common challenges in behavior change interventions with children.

Qualitative Research Methods Seminar (Debbe Thompson, PhD; dit@bcm.edu) - Interns will participate in a half day training regarding qualitative research methods that enable a behavioral science researcher to partner with the target audience to develop culturally and developmentally appropriate interventions or measurement surveys.

Other Elective Affiliates available upon request.

Appendix G.1 - Intern Evaluation
PSYCHOLOGY FELLOW EVALUATION FORM

DATE: SUPERVISOR:

INTERN:

EVALUATION PERIOD: July-Sept Oct-Dec Jan-Mar Apr-June (please underline)

EVALUATION PERIOD(S) SUPERVISED: July-Sept Oct-Dec Jan-Mar Apr-June

TRAINING ASSIGNMENT:

SUPERVISION REPORT BASED ON (please underline):
Direct observation, videotape, audiotape, case presentation, review of written work, review of raw test data, discussion of clinical interaction, comments from other staff

RATING KEY

ALL RATINGS ARE BASED ON THE FOLLOWING SCALE:

Rating:	*FAIL*	*CONDITIONAL*	*PASS*	*HIGH*	*HONORS*
	1	2	3	4	5

1 = Fail
2 = Conditional Pass (Specific Remediation REQUIRED; performance below level of training)
3 = Pass (Performance and Recommendations equal to Level of Training)
4 = High Pass (Performance greater than Level of Training)
5 = Honors (Exceptional Performance significantly above Level of Training)

PLEASE NOTE: To meet the requirements of the internship program, an intern receive have a *PASS* rating on ALL criteria, for ALL review periods. If a *PASS* rating is not obtained during any review period, a remedial plan must be developed and implemented in consultation with the Training Director. The remedial plan will outline: (1) the specific goals of the remedial plan, (2) measures to evaluate whether these goals are met, and (3) the time frame within which these goals are expected to be met.

A. ASSESSMENT/DIAGNOSIS/CONSULTATION

	Rating (1-5)
Skillfully conducts clinical interviews	
Effectively makes behavioral observations	
Promptly and proficiently selects and administers tests or assessment procedures in the relevant area of practice	
Accurately scores assessments	
Accurately interprets assessment results	
Bases conclusions on appropriate data (e.g., patient-report, assessment, behavioral observations)	
Thoughtfully considers appropriate differential diagnoses	
Effectively communicates findings in a well-organized written report	
Incorporates mental status exams, clinical interview techniques, or psychological assessments as appropriate to answer referral/consultation questions	

When functioning as a consultant, provides information and recommendations to team members to inform patient care	

Comments:

B. PSYCHOLOGICAL INTERVENTION

	Rating (1-5)
Able to form a therapeutic alliance with patients	
Generates appropriate case conceptualization within a preferred theoretical orientation, while able to draw on other orientations as appropriate	
Able to implement interventions to facilitate patient change	
Able to collaborate with patients in crisis to make appropriate short-term safety plans and intensify treatment as needed	
Demonstrates effort to expand knowledge through reading empirical literature and consultation as appropriate to enhance patient conceptualization and treatment	

Comments:

C. SCHOLARLY INQUIRY

	Rating (1-5)
Adopts a scientifically-minded, evidence-based approach to clinical practice	
Able to critically evaluate professional/empirical writings regarding assessment, diagnosis, and intervention	
Able to skillfully generate research ideas and questions	
Formulates appropriate experimental methods	
Appropriately collects data	
Appropriately analyzes data	
Draws research conclusions substantiated by results	
Clearly communicates research conclusions	

Comments:

D. AWARENESS OF AND SENSITIVITY TO CULTURAL DIVERSITY AND INDIVIDUAL DIFFERENCES

	Rating (1-5)
Demonstrates awareness of own attitudes and limitations regarding clinical practice/research with diverse populations, consulting professional literature or utilizing other professional resources as appropriate	
Demonstrates sensitivity to the potential effect of cultural background, ethnicity, nationality, language, age, gender, sexual orientation, religion, disability, and other aspects of human diversity on clinical practice/research	

Able to skillfully provide psychological services to diverse populations, including those different from oneself	

Comments:

E. ETHICAL & PROFESSIONAL CONDUCT

	Rating (1-5)
Consistently ethical and professional conduct in professional interactions	
Timely and reliable completion of expected patient care tasks	
Timely and reliable completion of other expected training activities (i.e., outside of patient care tasks)	
Regular attendance and active participation in program activities, including didactics and supervision	
Demonstrates positive coping strategies to manage personal and professional stressors so as to maintain professional functioning	
Able to work cooperatively with others, including those with differing points of view	
Ability to appropriately manage or resolve interpersonal differences	
Openness and responsiveness to feedback/constructive criticism in supervision	

Comments:

F. SUPERVISION

	Rating (1-5)
Demonstrates understanding and application of principles of effective supervision	
Able to effectively elicit clarifying information and offer suggestions to peers or supervisees to aid case conceptualization and treatment planning	

Comments:

REMEDIAL PLAN

PLEASE UNDERLINE:

No remedial plan is necessary.

A remedial plan will be developed in consultation with the Training Director.

INTERN
SIGNATURE_____ DATE_____

SUPERVISOR

SIGNATURE____ DATE________________

Appendix G.2 - Supervisor Evaluation Form

SUPERVISOR EVALUATION FORM

Rotation: **Training year:**

Supervisor's Name: **Evaluation Period** ☐1 ☐2 ☐3

Please complete questionnaire evaluating supervisor's skill and performance using the following rating scale (underline): **1 = Outstanding, 2 = Very Good, 3 = Average, 4 = Fair, 5 = Poor, NA = Not Applicable**

A. PROCEDURE, FORMAT, EFFORT	**outstanding 1**	**2**	**average 3**	**4**	**poor 5**	**N/A**
1. Used supervision time productively	☐	☐	☐	☐	☐	☐
2. Knowledge of internship policies, procedures and requirements	☐	☐	☐	☐	☐	☐
3. Kept regular appointments	☐	☐	☐	☐	☐	☐
4. Accessible for informal questions and discussions	☐	☐	☐	☐	☐	☐
5. Set clear supervision objectives and intern responsibilities	☐	☐	☐	☐	☐	☐
6. Used effective aids in supervision	☐	☐	☐	☐	☐	☐
7. Provided feedback on professional performance and development	☐	☐	☐	☐	☐	☐
8. Maintained reasonable expectations for intern's development	☐	☐	☐	☐	☐	☐

B. ASSESSMENT/TREATMENT SKILLS	**outstanding 1**	**2**	**average 3**	**4**	**poor 5**	**N/A**
1. Assisted in case conceptualization	☐	☐	☐	☐	☐	☐
2. Assisted in development of concrete goals	☐	☐	☐	☐	☐	☐
3. Integrated clinical and empirical information during supervision	☐	☐	☐	☐	☐	☐

	outstanding 1	2	average 3	4	poor 5	N/A
4. Assisted in selection of appropriate assessment/intervention strategies	☐	☐	☐	☐	☐	☐
5. Recommended alternative clinical perspectives	☐	☐	☐	☐	☐	☐
6. Recommended appropriate readings and other resources	☐	☐	☐	☐	☐	☐
7. Provided guidance in development of professional relationships	☐	☐	☐	☐	☐	☐
8. Assisted in development of written communication skills to generate meaningful reports and notes	☐	☐	☐	☐	☐	☐
9. Provided guidance in development of adequate skills to evaluate treatment outcomes	☐	☐	☐	☐	☐	☐
10. Provided assistance in learning referral and termination procedures	☐	☐	☐	☐	☐	☐
11. Addressed cultural diversity and individual differences	☐	☐	☐	☐	☐	☐

C. SUPERVISORY RELATIONSHIP

	outstanding 1	2	average 3	4	poor 5	N/A
1. Created environment offering freedom to make mistakes	☐	☐	☐	☐	☐	☐
2. Provided ongoing feedback	☐	☐	☐	☐	☐	☐
3. Provided easily acceptable feedback	☐	☐	☐	☐	☐	☐
4. Challenged intern to expand clinical skills	☐	☐	☐	☐	☐	☐

	outstanding 1	2	3	average 4	poor 5	N/A
5. Respected intern as an emerging professional	☐	☐	☐	☐	☐	☐
6. Exhibited commitment to intern's training	☐	☐	☐	☐	☐	☐
7. Exhibited characteristics of an excellent role model	☐	☐	☐	☐	☐	☐
8. Accurately conceptualized intern's strengths and developmental needs as an emerging psychologist	☐	☐	☐	☐	☐	☐
9. Communicated evaluation of intern's skills in a direct manner	☐	☐	☐	☐	☐	☐
10. Facilitated appropriate level of independence	☐	☐	☐	☐	☐	☐

D. GENERAL COMMENTS

1. What did you most enjoy about the supervision you received?

2. What did you least enjoy about the supervision you received?

3. What suggestions do you have for improving supervision on this rotation?

Appendix G.3- Rotation Evaluation Form

Rotation: _____Training year:_____July-Sept☐ Oct-Dec☐ Jan-June☐

Please complete questionnaire evaluating your primary rotation using the following rating scale:

1 = Outstanding, 2 = Very Good, 3 = Average, 4 = Fair, 5 = Poor, NA = Not Applicable

A. PROCEDURE, FORMAT, EFFORT	**outstanding 1**	**2**	**3**	**average 4**	**poor 5**	**N/A**
1. Breadth of clientele	☐	☐	☐	☐	☐	☐
2. Size of clinical caseload	☐	☐	☐	☐	☐	☐
3. Opportunities to refine individual intervention skills	☐	☐	☐	☐	☐	☐
4. Opportunities to refine couples/family therapy skills	☐	☐	☐	☐	☐	☐
5. Opportunities to refine group therapy skills	☐	☐	☐	☐	☐	☐
6. Opportunities to refine diagnostic interviewing skills	☐	☐	☐	☐	☐	☐
7. Opportunities to learn and refine psychological assessment skills	☐	☐	☐	☐	☐	☐

A. PROCEDURE, FORMAT, EFFORT	**outstanding 1**	**2**	**3**	**average 4**	**poor 5**	**N/A**
8. Integration of science into clinical practice (assessment and intervention)	☐	☐	☐	☐	☐	☐
9. Exposure to ethical issues	☐	☐	☐	☐	☐	☐
10. Exposure to professional issues	☐	☐	☐	☐	☐	☐
11. Opportunities for contact with professionals in related health care fields	☐	☐	☐	☐	☐	☐
12. Ability to clarify professional goals and aspirations	☐	☐	☐	☐	☐	☐
13. Opportunity to develop research and evaluation skills	☐	☐	☐	☐	☐	☐

A. PROCEDURE, FORMAT, EFFORT	**outstanding**		**average**		**poor**	
	1	**2**	**3**	**4**	**5**	**N/A**
14. Interpersonal support from internship staff	☐	☐	☐	☐	☐	☐
15. Professional stimulation from internship environment	☐	☐	☐	☐	☐	☐
16. Staff commitment to training	☐	☐	☐	☐	☐	☐
17. Opportunities to acquire consultation skills	☐	☐	☐	☐	☐	☐
18. Opportunities to acquire supervision skills	☐	☐	☐	☐	☐	☐
19. Opportunities to develop skills in crisis intervention and management	☐	☐	☐	☐	☐	☐
20. Internship staff morale	☐	☐	☐	☐	☐	☐
21. Degree to which intern felt involved with agency functions	☐	☐	☐	☐	☐	☐

A. PROCEDURE, FORMAT, EFFORT	**outstanding**		**average**		**poor**	
	1	**2**	**3**	**4**	**5**	**N/A**
22. Opportunities for exposure to appropriate professional role models	☐	☐	☐	☐	☐	☐
23. Amount of discretionary time available	☐	☐	☐	☐	☐	☐
24. Opportunities to refine assessment and intervention skills with respect to diversity and individual differences	☐	☐	☐	☐	☐	☐

25. What was the most positive experience on this rotation?

26. What was your most negative experience?

27. What suggestions would you make for improvement of this rotation?

Appendix G.4 - Topic Seminar Evaluation Form

PRESENTER: _____ Date: _____

TOPIC: _____

Please rate this seminar from 1 (Strongly Disagree) to 5 (Strongly Agree), on the following:

1. The goals of the seminar were clearly stated.	1	2	3	4	5
2. The goals of the seminar were achieved.	1	2	3	4	5
3. The information presented was new to me.	1	2	3	4	5
4. The material presented was clinically useful.	1	2	3	4	5
5. The presentation included information that was beneficial for my professional growth.	1	2	3	4	5
6. Relevant and recent empirical literature addressed.	1	2	3	4	5
7. The style of the presentation was effective/ interesting/enthusiastic.	1	2	3	4	5
8. Handouts, if provided, were useful. (If no handouts, write N/A)	1	2	3	4	5
9. Participation was encouraged.	1	2	3	4	5
10. The amount of time allotted for the presentation was appropriate.	1	2	3	4	5
11. The information presented was consistent with the topic listing.	1	2	3	4	5
12. I recommend continuation of this presentation for next year.	1	2	3	4	5

Comments:

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INTERN EVALUATION OF THE TRAINING DIRECTOR

Used with permission from Illinois State University

Please rate the Training Director's performance using the scale below:

5 = Excellent – training director performed above and beyond expectations
4 = Very Good
3 = Average
2 = Below Average
1 = Unacceptable – training director performed insufficiently
N/A

Developmental Mentoring Skills

1.	Was reponsive to the needs of the intern group.	1	2	3	4	5
2.	Was responsive to my needs.	1	2	3	4	5
3.	Was skilled in dealing with conflicts And disagreements within the intern cohort.	1	2	3	4	5
4.	Was skilled in offering me constructive feedback.	1	2	3	4	5
5.	Allowed time in intern meeting to address more immediatate concerns or personal issues.	1	2	3	4	5
6.	Appropriately supported my autonomy.	1	2	3	4	5
7.	Supported me in my professional development.	1	2	3	4	5
8.	Was an effective personal mentor.	1	2	3	4	5

Program Administration Skills

1.	Was clear in communicating expectations and responsibilities of interns.	1	2	3	4	5
2.	Presented materials in a timely fashion.	1	2	3	4	5
3.	Was effective as a liaison to other staff in the agency.	1	2	3	4	5
4.	Effectively advocated for interns' needs	1	2	3	4	5
5.	Kept interns apprised of changes within the agency.	1	2	3	4	5

Personal Skills

1. Was flexible and open to feedback.	1	2	3	4	5
2. Is available.	1	2	3	4	5
3. Is supportive/encouraging.	1	2	3	4	5
4. Establishes trusting environment.	1	2	3	4	5
5. Demonstrates appropriate use of power.	1	2	3	4	5
6. Is respectful of diversity/individual differences.	1	2	3	4	5
7. Demonstrates sense of humor.	1	2	3	4	5

Comments:

Appendix G.6 - BCM Affiliate Training Elective Evaluation Form

Name of Intern: _____ Date of Training Experience: _____

Faculty Member Name/Institution: _____

Description of Training Experience: _____

Please rate this training experience from 1 (Strongly Disagree) to 5 (Strongly Agree), on the following:

1. The goals of the training experience were clearly stated.	1	2	3	4	5
2. The goals of the training experience were achieved.	1	2	3	4	5
3. The information presented was new to me.	1	2	3	4	5
4. The material presented was clinically useful.	1	2	3	4	5
5. The training experience included information that was beneficial for my professional growth.	1	2	3	4	5
6. The training experience was effective/ interesting/ enthusiastic.	1	2	3	4	5
7. Handouts, if provided, were useful. (If no handouts, write N/A)	1	2	3	4	5
8. Participation was encouraged.	1	2	3	4	5
9. The amount of time allotted for the training experience was appropriate.	1	2	3	4	5
10. I recommend this training experience for next year.	1	2	3	4	5

Comments:

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Appendix G.7 - Seminar Series Evaluation Form

SEMINAR FACILITATOR: _____ Date: _____

Please rate this seminar from 1 (Strongly Disagree) to 5 (Strongly Agree), on the following:

1. The goals of the seminar were clearly stated.	1	2	3	4	5
2. The goals of the seminar are being achieved.	1	2	3	4	5
3. The seminar has been clinically useful.	1	2	3	4	5
4. The seminar has been beneficial to my professional growth.	1	2	3	4	5
5. Relevant and recent empirical literature addressed.	1	2	3	4	5
6. The style of the seminar has been effective/ interesting/enthusiastic.	1	2	3	4	5
7. Handouts, if provided, have been useful. (If no handouts, write N/A)	1	2	3	4	5
8. Participation was encouraged.	1	2	3	4	5
9. I have felt comfortable making suggestions to the seminar facilitator.	1	2	3	4	5
10. Seminar facilitator has been professional and respectful.	1	2	3	4	5
11. The amount of time allotted for discussion was appropriate.	1	2	3	4	5
12. I recommend that facilitator continues to run the seminar.	1	2	3	4	5

Comments:

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Appendix H.1 - BCM Social Media Policy

Applies to: Faculty, Staff, Residents & Clinical Postdoctoral Fellows, Postdoctoral Fellows, Students

PURPOSE

To address the proper use of various forms of Social Media by College Personnel.

DEFINITION

Social Media: Includes but is not limited to blogs, Facebook, MySpace, Wikipedia, Twitter, LinkedIn, YouTube (and other video sites), Google groups and websites.

POLICY

Baylor College of Medicine supports the use of Social Media by its community members as a way to facilitate communication. This Policy addresses various forms of Social Media. This Policy applies to College Personnel initiating any Social Media feed that involves the College, its schools, departments, programs, groups, organizations and individuals. The policy includes personal networking behavior when individuals might identify themselves as a representative of the College, infer involvement in College programs or initiatives, engage in conduct that would reflect negatively on the College, or use a bcm.edu address in the communication.

Language that is illegal, threatening, infringing of intellectual property rights, invasive of privacy, profane, libelous, harassing, abusive, hateful or otherwise injurious to any person or entity is prohibited and shall be removed. Do not post anything that you would not otherwise post in a public forum - there is no such thing as a private Social Media site and everything you post can live forever. Be professional and respectful at all times when using Social Media. Relationships such as doctor-patient, faculty-student, and supervisor-subordinate merit close scrutiny in the Social Media world. Use good ethical judgment when posting and follow all College policies and all applicable laws/regulations such as, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA). Physicians and those who interact with patients should follow the guidelines promulgated by the American Medical Association. Do not post anything that would do harm to the College, its personnel, patients, or any patients treated by College faculty, staff or learners at any of the College affiliated hospital partners. When you might be perceived as an agent of the College, make it clear in your postings that you are not representing the position of the College. If you use any College trademark or logo, add a disclaimer that the posting may not necessarily reflect the views and positions of the College.

In the event of a violation of this Policy, the College will take whatever corrective action is necessary to protect the integrity of the institution itself and its research and clinical projects and enterprises. In addition, it may at its discretion impose penalties upon the violator. The penalties for such violations may range from reprimand, suspension, to termination, and may depend upon the severity of the violation and what can be known about the intentions of the violator.

The Office of Communications oversees the College Social Media presence and authorizes all Social Media sites representing the College. The use of Social Media is recognized as an important way to generate relationships, and the Office of Communication will help departments, labs, programs and individuals develop Social Media messages to support their work while maintaining professional standards and upholding policies. See policies, best practices and guidelines: http://intranet.bcm.edu/?tmp=/pa/socialmedia

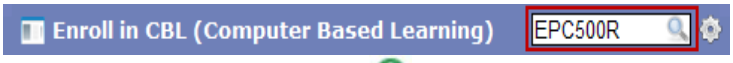
Epic and HIPAA Training for Residents/Fellows

BCM policy states that all residents and fellows must successfully complete Epic and HIPAA training prior to receiving Epic access.

Epic Training Information

In order to satisfy the Epic training requirement, all residents and fellows must complete the ***EPC500R–EpicCare for Residents and Fellows*** module.

1. Log in to myNetLearning at http://netlearn.bcm.edu with your BCM **Username** and **Password**. ***NOTE****: The preferred web browser is* ***Internet Explorer*** *and if you are accessing myNetLearning remotely, you must connect to BCM's VPN first at https://vpn.bcm.edu.*
2. From the **Enroll in CBL (Computer Based Learning)** section, a list of available online courses displays. To search, enter ***EPC500R*** in the **Keyword Search** field, and then click the **Search** icon .



3. Click the **green plus sign** to the left of the course titled ***EPC500R - EpicCare for Residents and Fellows***.
4. From the **Enroll in Course** window, click **Enroll**.
5. From the **Confirm Enroll** dialog box, click **Enroll.**
6. From the **Launch Course** screen, click **launch course** to view the module.
7. Once you have reviewed all required lessons (1-4), you will be able to complete the EPC500R assessment. To begin the assessment, click **Complete**.
8. A pop-up window displays, which includes instructions for completing the assessment. Click the **Take Test** button to close the course window and return to myNetLearning. ***NOTE: If you do not close the course window, the assessment will not be available.***
9. Click **take test** .
10. Click the **Click here to proceed** link.
11. There are 20 questions on the assessment. Once all questions have been answered, click **Grade Test**.
12. Click **Grade** to submit your exam for grading. ***NOTE: You must score an 80% or higher on the EPC500R assessment.***

HIPAA Training Information

In order to satisfy the HIPAA training requirement, all residents and fellows must complete the **Privacy and Security (HIPAA)** module.

1. Navigate to the AMP Corporate Training web site at https://corporatetraining.bcm.edu and log in with your BCM account.
2. Select the **Privacy and Security (HIPAA)** module. ***NOTE****: If you do not see this course, contact ampsupport@bcm.edu to request course to be loaded.*
3. When you have completed reviewing the course/training material, click **Course Completion** to complete the assessment.
4. Email proof of your completion to your **Clinical Delegate of Authority (CDA)** or supervisor. Acceptable forms of proof are a screenshot of the score or a scanned copy of the transcript. Your CDA will not be able to submit your Epic request until **Privacy and Security (HIPAA)** training is completed.

Requesting Epic Access

All requests for Epic access must be submitted by an Epic **Clinical Delegate of Authority (CDA)** on behalf of the user requiring access. The CDA may be the administrator or clinic manager in your department. Please check with your CDA to ensure the Epic access request process has been initiated. The CDA will not be able to submit the Epic request until **Privacy and Security (HIPAA)** training is completed.

Appendix H.3 - TMC Library

The Texas Medical Center is home to the largest concentration of medical professional and experts anywhere in the world. Collectively, the Texas Medical Center is the largest employer in Houston. The most recent figures show that there are currently 50,000 life science students studying at TMC institutions, and 5,700 researchers, with an additional 17,500 faculty who educate the next generation of health professionals. The Library plays a vital role for the institutions inhabiting the 1,345 square acre campus that is the TMC.

The TMC Library is one of the 56 institutions that make up the Texas Medical Center. Unique to medical and research libraries across the country, the TMC Library is a private, stand-alone and not-for-profit 501(c)3 organization independent from any university or research institution. Approximately 65,000 visitors walk through the Library doors annually.

As the only organization in the TMC serving all other member institutions, the Library is the most inclusive and collaborative space on campus. We provide a depth and breadth of electronic resources that rival other medical libraries, and we do so as cost efficiently as possible. We are a quiet space for study, and provide communal space for people to come together on neutral ground.

The TMC Library is located at 1133 John Freeman Blvd., conveniently situated between the two major medical schools on the TMC campus, and employs a full-functioning administrative and executive staff. The Library operates under a Dba as the The TMC Library.

Hours

The Texas Medical Center Library
1133 John Freeman Blvd.
Houston, TX 77030
713.795.4200

Day	Open	Closes
Monday – Thursday	7:00 a.m.	10:00 p.m.
Friday	7:00 a.m.	9:00 p.m.
Saturday	9:00 a.m.	5:00 p.m.
Sunday	1:00 p.m.	8:00 p.m.

Appendix I.1 - Paul Baer Research Award Self-Nomination Form

Intern Name:

Date:

Please list and describe your contributions to the following research activities. Please provide complete citations. For each citation, please provide a brief description of your role(s) and specify which aspects of the work occurred during internship year. If an item does not apply to you, simply respond with N/A.

1. Research projects that you worked on during the internship year. Please list and briefly describe research projects you participated in during the internship year. Be explicit about your role in the research (e.g. data analyses, clinical assessments, recruitment, etc.).

2. Peer-reviewed publications accepted for publication during the internship year.

3. Manuscripts currently under review for peer-reviewed publication.

4. Book chapters accepted for publication during the internship year.

5. Non-peer reviewed publications accepted for publication during the internship year.

6. Oral research presentations at meetings or conferences during the internship year.

7. Research posters presented at meetings or conferences during the internship year.

8. Conference abstracts published in conference proceedings during the internship year.

9. Grants or fellowships obtained during the internship year. Please specify your role (e.g., PI, co-investigator, collaborator), funding source, amount of funding received, and which aspects of the work occurred during internship year.

10. Grants or fellowships applied for during the internship year, regardless of whether or not your application has yet been successful. Please specify your role (e.g., PI, co-investigator, collaborator), funding source, amount of funding requested, and which aspects of the work occurred during internship year.

11. Research prizes or awards received during the internship year.

12. IRB proposals submitted during the internship year. Please list these and describe your role in submitting the proposals.

13. Reviewing manuscripts for peer-reviewed journals during the internship year. Please list the journals and number of manuscripts reviewed for each.

14. Unique research training you received during the internship year (e.g. new data analytic techniques, the use of equipment, etc.).

15. Please list any other research contributions during the internship year that you deem relevant.

16. Please provide comments describing your approach to integrating science and practice during the internship year.

Appendix I.2 - Intern Professionalism Clinical Excellence Award Nomination Form

Intern Nominee:

Nominator & Relationship to Nominee:

Date:

A strong candidate for the Psychology Intern Professionalism Award goes above and beyond expectations in terms of:

1. Professional behavior (e.g., excellent working relationships with supervisors, support staff and colleagues; conscientiousness in meeting work demands; timeliness in meetings and tasks; meticulous paperwork, etc.).
2. Ethical behavior (e.g., awareness of ethical principles and their application, attentive to confidentiality, sensitivity to the rights of clients, etc.).
3. Responsiveness to work community needs and willingness to volunteer when unusual needs arise.
4. Respect and compassion for clients.
5. Clinical case load and service provision (e.g., seeing extra patients, going "above and beyond" in service provision).
6. Clinical expertise (e.g., clinical skill above and beyond what is expected) and initiative to seek out information when a case presents outside area of expertise.

In general, this individual should be someone we all would be proud to represent us as an example of a psychologist.

Using the descriptions above, please rate the intern nominee in each of the following areas and provide examples and comments for each rating:

1. **Professional behavior**

1	2	3	4	5
Performing below what is expected		Performing at expected level		Performing well above what is expected

Comments:

2. **Ethical behavior**

1	2	3	4	5
Performing below what is expected		Performing at expected level		Performing well above what is expected

Comments:

3. **Responsiveness to work community needs**

1	2	3	4	5
Performing below what Is expected		Performing at expected level		Performing well above what is expected

Comments:

4. **Respect and compassion for clients**

1	2	3	4	5
Performing below what is expected		Performing at expected level		Performing well above what is expected

Comments:

5. **Clinical case load and service provision**

1	2	3	4	5
Performing below what is expected		Performing at expected level		Performing well above what is expected

Comments:

6. **Clinical expertise**

1	2	3	4	5
Performing below what is expected		Performing at expected level		Performing well above what is expected

Comments:

Appendix I.3 - Faculty Award Nomination Form

Training year:

Intern Nominating:

Faculty Nominee:

Training Role (Primary Site, Secondary Rotation, BPC Supervisor):

Please rate the extent to which the nominee exhibited these characteristics using the following rating scale: **5 = Outstanding, 4 = Very Good, 3 = Average, 2 = Fair, 1 = Poor, NA = Not Applicable:**

	poor 1	2	average 3	4	outstanding 5	N/A
1. Accessible for informal questions and discussions	☐	☐	☐	☐	☐	☐
2. Helped shape professional performance and development	☐	☐	☐	☐	☐	☐
3. Integrated clinical and empirical information during professional encounters	☐	☐	☐	☐	☐	☐
4. Provided guidance in development of professional relationships	☐	☐	☐	☐	☐	☐
5. Addressed cultural diversity and individual differences	☐	☐	☐	☐	☐	☐
6. Challenged intern to expand clinical and/or research skills	☐	☐	☐	☐	☐	☐
7. Respected intern as an emerging professional	☐	☐	☐	☐	☐	☐
8. Exhibited commitment to intern's training	☐	☐	☐	☐	☐	☐
9. Exhibited characteristics of an excellent role model	☐	☐	☐	☐	☐	☐

GENERAL COMMENTS

1. What did you most enjoy about interacting/working with the nominee?

2. What contributions to your training/experience/professional development did the nominee make during your internship year?

3. What character traits does the nominee have that make him/her a good candidate for this award?

4. In what ways do you feel the nominee went “above and beyond” what is typically expected of a mentor in this role?

Additional comments:

AMERICAN PSYCHOLOGICAL ASSOCIATION

ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT

Adopted August 21, 2002
Effective June 1, 2003
(With the 2010 Amendments
to Introduction and Applicability
and Standards 1.02 and 1.03,
Effective June 1, 2010)

With the 2016 Amendment
to Standard 3.04
Adopted August 3, 2016
Effective January 1, 2017

ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT

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AMENDMENTS TO THE 2002 "ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT" IN 2010 AND 2016

INTRODUCTION AND APPLICABILITY

The American Psychological Association's (APA's) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the Ethics Code) consists of an Introduction, a Preamble, five General Principles (A-E), and specific Ethical Standards. The Introduction discusses the intent, organization, procedural considerations, and scope of application of the Ethics Code. The Preamble and General Principles are aspirational goals to guide psychologists toward the highest ideals of psychology. Although the Preamble and General Principles are not themselves enforceable rules, they should be considered by psychologists in arriving at an ethical course of action. The Ethical Standards set forth enforceable rules for conduct as psychologists. Most of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context. The Ethical Standards are not exhaustive. The fact that a given conduct is not specifically addressed by an Ethical Standard does not mean that it is necessarily either ethical or unethical.

This Ethics Code applies only to psychologists' activities that are part of their scientific, educational, or professional roles as psychologists. Areas covered include but are not limited to the clinical, counseling, and school practice of psychology; research; teaching; supervision of trainees; public service; policy development; social intervention; development of assessment instruments; conducting assessments; educational counseling; organizational consulting; forensic activities; program design and evaluation; and administration. This Ethics Code applies to these activities across a variety of contexts, such as in person, postal, telephone, Internet, and other electronic transmissions. These activities shall be distinguished from the purely private conduct of psychologists, which is not within the purview of the Ethics Code.

Membership in the APA commits members and student affiliates to comply with the standards of the APA Ethics Code and to the rules and procedures used to enforce them. Lack of awareness or misunderstanding of an Ethical Standard is not itself a defense to a charge of unethical conduct.

The procedures for filing, investigating, and resolving complaints of unethical conduct are described in the current Rules and Procedures of the APA Ethics Committee. APA may impose sanctions on its members for violations of the standards of the Ethics Code, including termination of APA membership, and may notify other bodies and individuals of its actions. Actions that violate the standards of the Ethics Code may also lead to the imposition of sanctions on psychologists or students whether or not they are APA members by bodies other than APA, including state psychological associations, other professional groups, psychology boards, other state or federal agencies, and payors for health services. In addition, APA may take action against a member after his or her conviction of a felony, expulsion or suspension from an affiliated state psychological association, or suspension or loss of licensure. When the sanction to be imposed by APA is less than expulsion, the 2001 Rules and Procedures do not guarantee an opportunity for an in-person hearing, but generally provide that complaints will be resolved only on the basis of a submitted record.

The Ethics Code is intended to provide guidance for psychologists and standards of professional conduct that can be applied by the APA and by other bodies that choose to adopt them. The Ethics Code is not intended to be a basis of civil liability. Whether a psychologist has violated the Ethics Code standards does not by itself determine whether the psychologist is legally liable in a court action, whether a contract is enforceable, or whether other legal consequences occur.

The American Psychological Association's Council of Representatives adopted this version of the APA Ethics Code during its meeting on August 21, 2002. The Code became effective on June 1, 2003. The Council of Representatives amended this version of the Ethics Code on February 20, 2010, effective June 1, 2010, and on August 3, 2016, effective January 1, 2017. (see p. 16 of this pamphlet). Inquiries concerning the substance or interpretation of the APA Ethics Code should be addressed to the Office of Ethics, American Psychological Association, 750 First St. NE, Washington, DC 20002-4242. This Ethics Code and information regarding the Code can be found on the APA website, http://www.apa.org/ethics. The standards in this Ethics Code will be used to adjudicate complaints brought concerning alleged conduct occurring on or after the effective date. Complaints will be adjudicated on the basis of the version of the Ethics Code that was in effect at the time the conduct occurred.

The APA has previously published its Ethics Code, or amendments thereto, as follows:

American Psychological Association. (1953). *Ethical standards of psychologists.* Washington, DC: Author.

American Psychological Association. (1959). Ethical standards of psychologists. *American Psychologist, 14*, 279-282.

American Psychological Association. (1963). Ethical standards of psychologists. *American Psychologist, 18*, 56-60.

American Psychological Association. (1968). Ethical standards of psychologists. *American Psychologist, 23*, 357-361.

American Psychological Association. (1977, March). Ethical standards of psychologists. *APA Monitor*, 22-23.

American Psychological Association. (1979). *Ethical standards of psychologists.* Washington, DC: Author.

American Psychological Association. (1981). Ethical principles of psychologists. *American Psychologist, 36*, 633-638.

American Psychological Association. (1990). Ethical principles of psychologists (Amended June 2, 1989). *American Psychologist, 45*, 390-395.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47*, 1597-1611.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*, 1060-1073.

American Psychological Association. (2010). 2010 amendments to the 2002 *"Ethical Principles of Psychologists and Code of Conduct." American Psychologist, 65*, 493.

American Psychological Association. (2016). Revision of ethical standard 3.04 of the *"Ethical Principles of Psychologists and Code of Conduct"* (2002, as amended 2010). *American Psychologist, 71*, 900.

Request copies of the APA's Ethical Principles of Psychologists and Code of Conduct from the APA Order Department, 750 First St. NE, Washington, DC 20002-4242, or phone (202) 336-5510.

The modifiers used in some of the standards of this Ethics Code (*e.g., reasonably, appropriate, potentially*) are included in the standards when they would (1) allow professional judgment on the part of psychologists, (2) eliminate injustice or inequality that would occur without the modifier, (3) ensure applicability across the broad range of activities conducted by psychologists, or (4) guard against a set of rigid rules that might be quickly outdated. As used in this Ethics Code, the term *reasonable* means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time.

In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code in addition to applicable laws and psychology board regulations. In applying the Ethics Code to their professional work, psychologists may consider other materials and guidelines that have been adopted or endorsed by scientific and professional psychological organizations and the dictates of their own conscience, as well as consult with others within the field. If this Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner in keeping with basic principles of human rights.

PREAMBLE

Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work.

This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.

The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.

GENERAL PRINCIPLES

This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

Principle A: Beneficence and Nonmaleficence

Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

Principle B: Fidelity and Responsibility

Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

Principle C: Integrity

Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of

psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

Principle D: Justice

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.

Principle E: Respect for People's Rights and Dignity

Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

ETHICAL STANDARDS

1. Resolving Ethical Issues

1.01 Misuse of Psychologists' Work

If psychologists learn of misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.03 Conflicts Between Ethics and Organizational Demands

If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.04 Informal Resolution of Ethical Violations

When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved. (See also Standards 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority, and 1.03, Conflicts Between Ethics and Organizational Demands.)

1.05 Reporting Ethical Violations

If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations, or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when psychologists have been retained to review the work of another psychologist whose professional conduct is in question. (See also Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority.)

1.06 Cooperating with Ethics Committees

Psychologists cooperate in ethics investigations, proceedings, and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they address any confidentiality issues. Failure to cooperate is itself an ethics violation. However, making a request for deferment of adjudication of an ethics complaint pending the outcome of litigation does not alone constitute noncooperation.

1.07 Improper Complaints

Psychologists do not file or encourage the filing of ethics complaints that are made with reckless disregard for or willful ignorance of facts that would disprove the allegation.

1.08 Unfair Discrimination Against Complainants and Respondents

Psychologists do not deny persons employment, advancement, admissions to academic or other programs, tenure, or promotion, based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.

2. Competence

2.01 Boundaries of Competence

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

2.02 Providing Services in Emergencies

In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.

2.03 Maintaining Competence

Psychologists undertake ongoing efforts to develop and maintain their competence.

2.04 Bases for Scientific and Professional Judgments

Psychologists' work is based upon established scientific and professional knowledge of the discipline. (See also Standards 2.01e, Boundaries of Competence, and 10.01b, Informed Consent to Therapy.)

2.05 Delegation of Work to Others

Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. (See also Standards 2.02, Providing Services in Emergencies; 3.05, Multiple Relationships; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.02, Use of Assessments; 9.03, Informed Consent in Assessments; and 9.07, Assessment by Unqualified Persons.)

2.06 Personal Problems and Conflicts

(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.

(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties. (See also Standard 10.10, Terminating Therapy.)

3. Human Relations

3.01 Unfair Discrimination

In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.

3.02 Sexual Harassment

Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist's activities or roles as a psychologist, and that either (1) is unwelcome, is offensive, or creates a hostile workplace or educational environment, and the psychologist knows or is told this or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts. (See also Standard 1.08, Unfair Discrimination Against Complainants and Respondents.)

3.03 Other Harassment

Psychologists do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons' age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

3.04 Avoiding Harm

(a) Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

(b) Psychologists do not participate in, facilitate, assist, or otherwise engage in torture, defined as any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person, or in any other cruel, inhuman, or degrading behavior that violates 3.04a.

3.05 Multiple Relationships

(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

(b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See also Standards 3.04, Avoiding Harm, and 3.07, Third-Party Requests for Services.)

3.06 Conflict of Interest

Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.

3.07 Third-Party Requests for Services

When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality. (See also Standards 3.05, Multiple relationships, and 4.02, Discussing the Limits of Confidentiality.)

3.08 Exploitative Relationships

Psychologists do not exploit persons over whom they have supervisory, evaluative or other authority such as clients/patients, students, supervisees, research participants, and employees. (See also Standards 3.05, Multiple Relationships; 6.04, Fees and Financial Arrangements; 6.05, Barter with Clients/Patients; 7.07, Sexual Relationships with Students and Supervisees; 10.05, Sexual Intima-

cies with Current Therapy Clients/Patients; 10.06, Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients; 10.07, Therapy with Former Sexual Partners; and 10.08, Sexual Intimacies with Former Therapy Clients/Patients.)

3.09 Cooperation with Other Professionals

When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately. (See also Standard 4.05, Disclosures.)

3.10 Informed Consent

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

3.11 Psychological Services Delivered to or Through Organizations

(a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.

(b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.

3.12 Interruption of Psychological Services

Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement or by the client's/patient's relocation or financial limitations. (See also Standard 6.02c, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work.)

4. Privacy and Confidentiality

4.01 Maintaining Confidentiality

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)

4.02 Discussing the Limits of Confidentiality

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

4.03 Recording

Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing with Informed Consent for Research; and 8.07, Deception in Research.)

4.04 Minimizing Intrusions on Privacy

(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.

(b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.05 Disclosures

(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements.)

4.06 Consultations

When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard 4.01, Maintaining Confidentiality.)

4.07 Use of Confidential Information for Didactic or Other Purposes

Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients, or other recipients of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or organization has consented in writing, or (3) there is legal authorization for doing so.

5. Advertising and Other Public Statements

5.01 Avoidance of False or Deceptive Statements

(a) Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal resumes or curricula vitae, or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations, and published materials. Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated.

(b) Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings.

(c) Psychologists claim degrees as credentials for their health services only if those degrees (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which they practice.

5.02 Statements by Others

(a) Psychologists who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.

(b) Psychologists do not compensate employees of press, radio, television, or other communication media in return for publicity in a news item. (See also Standard 1.01, Misuse of Psychologists' Work.)

(c) A paid advertisement relating to psychologists' activities must be identified or clearly recognizable as such.

5.03 Descriptions of Workshops and Non-Degree-Granting Educational Programs

To the degree to which they exercise control, psychologists responsible for announcements, catalogs, brochures, or advertisements describing workshops, seminars, or other non-degree-granting educational programs ensure that they accurately describe the audience for which the program is intended, the educational objectives, the presenters, and the fees involved.

5.04 Media Presentations

When psychologists provide public advice or comment via print, Internet, or other electronic transmission,

they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

5.05 Testimonials

Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence.

5.06 In-Person Solicitation

Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this prohibition does not preclude (1) attempting to implement appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services.

6. Record Keeping and Fees

6.01 Documentation of Professional and Scientific Work and Maintenance of Records

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also Standard 4.01, Maintaining Confidentiality.)

6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work

(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. (See also Standards 4.01, Maintaining Confidentiality, and 6.01, Documentation of Professional and Scientific Work and Maintenance of Records.)

(b) If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice. (See also Standards 3.12, Interruption of Psychological Services, and 10.09, Interruption of Therapy.)

6.03 Withholding Records for Nonpayment

Psychologists may not withhold records under their control that are requested and needed for a client's/patient's emergency treatment solely because payment has not been received.

6.04 Fees and Financial Arrangements

(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.

(b) Psychologists' fee practices are consistent with law.

(c) Psychologists do not misrepresent their fees.

(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible. (See also Standards 10.09, Interruption of Therapy, and 10.10, Terminating Therapy.)

(e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment. (See also Standards 4.05, Disclosures; 6.03, Withholding Records for Nonpayment; and 10.01, Informed Consent to Therapy.)

6.05 Barter with Clients/Patients

Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (See also Standards 3.05, Multiple Relationships, and 6.04, Fees and Financial Arrangements.)

6.06 Accuracy in Reports to Payors and Funding Sources

In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standards 4.01, Maintaining Confidentiality; 4.04, Minimizing Intrusions on Privacy; and 4.05, Disclosures.)

6.07 Referrals and Fees

When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer-employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself. (See also Standard 3.09, Cooperation with Other Professionals.)

7. Education and Training

7.01 Design of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program. (See also Standard 5.03, Descriptions of Workshops and Non-Degree-Granting Educational Programs.)

7.02 Descriptions of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

7.03 Accuracy in Teaching

(a) Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements. (See also Standard 5.01, Avoidance of False or Deceptive Statements.)

(b) When engaged in teaching or training, psychologists present psychological information accurately. (See also Standard 2.03, Maintaining Competence.)

7.04 Student Disclosure of Personal Information

Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

7.05 Mandatory Individual or Group Therapy

(a) When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program. (See also Standard 7.02, Descriptions of Education and Training Programs.)

(b) Faculty who are or are likely to be responsible for evaluating students' academic performance do not themselves provide that therapy. (See also Standard 3.05, Multiple Relationships.)

7.06 Assessing Student and Supervisee Performance

(a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.

(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

7.07 Sexual Relationships with Students and Supervisees

Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority. (See also Standard 3.05, Multiple Relationships.)

8. Research and Publication

8.01 Institutional Approval

When institutional approval is required, psychologists provide accurate information about their research proposals and obtain approval prior to conducting the research. They conduct the research in accordance with the approved research protocol.

8.02 Informed Consent to Research

(a) When obtaining informed consent as required in Standard 3.10, Informed Consent, psychologists inform participants about (1) the purpose of the research, expect-

ed duration, and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants' rights. They provide opportunity for the prospective participants to ask questions and receive answers. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing with Informed Consent for Research; and 8.07, Deception in Research.)

(b) Psychologists conducting intervention research involving the use of experimental treatments clarify to participants at the outset of the research (1) the experimental nature of the treatment; (2) the services that will or will not be available to the control group(s) if appropriate; (3) the means by which assignment to treatment and control groups will be made; (4) available treatment alternatives if an individual does not wish to participate in the research or wishes to withdraw once a study has begun; and (5) compensation for or monetary costs of participating including, if appropriate, whether reimbursement from the participant or a third-party payor will be sought. (See also Standard 8.02a, Informed Consent to Research.)

8.03 Informed Consent for Recording Voices and Images in Research

Psychologists obtain informed consent from research participants prior to recording their voices or images for data collection unless (1) the research consists solely of naturalistic observations in public places, and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm, or (2) the research design includes deception, and consent for the use of the recording is obtained during debriefing. (See also Standard 8.07, Deception in Research.)

8.04 Client/Patient, Student, and Subordinate Research Participants

(a) When psychologists conduct research with clients/patients, students, or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation.

(b) When research participation is a course requirement or an opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities.

8.05 Dispensing with Informed Consent for Research

Psychologists may dispense with informed consent only (1) where research would not reasonably be assumed to create distress or harm and involves (a) the study of normal educational practices, curricula, or classroom management methods conducted in educational settings; (b) only anonymous questionnaires, naturalistic observations, or archival research for which disclosure of responses would not place participants at risk of criminal or civil liability or damage their financial standing, employability, or reputation, and confidentiality is protected; or (c) the study of factors related to job or organization effectiveness conducted in organizational settings for which there is no risk to participants' employability, and confidentiality is protected or (2) where otherwise permitted by law or federal or institutional regulations.

8.06 Offering Inducements for Research Participation

(a) Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation.

(b) When offering professional services as an inducement for research participation, psychologists clarify the nature of the services, as well as the risks, obligations, and limitations. (See also Standard 6.05, Barter with Clients/Patients.)

8.07 Deception in Research

(a) Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study's significant prospective scientific, educational, or applied value and that effective nondeceptive alternative procedures are not feasible.

(b) Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.

(c) Psychologists explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data. (See also Standard 8.08, Debriefing.)

8.08 Debriefing

(a) Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.

(b) If scientific or humane values justify delaying or withholding this information, psychologists take reasonable measures to reduce the risk of harm.

(c) When psychologists become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.

8.09 Humane Care and Use of Animals in Research

(a) Psychologists acquire, care for, use, and dispose of animals in compliance with current federal, state, and local laws and regulations, and with professional standards.

(b) Psychologists trained in research methods and experienced in the care of laboratory animals supervise all procedures involving animals and are responsible for ensuring appropriate consideration of their comfort, health, and humane treatment.

(c) Psychologists ensure that all individuals under their supervision who are using animals have received instruction in research methods and in the care, maintenance, and handling of the species being used, to the extent appropriate to their role. (See also Standard 2.05, Delegation of Work to Others.)

(d) Psychologists make reasonable efforts to minimize the discomfort, infection, illness, and pain of animal subjects.

(e) Psychologists use a procedure subjecting animals to pain, stress, or privation only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.

(f) Psychologists perform surgical procedures under appropriate anesthesia and follow techniques to avoid infection and minimize pain during and after surgery.

(g) When it is appropriate that an animal's life be terminated, psychologists proceed rapidly, with an effort to minimize pain and in accordance with accepted procedures.

8.10 Reporting Research Results

(a) Psychologists do not fabricate data. (See also Standard 5.01a, Avoidance of False or Deceptive Statements.)

(b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

8.11 Plagiarism

Psychologists do not present portions of another's work or data as their own, even if the other work or data source is cited occasionally.

8.12 Publication Credit

(a) Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed. (See also Standard 8.12b, Publication Credit.)

(b) Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Mere possession of an institutional position, such as department chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are acknowledged appropriately, such as in footnotes or in an introductory statement.

(c) Except under exceptional circumstances, a student is listed as principal author on any multiple-authored article that is substantially based on the student's doctoral dissertation. Faculty advisors discuss publication credit with students as early as feasible and throughout the research and publication process as appropriate. (See also Standard 8.12b, Publication Credit.)

8.13 Duplicate Publication of Data

Psychologists do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.

8.14 Sharing Research Data for Verification

(a) After research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release. This does not preclude psychologists from requiring that such individuals or groups be responsible for costs associated with the provision of such information.

(b) Psychologists who request data from other psychologists to verify the substantive claims through reanalysis may use shared data only for the declared purpose. Requesting psychologists obtain prior written agreement for all other uses of the data.

8.15 Reviewers

Psychologists who review material submitted for presentation, publication, grant, or research proposal review respect the confidentiality of and the proprietary rights in such information of those who submitted it.

9. Assessment

9.01 Bases for Assessments

(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on informa-

tion and techniques sufficient to substantiate their findings. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

(b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations. (See also Standards 2.01, Boundaries of Competence, and 9.06, Interpreting Assessment Results.)

(c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

9.02 Use of Assessments

(a) Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

(b) Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.

(c) Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues.

9.03 Informed Consent in Assessments

(a) Psychologists obtain informed consent for assessments, evaluations, or diagnostic services, as described in Standard 3.10, Informed Consent, except when (1) testing is mandated by law or governmental regulations; (2) informed consent is implied because testing is conducted as a routine educational, institutional, or organizational activity (e.g., when participants voluntarily agree to assessment when applying for a job); or (3) one purpose of the testing is to evaluate decisional capacity. Informed consent includes an explanation of the nature and purpose of the assessment, fees, involvement of third parties, and limits of confidentiality and sufficient opportunity for the client/patient to ask questions and receive answers.

(b) Psychologists inform persons with questionable capacity to consent or for whom testing is mandated by law or governmental regulations about the nature and purpose of the proposed assessment services, using language that is reasonably understandable to the person being assessed.

(c) Psychologists using the services of an interpreter obtain informed consent from the client/patient to use that interpreter, ensure that confidentiality of test results and test security are maintained, and include in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, discussion of any limitations on the data obtained. (See also Standards 2.05, Delegation of Work to Others; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.06, Interpreting Assessment Results; and 9.07, Assessment by Unqualified Persons.)

9.04 Release of Test Data

(a) The term *test data* refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of *test data.* Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also Standard 9.11, Maintaining Test Security.)

(b) In the absence of a client/patient release, psychologists provide test data only as required by law or court order.

9.05 Test Construction

Psychologists who develop tests and other assessment techniques use appropriate psychometric procedures and current scientific or professional knowledge for test design, standardization, validation, reduction or elimination of bias, and recommendations for use.

9.06 Interpreting Assessment Results

When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations. (See also Standards 2.01b and c, Boundaries of Competence, and 3.01, Unfair Discrimination.)

9.07 Assessment by Unqualified Persons

Psychologists do not promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision. (See also Standard 2.05, Delegation of Work to Others.)

9.08 Obsolete Tests and Outdated Test Results

(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.

(b) Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

9.09 Test Scoring and Interpretation Services

(a) Psychologists who offer assessment or scoring services to other professionals accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use.

(b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations. (See also Standard 2.01b and c, Boundaries of Competence.)

(c) Psychologists retain responsibility for the appropriate application, interpretation, and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.

9.10 Explaining Assessment Results

Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance.

9.11 Maintaining Test Security

The term *test materials* refers to manuals, instruments, protocols, and test questions or stimuli and does not include *test data* as defined in Standard 9.04, Release of Test Data. Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

10. Therapy

10.01 Informed Consent to Therapy

(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)

(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.)

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

10.02 Therapy Involving Couples or Families

(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained. (See also Standard 4.02, Discussing the Limits of Confidentiality.)

(b) If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such as family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately. (See also Standard 3.05c, Multiple Relationships.)

10.03 Group Therapy

When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality.

10.04 Providing Therapy to Those Served by Others

In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential client's/patient's welfare. Psychologists discuss these issues with the client/patient or another legally authorized person on behalf of the client/patient in order to minimize the risk of confusion and conflict, consult with the other service providers when appropriate, and proceed with caution and sensitivity to the therapeutic issues.

10.05 Sexual Intimacies with Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with current therapy clients/patients.

10.06 Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.

10.07 Therapy with Former Sexual Partners

Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies.

10.08 Sexual Intimacies with Former Therapy Clients/Patients

(a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.

(b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5) the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient. (See also Standard 3.05, Multiple Relationships.)

10.09 Interruption of Therapy

When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient. (See also Standard 3.12, Interruption of Psychological Services.)

10.10 Terminating Therapy

(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.

(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.

(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.

AMENDMENTS TO THE 2002 "ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT" IN 2010 AND 2016

2010 Amendments

Introduction and Applicability

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner. ~~If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing authority~~ in keeping with basic principles of human rights.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. ~~If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority,~~ Under no circumstances may this standard be used to justify or defend violating human rights.

1.03 Conflicts Between Ethics and Organizational Demands

If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and ~~to the extent feasible, resolve the conflict in a way that permits adherence to the Ethics Code.~~ take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

2016 Amendment

3.04 Avoiding Harm

(a) Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

(b) Psychologists do not participate in, facilitate, assist, or otherwise engage in torture, defined as any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person, or in any other cruel, inhuman, or degrading behavior that violates 3.04a.

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750 First Street, NE
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www.apa.org

Printed in the United States of America

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02.2.01 - Academic Freedom

Human Resources: Academic Freedom, Affirmative Action & Equal Employment

Date: 07/11/2005

Last Update: 07/11/2005

Applies to: Faculty, Staff, Residents & Clinical Postdoctoral Fellows, Postdoctoral Fellows, Students

Baylor College of Medicine endorses and encourages the rights and obligations of its faculty with regard to academic freedom. Academic freedom in the discourse between teachers and students is essential to the pursuit of knowledge and truth. Faculty members, trainees, and staff are entitled to the free pursuit of scholarship and research, including publication, within the confines of legal and regulatory constraints and Baylor College of Medicine policy. Faculty also have the freedom to express their personal ideas and opinions in public forums as long as there is the clear representation that the ideas and opinions do not necessarily reflect those of Baylor College of Medicine. Faculty should state that their opinions are not reflective of the institution, unless they are designated to speak for the College.

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02.2.10 - Affirmative Action

Human Resources: Academic Freedom, Affirmative Action & Equal Employment

Date: 08/01/1993

Last Update: 08/16/2004

Applies to: Faculty,Staff,Residents & Clinical Postdoctoral Fellows,Postdoctoral Fellows

PURPOSE

To state the commitment of Baylor College of Medicine to equal employment opportunity and to define the responsibilities of the Affirmative Action Program.

POLICY

Baylor College of Medicine is committed to ensuring equal opportunity for all qualified persons without taking into account race, color, national origin, creed, sex, sexual orientation, ancestry, age, veteran status or disability unrelated to job requirements.

Baylor College of Medicine's Affirmative Action Program shall reaffirm and guarantee that equal opportunity is applied to all personnel actions, including but not limited to recruitment, hiring, promotion, demotion, transfer, layoff, and training.

Additionally, the Affirmative Action Program is designed to correct any employment practices that may cause the exclusion of protected classes from Baylor College of Medicine's workforce.

RESPONSIBILITY

The Vice President for Human Resources is designated as the Affirmative Action Officer and is responsible for planning, coordinating, and monitoring the program with the assistance of the Director of Employee Relations and Regulatory Compliance.

While the Vice President for Human Resources is responsible for implementing and monitoring this program, all personnel with administrative assignments share in this responsibility and will be expected to carry out specific tasks in support of this College wide program.

Employees and/or applicants who have questions concerning Baylor College of Medicine's Affirmative Action Program may visit the Department of Human Resources, Room BCM-T105, from 8:00 a.m. - 5:00 p.m., Monday through Friday.

RESOURCES

Executive Order 11246
Title VII of the Civil Rights Act of 1964
Title IX of the Education Amendments of 1972
Rehabilitation Act of 1973
Vietnam Era Veterans Readjustment Assistance Act of 1974

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02.2.30 - Disability

Human Resources: Academic Freedom, Affirmative Action & Equal Employment

Date: 08/01/1992

Last Update: 10/20/2015

Applies to: Faculty, Staff, Residents & Clinical Postdoctoral Fellows, Postdoctoral Fellows

PURPOSE

To define the College's responsibilities under the Americans with Disabilities Act of 1990 (ADA) and the Rehabilitation Act of 1973.

POLICY

(1) Baylor College of Medicine does not discriminate against qualified individuals on the basis of physical or mental disability in recruiting, advertising, interviewing, hiring, promoting, compensating (including benefits), assigning, demoting, terminating, or in any other aspect of employment. The College does not (i) use standards or methods of administration that are not job related or are not consistent with a valid business purpose, or (ii) enter into contracts that have the effect of discriminating on the basis of disability or perpetuate such discrimination. The College is committed to taking affirmative action to recruit, hire, train, develop, and promote qualified individuals with disabilities and to make reasonable accommodation for their unique needs.

(2) As required by the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, Baylor College of Medicine will make reasonable accommodation for individuals with disabilities employed at the College. The College prohibits unlawful recruitment and hiring practices that operate against the interest of an integrated workforce that includes individuals with disabilities.

Definitions

(1) Disability is defined as a "physical or mental impairment that substantially limits one or more of the major life activities of such individuals, having a record or such an impairment; or being regarded as having such an impairment."

(2) Qualified individual with a disability is defined "as an individual with a disability who with or without reasonable accommodation, can perform the essential functions of the employment position" that such individual holds or desires.

(3) Reasonable accommodation may include making existing facilities used by employees readily accessible to and usable by individuals with disabilities; job restructuring; modifying work schedules; acquiring or modifying equipment or devices; adjusting or modifying examinations, training materials and policies; providing qualified readers or interpreters; and other reasonable accommodations

for persons with disabilities, provided that making such accommodation does not constitute an undue hardship for Baylor.

GUIDELINES

(1) Generally, in maintaining a proper work environment, supervisors must:

(a) give consideration to qualified applicants and employees with known disabilities;

(b) be conscious both of the sensitivities and of the unique needs of individuals with disabilities;

(c) periodically review personnel records of all employees in the departments to determine the availability of promotable and transferable qualified individuals, including those with known disabilities; and

(d) determine if the present and potential skills of such individuals are being fully utilized and developed.

(2) Prior to advertising a job position or interviewing applicants for an available position; supervisors must, in accordance with guidance provided by Human Resources, prepare a written detailed job description outlining:

(a) the general duties required of the position available;

(b) the purpose of the position available; and

(c) the essential function(s) required of the position available that take into account:
(i) the supervisor's judgment as to which functions are essential;
(ii) the amount of time spent on performing the essential functions;
(iii) the consequences of not requiring the incumbent to perform the essential functions;
(iv) the degree of expertise or skill needed to perform the essential functions; and
(v) the past work experience of both past and current incumbents in the job or in similar jobs.

(3) Supervisors must, in properly considering all qualified candidates for a position, secure the assistance of Human Resources in the following areas:

(a) Determining whether a qualified person has a disability and whether they qualify for reasonable accommodation under the ADA since these are difficult questions that should be discussed by experts in the field;

(b) Determining what constitutes a "reasonable accommodation" since the ADA excludes accommodations that are denied justifiably because:

(i) of legitimate, nondiscriminatory reason(s),
(ii) of reason(s) shown to be job-related and consistent with business necessity and such performance cannot be accomplished with reasonable accommodation,
(iii) the accommodation poses a direct threat to the health or safety of the individual or others in the workplace,
(iv) the requested or necessary accommodations imposes an undue hardship on the employer, or
(v) the accommodations are prohibited by other federal laws.

(c) Consulting with Human Resources as to the proper steps in determining when and how to request reasonable accommodation.

(d) Determining when medical examinations are appropriate and how these medical records should be handled since the records must not be included in the individuals personnel file.

(e) Determining whether the utilization of selection criteria, including tests and other screening mechanisms for candidates for the job, comply with the law.

(4) In furtherance of this policy, supervisors follow the guidelines listed below:

(a) Supervisors are required to complete the Recruitment/Interview Report whenever an applicant is considered for employment. This form must be returned to the Employment Division, Human Resources.

(b) All promotions received by employees with a known disability must be documented appropriately and sent to the Affirmative Action Manager, Human Resources, for record keeping.

(c) Human Resources must ensure that medical examination results of all employees are separate from all other employment and related records.

(d) Supervisors must send to the Affirmative Action Manager a copy of all requests for reasonable accommodations including the supervisors response to such request.

(e) The Affirmative Action Manager must provide each department administrator with a confidential annual report of employees in their department with disabilities.

(5) Once a supervisor determines that an applicant with a known disability is a qualified individual which can perform the essential functions of the available position, the supervisor should:

(a) meet with the qualified individual with a known disability to discuss the purpose and essential functions of the particular position available;

(b) consult with the qualified disabled individual to ascertain the precise job related limitation(s) that could occur in the available position, and whether and how he/she could be reasonably accommodated;

(c) identify potential reasonable accommodations which the employer can make and assess the effectiveness that each accommodation would have in enabling the individual to perform the essential functions of the position; and

(d) consider the preference of the qualified individual to be accommodated, then select and request the accommodation that is reasonable for the employer and appropriate for the individual.

Recourse

(1) Should a request for accommodation be deemed unreasonable by the department supervisor, he/she must advise the Affirmative Action Manager in writing. The Affirmative Action Manager shall then convene the Reasonable Accommodation Subcommittee of the Affirmative Action Committee to review the denial of the accommodation request.

This Subcommittee includes the Affirmative Action Manager, Vice President for Legal Affairs, an Affirmative Action Committee member with a disability, and other Affirmative Action Committee members. The Subcommittee shall make a recommendation regarding the request. The recommendation will then be presented to the supervisor and the department chair. If the employee with a disability is not satisfied with the decision of the department chair, that person can utilize the formal grievance procedures of the College applicable to the candidate for the position.

(2) An employee with a disability who feels discriminated against in promotion, compensation (including benefits), assignment, demotion, or termination, can file an internal complaint with the Affirmative Action Manager. If the Affirmative Action Manager cannot resolve the matter to the satisfaction of the employee the grievance procedure of the College is also available.

RESOURCES

Americans with Disabilities Act of 1990
Rehabilitation Act of 1973

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02.2.40 - Diversity

Human Resources: Academic Freedom, Affirmative Action & Equal Employment

Date: 01/23/2013

Last Update: 09/08/2014

Applies to: Faculty, Staff, Residents & Clinical Postdoctoral Fellows, Postdoctoral Fellows, Students

Baylor College of Medicine fosters diversity among its students, trainees, faculty, and staff as a prerequisite to accomplishing our institutional mission and setting standards for excellence in training healthcare providers and biomedical scientists, promoting scientific innovation, and providing patient-centered care.

- Diversity, respect, and inclusiveness create an environment that is conducive to academic excellence, and strengthens our institution by increasing talent, encouraging creativity, and ensuring a broader perspective.
- Diversity helps position Baylor to reduce disparities in health and healthcare access and to better address the needs of the community we serve.
- Baylor is committed to recruiting and retaining outstanding students, trainees, faculty, and staff from diverse backgrounds by providing a welcoming, supportive learning environment for all members of the Baylor community.

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23.1.07 - Student Disability Policy

Students & Learners: Student Services

Date: 06/22/2015

Last Update: 05/27/2015

Applies to: Faculty, Staff, Students

RATIONALE

Baylor College of Medicine (BCM) is committed to providing equal educational access for qualified students with disabilities in accordance with state and federal laws including the Americans with Disabilities Act of 1990, as amended in 2008, and Section 504 of the Rehabilitation Act of 1973. To effectuate equal access for students with disabilities, this policy formalizes BCM criteria for requesting reasonable accommodations, defines parameters for consideration of such requests, and outlines procedures for appeal.

STAKEHOLDERS AFFECTED BY THIS POLICY

Compliance with this policy is mandatory for applicants and students enrolled in all BCM degree-granting programs and certificate programs, and for BCM administration and faculty responsible for implementing and managing educational program technical requirements for admission in accordance with accreditation standards as well as state and federal laws.

DEFINITIONS

Auxiliary Aids and Services: Accommodations that assist students with disabilities in the educational setting will be determined on a case by case basis based upon the individual's documented disability and the technical requirements of the educational program.

Disability: A person that has a physical or mental impairment which substantially limits one or more major life activities, or a record of such impairment.

Disability Coordinator: Official within the Office of Student Services designated by BCM who is responsible for the coordination of requests for student accommodations. The Coordinator is responsible for reviewing and making recommendations for reasonable accommodations within the academic unit; the recommendations will be in compliance with the state and federal law and will be reasonable in the context of the technical standards of the student's educational program.

Qualified student with a disability: A student with a documented disability who, with or without reasonable modifications and accommodations, meets the essential eligibility requirements and requisite academic and technical standards required for admission and participation in the educational program and activities.

Reasonable Accommodations: A modification or adjustment to a course, program, or activity that enables a qualified individual with a disability to have full and equal enjoyment of the education and training offered by BCM and demonstrate an acceptable level of competency. What constitutes a reasonable accommodation will be determined on a case-by-case basis. Requests for modifications to course or program requirements that are essential to completion of graduation competencies, or which relate directly to licensing requirements will not generally be regarded as reasonable modifications.

POLICY

In selecting students and monitoring their progress through the curriculum, the faculty of the Schools of Medicine, Biomedical Sciences, Tropical Medicine, and Allied Health Sciences are guided by standards set by the Commission on Colleges of the Southern Association of Colleges and Schools, the Liaison Committee on Medical Education, Council on Accreditation of Nurse Anesthesia Educational Programs, Accreditation Review Commission on Education for the Physician Assistant, and the National Commission on Prosthetic and Orthotic Education. BCM policies are guided by the provisions of the Americans with Disabilities Act (ADA).

Though education and training of students in medicine, M.D./Ph.D. and allied health professions is the faculty's primary responsibility, the faculty is equally cognizant of its responsibilities to patients as part of the educational process, and to future patients who entrust their welfare and lives to BCM graduates. The faculty must therefore carefully consider the personal and emotional characteristics, motivation, industry, maturity, resourcefulness, and personal health of each aspiring health care provider.

Guided by the AAMC's Special Advisory Panel on Technical Standards for Medical School Admission (1979, 1993) and other applicable accreditation agencies, a qualified candidate for the M.D. degree and/or Allied Health degree must possess each technical ability and skill described herein for the six essential areas, with or without the provision of reasonable accommodations. Although exceptions may be considered depending on the program of study and other relevant factors, the faculty of the Graduate School of Biomedical Sciences also endorses these six areas as optimal for the training of future scientists. Candidates unable to meet these eligibility requirements with or without reasonable accommodation cannot be considered qualified individuals with a disability under Title III of the ADA or Section 504 of the Rehabilitation Act. Consequently, BCM is not required to provide auxiliary aids or services, nor to modify its policies or procedures to effectuate equal access for those unqualified candidates pursuant to applicable laws. The privilege to enroll and remain enrolled in the medicine, M.D./Ph.D. and allied health programs is contingent upon each student's ability to demonstrate and build upon the skills described below. Specific programs may have technical standards in addition to those listed in this policy; please refer to the program student handbook for detailed information. The six essential areas are detailed as follows:

1. **Observation:** Students must be able to observe demonstrations and experiments in the basic sciences. Students must be able to observe a patient accurately at a distance and close at hand. Observation necessitates the functional use of the sense of vision and somatic sensation. It is enhanced by the functional use of the sense of smell.
2. **Communication:** Students should be able to speak, to receive information in oral form, and to observe patients in order to elicit information, to describe changes in mood, activity and posture, and to perceive non-verbal communications. Students must be able to communicate effectively with patients. Communication includes not only speech, but also reading and writing. Students must be able to communicate effectively, efficiently, and rapidly, when required, in oral and written form with patients and with all members of the health care team.
3. **Motor:** Students should have sufficient motor function to elicit information from patients by palpation, auscultation, percussion, and other diagnostic maneuvers. Students should be able to execute motor movements reasonably required to provide general care and emergency treatment to patients within the specified scope of practice. Examples of emergency treatment reasonably required of physicians and healthcare providers include but are not limited to cardiopulmonary resuscitation, administration of intravenous medication, application of pressure to stop bleeding, opening of obstructed airways, suturing of a simple wound, and performance of simple obstetrical maneuvers.
4. **Intellectual-Conceptual, Integrative and Quantitative Abilities:** Students must be able to demonstrate ability in measurement, calculation, reasoning, analysis, synthesis and problem solving. Students must possess the intellectual, integrative and quantitative abilities to carry out these responsibilities independently.
5. **Behavioral and Social Attributes:** Students must possess the emotional health required for full utilization of their intellectual abilities, the exercise of good judgment, the prompt completion of all responsibilities attendant to the diagnosis and care of patients, and the development of mature, sensitive, and effective relationships with patients. Students must be

able to tolerate physically taxing workloads and to function effectively under stress. They must be able to adapt to changing environments, to display flexibility and to learn to function in the face of uncertainties and ambiguities inherent in the clinical problems of many patients. Compassion, integrity, concern for others, interpersonal skills, interest and motivation are all personal qualities that should be assessed during the admissions and education processes.

6. **Ethical Standards:** Students must demonstrate professional demeanor and behavior, and must perform in an ethical manner in all dealing with peers, faculty, staff and patients.

A qualified candidate with a disability who meets these standards with or without reasonable accommodation may receive an offer of admission to BCM. The Disability Coordinator will work with enrolled students and other BCM personnel to determine the functional challenges imposed by the documented disability, and determine which auxiliary aids and services and/or modifications to BCM practices or procedures constitute reasonable accommodation under the totality of the circumstances. Although what constitutes a "reasonable accommodation" will be determined on a case-by-case basis, the use of a trained intermediary to observe, interpret information, and/or perform technical procedures is deemed intrinsically unreasonable. Such activities overlap with the functional skills required to demonstrate technical competency in each essential area outlined above, and are so inextricably integral to the clinical and scientific decision-making skills that BCM requires. BCM establishes this rule to prioritize the safety of the patient, emphasize the importance of complete information gathering through reliable and independent means, and maintain curricular integrity.

Newly accepted and currently enrolled students are responsible for initiating a disability-related request for reasonable accommodation or modification no less than 30 business days prior to the start of the course for which accommodation is requested. Requests received less than 30 days before the course begins will be reviewed in line with other requests, which may delay implementation of any approved accommodation or modification.

Prospective students may request information about the process for initiating a disability-related request for reasonable accommodation or modification from the Disability Coordinator in the Office of Student Services at any time during the application process. Students who have been offered admission should submit the request for accommodation promptly, before or shortly after accepting the offer of admission, in all cases at least 30 days before classes begin. Requests are processed on an ongoing basis; however, delays in implementation may occur based upon the nature of the request.

RESPONSIBILITIES

Office of Student Services: The Disability Coordinator

The Office of Student Services is the primary responsible office for policy implementation, but relies on the Offices of Compliance to investigate allegations of noncompliance with this policy, and on the Office of Human Resources to implement disciplinary action. The Disability Coordinator is the designated official within the Office of Student Services responsible for determining and coordinating appropriate accommodations and/or auxiliary aids and services for qualified prospective, newly admitted, or currently enrolled students. Any questions about College compliance with these rules and policies should be directed to the Disability Coordinator. The Disability Coordinator is the primary contact and reports to the Associate Provost of Student Services in the Office of Student Services. BCM's Disability Coordinator engages personnel to prioritize BCM compliance with its obligations regarding disability non-discrimination and accommodation. Accommodations are implemented through collaboration with responsible parties, academic units and the Student Disability Committee.

Other responsibilities of the Disability Coordinator include:

1. Determine what type of documentation is necessary to establish a student's level of disability and its impact on the student's access to educational opportunities and benefits of enrollment at BCM. This is accomplished in coordination with the Student Disability Committee, which has representation from four academic units (GSBS, SAHS, SOM, NSTM) and assists with the implementation of approved accommodation requests.
2. Perform initial review and processing of all requests for accommodations according to state and federal law and the institution's policies,

3. Triage student reports of alleged harassment or discrimination, and transmit to Human Resources for subsequent investigation;
4. For accommodations involving national board examinations or examinations administered external to BCM, submit documentation to the outside entity 90 days prior to the exam date, although timely submission of documentation is ultimately the student's responsibility. Additionally, the Disability Coordinator serves as a resource and assists students and academic advisors by providing instructions and timelines for the licensure application process.
5. Determine the need for a second professional opinion concerning the nature or severity of a student's requested accommodation. If the total cost of obtaining a second opinion exceeds student insurance coverage, BCM will assume responsibility for the balance.
6. Conduct an annual review of the implementation process with the assistance of the Student Disability Committee.
7. Generate an annual report containing accommodation requests, approvals, denials, appeals and resolutions for submission to the Office of the Provost, the Office of Compliance, and the Vice President of Human Resources.
8. In addition to academic issues, coordinate non-academic issues with other entities (i.e., TMC Parking) including access to facilities and non-academic events.

Office of Compliance

The Office of Compliance will be notified if members of staff, faculty, or administration fail to comply with this policy. The Office of Compliance will take appropriate steps to investigate all reports of potential noncompliance with this policy, and will recommend disciplinary action where appropriate.

Office of Human Resources

The Office of Human Resources is responsible for managing the Dispute Resolution Process, as described in this policy under "Procedures for Implementation and Management." The VP of Human Resources will be responsible for implementing any disciplinary actions recommended by the Office of Compliance.

PROCEDURES FOR IMPLEMENTATION AND REVIEW

The Disability Coordinator will work in collaboration with the Chairperson of the Student Disability Committee to monitor accommodation requests, approvals and denials as well as progress of implementation. The Office of Student Services will work collaboratively with the Offices of Compliance and Human Resources to effectuate equal access for qualified students with documented disabilities. Due to the collaborative nature of implementation, information about a student's disability including requests for accommodation and supporting documentation will be kept strictly confidential, except that it may be shared with parties participating in the determination of disability and/or implementation of an accommodation/modification, such as experts consulted about accommodation requests, faculty members and other BCM personnel responsible for ensuring a safe and accessible learning environment. To preserve confidentiality, Student Disability Committee members will review only de-identified student disability documentation.

I. Determination of Disability

1. The Disability Coordinator will determine whether accommodation or auxiliary aids or services are appropriate following an individual assessment of a student's written documentation and a private meeting with the student. Factors to be considered in determining the reasonableness of requested accommodations, auxiliary aids and services include but are not limited to:

    a. The nature of the student's disability,
    b. Accommodations, auxiliary aids and/or services that have worked for the student in the past,
    c. Whether the requested accommodation, auxiliary aides and/or services will allow the student to effectively access and participate in the course or academic program, and

d. Whether the requested accommodation, auxiliary aids and/or services will fundamentally alter the essential requirements of the course or program.

2. BCM is not required to modify a course or academic program if doing so would fundamentally alter the nature of that course or program. Decisions regarding reasonable accommodation, auxiliary aids and/or services may require consultation with BCM's Student Disability Committee, faculty and/or administrators to consider the fundamental nature of a course or academic program.

II. Notification of Findings

The Disability Coordinator will provide a student with written notice regarding the determination of disability and any approved accommodations or modifications within ten (10) business days of receiving the request for accommodation. If a student's request requires additional consideration beyond the ten (10) business day timeframe, the Disability Coordinator will provide the student with written notice within ten (10) business days of the status of the request and the proposed date for a final determination.

III. Implementation of Reasonable Accommodation(s)

Some accommodations, such as auxiliary aids and services, may be approved and provided directly through the Office of Student Services. Other accommodations may require cooperation from faculty members teaching courses in which students are enrolled.

The Disability Coordinator will work with the student's course director to implement an approved accommodation and/or modification. The course director may not disclose the student's disability to any other student or faculty member without the student's consent. Faculty members may not deny an approved accommodation without consulting the Disability Coordinator to consider alternate means to accommodate a student's disability.

IV. Implementation of Reasonable Modification(s)

1. A student with a documented disability may request a modification of certain generally applicable academic requirements through timely submission of a request to the Disability Coordinator. Once the need is identified, the student must provide current documentation of the disability and a statement describing the requested modification and the basis for the request. BCM does not cover costs associated with producing or compiling initial documentation.

2. The Disability Coordinator verifies the disability is adequately documented by current information consistent with BCM requirements for documentation of a disability.

3. The Disability Coordinator then performs an individualized assessment of the student's request, including:
    a. The nature of the disability and the relationship to the requested modification.
    b. Whether the requested modification will provide the student with equal educational access; and
    c. Whether the requested modification would fundamentally alter the essential requirements or standards, or would change the fundamental nature of the program.

4. The Disability Coordinator will provide written notice of a decision to the student within ten (10) business days of receiving request. The deadline may be extended for just cause. If the request is denied, the notice will include the reason for the decision.

5. A student who disagrees with a decision on the modification of academic requirements may seek Informal or Formal Resolution regarding the decision of the Disability Coordinator.

V. Dispute Resolution & Student Appeals

A student requesting a reasonable accommodation and/or modification may seek dispute resolution in accordance with the procedures below if the student believes the approved accommodation does not facilitate full and equal enjoyment of the education and training benefits offered by BCM. Two types of dispute resolution are available, and the VP of Human Resources or designee will serve as the arbitrator. Students are required to invoke the informal dispute resolution process prior to seeking formal dispute resolution.

a. **Informal Dispute Resolution** –Within ten (10) business days of receiving notice from the Disability Coordinator or of any perceived failure to provide reasonable accommodation or modification, a student may seek informal dispute resolution through the Disability Coordinator. If the Disability Coordinator cannot reach agreement with the student to resolve the concerns informally, the Disability Coordinator will notify the student in writing, copying the Office of Human Resources, stating that the dispute remains unresolved and that the student may proceed with formal dispute resolution if desired.

b. **Formal Dispute Resolution** – A student may formally petition for an appeal in writing. The student must submit the petition for appeal to the VP of Human Resources or designee within fifteen (15) business days of the end of the informal dispute resolution process, as signified by the date of notice to the Office of Human Resources. Petitions for appeal must include:

    i. The original request and all supporting documentation,
    ii. A copy of the "notice of the decision" issued by the Student Disability Committee and/or Disability Coordinator, and
    iii. A statement of the basis for the alleged lack of access to full and equal enjoyment of BCM education and training benefits, which must describe why the approved accommodation or modification does not facilitate such access and be made on grounds other than the general dissatisfaction with the decision.

c. As the ultimate evaluator, the VP of Human Resources or designee (hereafter "Evaluator") will review the petition for appeal submitted by the student. The Evaluator has the discretion to interview the student, Disability Coordinator, any faculty member(s) involved and any other person deemed relevant under the circumstances. Anyone selected for an interview has a good faith duty to be candid and cooperate fully with the Evaluator, who will issue a final decision and notify the student and Disability Coordinator within fifteen (15) business days of receiving the petition. The decision of the VP of Human Resources or designee will be final. The process for appeal of a decision for modification of academic requirements will supplant all other appeal procedures provided in this policy or any other grievance procedure related to request for accommodations. The Evaluator will consider:

    i. Whether the proper criteria and facts were considered by the Disability Coordinator and/or Student Disability Committee or whether improper or extraneous facts or criteria were considered that substantially affected the decision maker to the detriment of the student,
    ii. Whether any procedural irregularities substantially affected the outcome of the decision to the detriment of the student, and
    iii. Whether the decision was reasonable given the proper facts, criteria and procedure.

VI. Schedule for Policy Review & Update

This policy shall be reviewed and revised as necessary, but at least every 2 years, or more frequently based on changes to applicable law or needs identified by senior leadership.

STAKEHOLDER COMPLIANCE

Applicants and Students enrolled in BCM degree-granting and/or certificate programs

Students must provide timely, relevant, and complete written documentation of a disability for which accommodation is requested. Students must also submit timely requests for reasonable accommodation or modification, and the request should occur no less than 30 business days prior to the start of the course. Written documentation must include:

1. A diagnostic statement from an appropriate professional identifying the disability, date of the current diagnostic evaluation and the date of the original diagnosis. The diagnostic statement must also contain the date of the last clinical visit, which must not be more than six months prior to the date of the letter;

2. A description of the current functional impact of the disability;

3. Treatments, medications, assistive devices or services currently prescribed;

4. A description of any functional limitation with and without assistive devices including the professional's opinion on how this would affect the student's ability to function in a clinic or research environment appropriate to the student's curriculum; and

5. The relevant credentials of the diagnosing professional(s), such as medical specialty and professional licensure.

Any costs related to producing or compiling this initial documentation will be the responsibility of the student and/or applicant. Students who fail to meet the requirements for written documentation and/or deadlines for submission will face delayed implementation of any approved reasonable accommodations or modifications.

RELATED POLICIES

Code of Conduct

APPLICABLE LAWS, REGULATIONS & STANDARDS

Section 504 of the Rehabilitation Act of 1973;

1991 Americans with Disabilities Act (ADA) & 2008 Amendments to the ADA;

AAMC Special Advisory Panel on Technical Standards for Medical School Admission, approved by the AAMC Executive Council on January 18, 1979; Medical Students with Disabilities: A Generation of Practice (AAMC 2005).

Baylor College of Medicine

GIVING LIFE TO POSSIBLE

Diversity and Inclusion Policies

Baylor College of Medicine Diversity and Inclusion Policy

Baylor College of Medicine fosters diversity among its students, trainees, faculty and staff as a prerequisite to accomplishing our institutional mission, and setting standards for excellence in training healthcare providers and biomedical scientists, promoting scientific innovation, and providing patient-centered care.

- Diversity, respect, and inclusiveness create an environment that is conducive to academic excellence, and strengthens our institution by increasing talent, encouraging creativity, and ensuring a broader perspective.
- Diversity helps position Baylor to reduce disparities in health and healthcare access and to better address the needs of the community we serve.
- Baylor is committed to recruiting and retaining outstanding students, trainees, faculty and staff from diverse backgrounds by providing a welcoming, supportive learning environment for all members of the Baylor community.

Diversity and Inclusion Related Policies (Baylor login required)

- Diversity and Inclusion Policy **<https://intranet.bcm.edu/index.cfm?fuseaction=Policies.Display_Policy&Policy_Number=02.2.40>**
- Academic Freedom Policy **<https://intranet.bcm.edu/index.cfm?fuseaction=Policies.Display_Policy&Policy_Number=02.2.01>**
- Affirmative Action and Equal Employment Opportunity Policy **<https://intranet.bcm.edu/index.cfm?fuseaction=Policies.Display_Policy&Policy_Number=02.2.10>**
- Disability Policy **<https://intranet.bcm.edu/index.cfm?fuseaction=Policies.Display_Policy&Policy_Number=02.2.30>**
- Student Disability Policy **<https://intranet.bcm.edu/index.cfm?fuseaction=Policies.Display_Policy&Policy_Number=23.1.07>**
- Supplier Diversity Program **<https://intranet.bcm.edu/index.cfm?fuseaction=Policies.Display_Policy&Policy_Number=03.1.10>**
- Volunteer Time-Off from Work Policy **<https://intranet.bcm.edu/index.cfm?fuseaction=Policies.Display_Policy&Policy_Number=02.8.15>**
- Faculty/Staff/Learner Advocacy Guidelines **<https://intranet.bcm.edu/downloads/Faculty-Staff-Learner-Advocacy-Guidelines.pdf>**

Office of Institutional Diversity, Inclusion and Equity

Phone: (713) 798-8646

Email: institutionaldiversity@bcm.edu