BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
Board of Vocational Nursing and Psychiatric Technicians
2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833-2945
www.bvnpt.ca.gov

CALIFORNIA PSYCHIATRIC TECHNICIAN LICENSURE EXAMINATION (CAPTLE)

Expert Examiner Application

Directions:

1. Please type or print all requested information.
2. Please complete all sections of the application to ensure timely processing.
3. Return the form by email to BVNPT.Education@dca.ca.gov or by mail to the BOARD OF VOCATIONAL NURSING & PSYCHIATRIC TECHNICIANS, Attention: Education Division, 2535 Capitol Oaks Drive, Suite 205, Sacramento, CA 95833.

Full Name: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Email Address: _____

Licensure:

Are you currently licensed as a psychiatric technician? ☐ Yes ☐ No

- PT License Number: _____ Expiration: _____

Are you currently employed in a psychiatric technician practice giving direct client care during the last five years? ☐ Yes ☐ No

Employment:

- Present Employer: _____
- Business Address: _____
- Present Job Title: _____

Please indicate your area(s) of specialty practice:_____

_____

Please indicate the average number of hours you practice per week:

☐ 0 – 8 Hours ☐ 17 – 24 Hours ☐ 33 – 40 Hours

☐ 9 – 16 Hours ☐ 25 – 32 Hours ☐ Over 40 Hours

Please indicate the type of setting in which you practice:

☐ Education ☐ Psychiatric Facility ☐ Clinic ☐ Developmental Center

☐ Corrections ☐ Residential Care ☐ Home Care ☐ Emergency Psychiatry

If selected, are you able to attend workshops lasting three to five days? ☐ Yes ☐ No

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

Educational Institution	Area of Major Concentration	Degree/Credits Completed

Professional Experience: Please list last five years of employment, present employer first.

Employer Institution	Position/Title	Clinical Specialty	Length of Time

Sign and date:

_____ _____

Signature Date

PLEASE DO NOT WRITE BELOW THIS LINE

For Official Board Use

Application Processing: Received: _____ Review: _____ Evaluation: _____

Date: Approval: _____ Alternate: _____ Rejection: _____

Reviewed By: _____