Telesupervision for Postdoctoral Psychologist Licensure: Policy Review and Rural Workforce Implications

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Abstract

In order to become professionally licensed, psychologists in most states are required to complete a period of supervised postdoctoral training. Clinical supervision of postdoctoral supervisees is increasingly delivered via telesupervision, i.e., supervision conducted from a distance using technology. However, telesupervision is not permissible in every U.S. state. In states where postdoctoral telesupervision is limited or prohibited by licensing authorities, pre-licensed psychologists who want to work in historically underserved rural areas may be forced to take postdoctoral positions in metropolitan areas where in-person clinical supervision is more available. Further complicating this issue, the legal status of telesupervision across the U.S. is not well documented following the COVID-19 pandemic, when some states changed their telesupervision regulations. This article is the first post-pandemic review of postdoctoral telesupervision policies across all 50 U.S. states and Washington, D.C. This policy review illustrates how legal restrictions on telesupervision vary from state to state, and in some states the permissibility of telesupervision is unclear. Implications for mental health workforce development are also discussed, particularly for rural states that may benefit disproportionately from access to postdoctoral telesupervision.

Keywords: telesupervision, telehealth, rural mental health, workforce development

Public health significance statement: To obtain professional licensure, psychologists must complete a period of supervised clinical practice, and telesupervision (conducted via videoconferencing technology at a distance) allows pre-licensed psychologists to work in historically underserved rural areas where in-person clinical supervision is not available. However, the permissibility of postdoctoral telesupervision varies from state to state, and these

regulatory differences are not well documented. To address this problem, this policy review examined telesupervision policies across all 50 U.S. states and Washington, D.C. and explored how postdoctoral telesupervision permissibility could enhance rural workforce development.

Telesupervision for Postdoctoral Psychologist Licensure: Policy Review and Rural Workforce Implications

Clinical supervision is the signature pedagogy (Shulman, 2005) of the mental health professions and a requirement for professional licensure (Barnett et al., 2007). Postdoctoral supervision of psychologists seeking licensure is therefore a critical part of mental health workforce development. *Telesupervision*—conducting clinical supervision from a distance using technology—is an emerging practice that can contribute to workforce development efforts, especially in rural and remote areas without adequate mental health services or supervisors (McCord et al., 2020; Riding-Malon & Werth, 2014; Tarlow et al., 2020). Historically, pre-licensed psychologists were limited to working in communities with readily available in-person supervision, i.e., disproportionately in well-resourced urban areas. Telesupervision, on the other hand, makes it possible for pre-licensed psychologists to work in underserved areas (where supervisors are often scarce) while supervisors conduct clinical supervision sessions, evaluate supervisee competence, review patient records, provide instruction, and deliver feedback at a distance.

There is a growing demand for telesupervision research, policy, and implementation recommendations, particularly following the COVID-19 pandemic (Hames et al., 2020). For example, in a recent position article calling for systemic change to predoctoral internships, 23 health-service psychology trainees advocated for the development of telesupervision competencies and practices (Palitsky et al., 2022). Prior to the pandemic, the World Health Organization (2018) listed telesupervision as a means to address provider shortages in underserved areas. Hames et al. (2020) conducted a systematic review of training clinic practices in the U.S. and Canada at the start of the COVID-19 pandemic and noted the general lack of

standardized telesupervision practices, challenges with navigating regulatory and legal requirements, and difficulties managing challenging supervision situations remotely. Although the telesupervision literature is currently limited, some recent work has addressed this demand.

The Western Interstate Commission for Higher Education (WICHE, 2023) published a report describing postdoctoral telesupervision regulations in 12 Western states. The report highlighted the potential role of telesupervision in rural mental health workforce development and advocated for rural states where telesupervision is restricted to adopt telesupervision models similar to those implemented in telesupervision-permissive states. WICHE proposed best practices for postdoctoral telesupervision, suggesting regulatory specifications for the mode and frequency in which supervision is received, how supervisors are approved, how supervisee progress is monitored, and what work settings are appropriate for postdoctoral supervisees. These recommendations align with considerations raised in the telesupervision literature predating the COVID-19 pandemic (Wood et al., 2005). The WICHE report is one example of recent advocacy in support of telesupervision as a mode of training in need of well-articulated practice standards.

Effectiveness and Acceptability of Telesupervision

While not yet conclusive, emerging telesupervision research has illustrated its potential as an effective and acceptable clinical supervision modality. For example, in a pre-pandemic study, Tarlow et al. (2020) conducted a multiple-baseline single case study comparing in-person and telesupervision outcomes. Predoctoral supervisees in the study had similar supervision satisfaction and supervisory working alliance ratings across both modalities, and qualitative interviews with participants revealed themes such as technology issues, the importance of supervisor characteristics and technological ability, and supervision modality preferences.

Thompson et al. (2022) conducted a mixed methods study with a nationwide sample of 144 trainees, finding that telesupervision generally met or exceeded trainee expectations. Participants conveyed the convenience of and their comfort with telesupervision but also their experiences with technology issues and difficulty recognizing nonverbal cues. Soheilian et al. (2022) also conducted a mixed methods study with over 300 trainees across many U.S. health-service psychology programs, reporting mixed but generally positive experiences with telesupervision. Results indicated that telesupervision helped improve training flexibility and added unique benefits like screen sharing and improving teletherapy skills via practice with telesupervision. However, results also indicated that telesupervision raised unique ethical concerns, decreased supervisees' access to supervisors, and created new technology and organizational challenges. Shearer et al. (2024) conducted another mixed methods study of 242 supervisors and 128 trainees in the U.S. Department of Veterans Affairs (VA) Health Care System system, which found that supervisees and supervisors had near-equivalent experiences with in-person supervision and telesupervision. Results indicated the benefits of flexibility and increased supervisor access with telesupervision but challenges in building rapport, demonstrating certain clinical skills to supervisors, and greater difficulty sharing training resources. The study also emphasized the need for clear supervision plans, reliable technology infrastructure, and the perceived benefits of blended in-person and telesupervision. Across studies conducted before, during, and after the COVID-19 pandemic, no data indicated that telesupervision is an unacceptable or ineffective supervision modality. In fact, many data show its distinct benefits. The results of these studies are also consistent with telesupervision research conducted well before the pandemic (Reese et al., 2009).

On the other hand, perceived limitations of telesupervision may cause skepticism for some stakeholders. Varela et al. (2021) conducted a systematic review of the pre-pandemic telesupervision literature, highlighting negative themes such as frequent technological issues, challenges recognizing nonverbal cues, patient safety concerns, and challenges forming a supervisor-supervisee relationship. These concerns accompanied the recurring positive theme of increased supervision flexibility with telesupervision. The authors also emphasize methodological limitations of research such as the possibility of unaddressed researcher bias, low sample size, and lack of psychologist supervisees in the samples that limit generalization of results to doctoral-level training. These limitations highlight the need for more telesupervision research and may explain the hesitancy of some state licensing boards to permit its use with postdoctoral supervisees.

Clinical Supervision and Rural Workforce Development

Data indicate there are fewer than half the number of psychologists per capita in rural versus urban counties throughout the U.S. (Andrilla et al., 2022). While the causes of this phenomenon are complex, access to clinical supervision is a recurring theme with recruitment and retention of rural mental health workers. Domino et al. (2018) stated that obtaining clinical supervision in rural areas is a barrier to rural workforce development and noted a trend of students leaving rural areas for predoctoral internships and never returning. Others have also argued that the locations of predoctoral internships (disproportionately in urban areas) also affect eventual practice location (Jameson & Blank, 2007). A qualitative thematic analysis from interviews with clinicians, administrators, and program directors in rural Nebraska detailed the systemic nature of many rural workforce development trends, including that trainees have difficulty obtaining supervision hours for licensure and lack of supervisors in rural areas

(Watanabe-Galloway et al., 2015). Others have also argued that programs can better recruit students interested in rural clinical work and encourage rural clinical placements after graduation by expanding access to supervision and consultation to these areas (Dyck et al., 2008).

Need for Clarity on Licensing Regulation of Telesupervision

Despite these potential benefits, regulatory limitations on the use of telesupervision for postdoctoral trainees vary widely across states. The last nationwide review of telesupervision policies in the U.S., conducted in 2017, found that only 13 states permitted postdoctoral telesupervision for psychologists, with several of those states restricting the total number of supervision hours that can be conducted remotely (Schultz et al., 2019). Several states changed their telesupervision restrictions during the COVID-19 pandemic through emergency orders or legislative actions (Hames et al., 2020). However, no nationwide review of telesupervision policies has been conducted since these pandemic-era changes were implemented, and as a result the permissibility of telesupervision across the U.S. is not well documented. An updated state-by-state review of telesupervision policies and regulatory language will provide valuable information about which jurisdictions permit telesupervision for postdoctoral licensure requirements and which states limit its use—information that has important implications for mental health workforce development across the country, but particularly in rural states.

Telesupervision Policy Differences Across the United States

Between April and October 2024, we reviewed licensure laws and administrative rules governing the use of telesupervision in all 50 U.S. states and Washington, D.C., and then categorized each jurisdiction based on the permissibility of telesupervision for postdoctoral supervisees. States were grouped into five categories of postdoctoral telesupervision permissibility: telesupervision permitted, permitted with restrictions, prohibited, prohibited with

exceptions, and policy unclear. The following sections describe each category and include sample regulatory language from states in each category. Table 1 lists all states by category and cites relevant regulations for each jurisdiction. These results are also summarized in the Figure 1 map.

Telesupervision Permitted

Twenty-eight jurisdictions explicitly permit the use of telesupervision for postdoctoral supervision hours. Regulatory policies in these jurisdictions generally state the equivalence between in-person supervision and telesupervision. Telesupervision can account for all of a postdoctoral supervisee's required supervision hours in these jurisdictions. For example, the Iowa Board of Psychology states that "the supervisee and supervisor shall meet individually in person or via videoconferencing during each week in which postdoctoral residency hours are accrued." In another example, Pennsylvania's State Board of Psychology "considers 'face-to-face' supervision to be met if a HIPAA-compliant electronic platform is used that allows for synchronous audio and video communication between the supervisor and psychology resident."

Telesupervision Permitted with Restrictions

Two states (Tennessee and South Carolina) permit telesupervision for postdoctoral supervision hours with some restrictions. Regulatory policies in these jurisdictions state that telesupervision may be used for *some* but not all of the postdoctoral supervisee's required supervision hours. In Tennessee, for example, "no more than seventy-five percent of supervision can be obtained through video conferencing." In South Carolina, at least half of supervision must be in person, while the rest may be obtained virtually.

Telesupervision Prohibited with Exceptions

Six states (Alaska, Kentucky, Louisiana, Maryland, Virginia, and West Virginia) generally prohibit the use of telesupervision for postdoctoral supervision hours while allowing for some exceptions. Regulatory policies in these jurisdictions state that supervision must be in-person except when an alternate plan of supervision is approved by the licensing authority. If approved, this alternative plan may also include limits to the amount of telesupervision allowed. For example, in West Virginia, "individual supervision is in person, face-to-face, unless express permission to do otherwise for a minimal portion of the supervision hours is granted by Board majority and is documented in this contract." Similarly, in Kentucky, "[two-way] interactive video, may be substituted for the supervisory contact … upon specific approval by the board." Furthermore, Louisiana code states that "Telesupervision shall … only be utilized when in-person supervision in the service delivery setting is not feasible or under other extenuating circumstances … not account for more than 50 percent of the required supervisory contact for that supervisees' level of training, except under extending circumstances which have been approved by the board."

Telesupervision Prohibited

Four states (Arkansas, Illinois, Indiana, and North Carolina) prohibit all use of telesupervision for postdoctoral supervision hours. Regulatory policies in these jurisdictions explicitly state that supervision must be in-person. For example, in Illinois, "supervision needs to be on a one- on -one basis and be delivered face -to -face. Group supervision, telephonic supervision, email or web--based supervision and supervision by mental health professionals who aren't psychologists all can be used to augment your individual supervision by a Licensed Clinical Psychologist, but they cannot substitute for this experience."

Telesupervision Permissibility Unclear

The permissibility of telesupervision in 13 states was still unclear after our initial policy review, so we contacted those licensing boards directly and requested clarification. Nine state licensing boards responded to our requests. Telesupervision policies remain unclear in nine states, including in five states where licensing boards responded to our inquiry. The regulatory policies in many of these jurisdictions require that supervision is "face-to-face" but do not define that term—unlike states that clearly define "face-to-face" as inclusive of telesupervision (like Pennsylvania) or exclusive of telesupervision (like Arkansas). For example, in Idaho, "[One] hour per week of face-to-face individual contact per [40] hours of applicable experience is a minimum," but "face-to-face" is undefined.

Telesupervision Policy Implications and Recommendations

In nearly every U.S. state, psychologist licensure requires postdoctoral supervised clinical experience, yet the permissibility of telesupervision for postdoctoral supervisees was not well documented across jurisdictions, despite significant implications of licensing policy on workforce development (particularly in more rural states that could disproportionately benefit from telesupervision availability). This policy review revealed widespread variation in the permissibility of telesupervision, in addition to considerable lack of clarity about permissibility in some jurisdictions. In a significant nationwide policy shift since the last telesupervision policy review in 2017, a majority of U.S. state licensing boards now appear to explicitly permit postdoctoral telesupervision in place of or in combination with in-person supervision, whereas other states permit or prohibit telesupervision with varying degrees of exceptions.

One recurring issue in these regulatory differences is whether synchronous video telesupervision is considered a "face-to-face" modality. Many state licensing boards have indicated that telesupervision is a "face-to-face" modality while others have either defined "face-

to-face" as "in-person" or not defined the term "face-to-face" at all. As Cason (2017) argued, services delivered via telehealth are clearly not in-person, but they *should* be considered face-to-face:

> [T]he increasingly outdated and narrow use of the terminology 'face-to-face' (often abbreviated as F2F) [connotes] clinical interactions in which both the client and the practitioner are physically present in the same room or space. An expanded definition is necessary because when delivered synchronously via videoconferencing, telehealth also provides face-to-face services (i.e., the practitioner and the client view each other's faces). Terminology that uses face-to-face to connote only in-person care is limiting and perpetuates language that is out of line with progressive US regulatory language and broad interpretation within existing regulatory language. Therefore, the use of face-to-face should include telehealth applications (p. 77).

We agree with Cason that video telesupervision should be considered a "face-to-face" practice, and further suggest that the widespread ambiguity about the definition of "face-to-face" supervision does not serve the public, clinical supervisors, or postdoctoral supervisees.

Telesupervision policies also illustrate ethical tensions between regulatory prudence and innovations that reduce health service disparities. There is an urgent need to address rural psychologist workforce shortages. Regulatory innovations like the Psychology Interjurisdictional Compact (PSYPACT; psypact.gov) have increased the reach of already licensed psychologists practicing teletherapy while also introducing complexity into telepsychology practice. PSYPACT member states, by entering into the interjurisdictional compact, agree to permit remote practice by psychologists licensed under different training requirements, which may have included telesupervised postdoctoral practice. For example, a psychologist licensed in Pennsylvania (a PSYPACT state where telesupervision is permitted) could practice remotely in

Virginia (a PSYPACT state where telesupervision is prohibited). This extends to other licensing requirements beyond telesupervision as well. For example, a psychologist licensed in Alabama (a PSYPACT state where no postdoctoral training is required) could practice remotely in North Carolina (a PSYPACT state that requires postdoctoral training). Despite this complexity, PSYPACT does not affect telesupervision regulations where they exist (PSYPACT, n.d.) and interjurisdictional compacts like PSYPACT cannot address the underlying shortage of rural psychologists, nor can teletherapy ensure sufficient capacity and equity for rural communities (McCord et al., 2022). In contrast, permitting postdoctoral telesupervision is a structural intervention within the mental health workforce development pipeline that can have a tangible effect on supervisees and the communities they seek to serve.

This policy review revealed that regulatory barriers exist in many states where pre-licensed psychologists may seek to provide mental health services in rural communities—the very same rural communities which experience substantial mental health care worker shortages. In states where postdoctoral telesupervision is prohibited with exceptions, securing "alternate supervision plan" applications may be an imposing barrier for supervisees and the rural communities they would otherwise serve. In states with unclear postdoctoral telesupervision permissibility, supervisees may not be able to adequately plan for rural postdoctoral practice. In states where postdoctoral telesupervision is prohibited, pre-licensed psychologists may have to choose a postdoctoral position that is distant from their desired location of practice. These policy barriers may in turn restrict the development of future clinical supervisors, as pre-licensed psychologists of today will be the clinical supervisors of tomorrow. These regulatory limitations could also result in fewer opportunities for supervisees to develop competencies working with rural populations (or other underserved populations) at a formative stage of professional development. To illustrate the "real world" effects of these regultory barriers, consider the brief

vignette in Box 1, which summarizes the fourth author's (BCT) experience navigating telesupervision policies for a rural postdoctoral position.

Licensing boards and other professional gatekeepers certainly have reason to be prudent with their gatekeeping authority. Licensing boards and clinical supervisors play a critical role in the training of and privilege-granting to psychologists. As Hess (1977) stated, "A professional board is a state agency acting to protect the public, not to serve the profession" (p. 365). Similarly, clinical supervisors are gatekeepers to the profession and must be able to exercise their professional judgment to ensure the competence of their supervisees. Telesupervision raises new considerations for supervisors and supervisees that have the potential to negatively affect the public. For example, supervisors may have less cultural knowledge about the communities where supervisees are working. They may also feel less comfortable evaluating supervisee competencies via live video conferencing technology. Without conscientious planning, remotely located supervisors may also be less accessible to supervisees navigating ethical challenges and clinical emergencies. These challenges demonstrate a need for clear standards for telesupervision practice. All stakeholders deserve clarity about how to identify practice settings appropriate for telesupervised practice, ensure adequate technology to support it, and maintain contingency plans in the event of emergencies, incompetence, or misconduct.

Stakeholders should also consider the large body of evidence demonstrating the efficacy of teletherapy when evaluating the risks and benefits of telesupervision. Numerous high quality clinical trials have demonstrated how traditional in-person psychotherapy and video teletherapy produce similar patient outcomes for the treatment of a wide range of populations and disorders (Lin et al., 2021). For this reason, U.S. health care providers, insurers, regulators, and patients have largely embraced video teletherapy. Given the fundamental similarities between psychotherapy and clinical supervision (Bernard & Goodyear, 2019), it may be reasonable to

assume that the same technology which is used by psychotherapists to effectively evaluate and intervene with patients can also be used by clinical supervisors to do the same with supervisees. Although "the absence of evidence is not the evidence of absence," stakeholders wary of permissive telesupervision policies should also consider that more than half of all U.S. states already permit telesupervision as a substitute for in-person supervision (without restrictions)—and some states have apparently done so for years—and no corresponding increase in harm to the public or to supervisees has been documented.

Licensing boards and legislators are in a position to expand access to telesupervision for pre-licensed psychologists, and they can also play an important role in the safe implementation of telesupervision. Just as the American Psychological Association (APA) has recently revised its doctoral accreditation standards to permit telesupervision in doctoral programs that establish common sense policies to protect patients (APA Commission on Accreditation, 2024), licensing boards can similarly permit telesupervision for postdoctoral supervisees while still protecting the public. States like Arizona have already adopted this approach, where telesupervision is permitted only when supervisors conduct a risk analysis to determine they are competent in the telesupervision modality and that telesupervision is appropriate for supervisees and patients (see Box 2).

We conclude this policy review with five recommendations for improving rural workforce development with telesupervision. First, clearly permitting postdoctoral telesupervision—as already done in a majority of U.S. states—would remove a major barrier for pre-licensed psychologists who wish to engage in rural practice where there is limited access to in-person clinical supervisors. As many states have already demonstrated, expanding the permissibility of postdoctoral telesupervision can be accomplished with regulations that support its safe, ethical, and effective use (e.g., see Box 2). Second, consistent with broader trends in

telehealth policy (Cason, 2017), regulations should explicitly define "face-to-face" clinical supervision to include synchronous video telesupervision (in which supervisee and supervisor can indeed see each others' faces). Third, in states where telesupervision permissibility is either unclear or prohibited with exceptions, licensing boards should establish clear criteria for alternate supervision plans involving telesupervision. This will help supervisees plan for postdoctoral positions in rural areas that have less clinical supervisors and help ensure their quality of supervision. Fourth, the profession should develop standards and guidelines for telesupervision practice across different stages of training (e.g., practicum, predoctoral internship, and postdoctoral practice) that articulate competencies and practice requirements across domains (see, e.g., Maheu et al., 2021). Fifth, more research should examine the effectiveness and acceptability of telesupervision as well the impact telesupervision has on psychologists and patients in rural communities.

This policy review is limited by the constantly changing nature of state licensure laws, by focusing on psychologists alone rather than other mental health licenses, and by challenges in clarifying licensing regulations in some jurisdictions. Future policy reviews and research should examine regulations for other mental health professions and identify the ramifications telesupervision permissibility has for connecting supervisors and supervisees in other mental health care specialties. Postdoctoral telesupervision policies can enable pre-licensed psychologists to serve in rural communities, and telesupervision policy and research have broad relevance across all stages of training with potentially widespread impacts on the populations and communities they seek to serve.

Conclusion

The goals of this policy review were to clarify the current status of telesupervision regulations for postdoctoral psychologist licensure across the United States and identify

implications for rural mental health workforce development. More than half of U.S. states currently permit postdoctoral telesupervision without restriction (i.e., telesupervision hours are interchangeable with in-person supervision hours), a significant increase since the COVID-19 pandemic, and in many states policies are in place to promote safe and effective telesupervision practice. The growing permissibility of postdoctoral telesupervision is consistent with the emerging evidence base which supports its use. Research conducted before, during, and after the COVID-19 pandemic suggests that telesupervision is an effective and acceptable supervision modality for both supervisees and supervisors. Finally, expanding the permissibility of postdoctoral telesupervision is a promising strategy for rural mental health workforce development and health equity, as it allows pre-licensed psychologists to establish careers in historically underserved rural communities while being supervised remotely. The American Psychological Association recently resolved to advance health equity by using “innovative methodologies and tools to integrate community resources and diverse approaches to address health equity topics" (APA, 2021, p. 3). Broadening telesupervision permissibility for pre-licensed psychologists, clarifying telesupervision regulations, and articulating evidence-based telesupervision standards and guidelines will promote this goal during a key stage of psychologist training and in rural communities that need greater access to mental health care.

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Box 1

How Telesupervision Policy Affects Workforce Development: An Illustrative Personal Account

Behind every telesupervision policy are personal stories of psychologists like myself (BCT) seeking both licensure and careers in historically underserved areas. After graduating with a doctoral degree in clinical-community psychology, I had a strong desire for a primarily telehealth postdoctoral position at an Alaskan Tribal Health Organization that matched my doctoral training focused on serving Alaskan, rural, and Indigenous communities. Postdoctoral training opportunities of this nature were very limited due in large part to the state's policy against telesupervision except with pre-approved alternate supervision plans (Alaska is classified in Table 1 as a state where postdoctoral telesupervision is "prohibited with exceptions"). I engaged with a Tribal Health Organization eager to establish a telehealth position in a remote region of Alaska where no in-person postdoctoral supervision was available. From my perspective, the licensing board's website and published regulations on the topic provided almost no information on the nature of acceptable alternate supervision plans (i.e., telesupervision plans), the rationale of the prohibition against telesupervision, or the decision criteria for approving exceptions. Attempts to obtain this information were unsuccessful. I solicited advice from psychologists with extensive supervision experience and was informed the licensing board had denied alternate supervision plan requests which proposed a high ratio of telesupervision to in-person supervision. I felt forced to pursue a more traditional postdoctoral position in an urban setting out of concerns about the timeliness of the licensing board's response to an application for alternate supervision, a high uncertainty of approval, and the possibility of significant licensure delays. Ultimately, I was not able to establish a career providing psychological services in a Tribal Health Organization with underserved, rural, Indigenous stakeholders and have initiated a career path in an urban setting where I am able to satisfy the in-person supervision requirements for licensure.

Box 2

Sample Regulatory Policy for Permitting Safe Telesupervision

Before providing supervision by telepractice, a licensee … shall conduct a risk analysis as clinically indicated and document whether providing supervision by telepractice:

1. Is appropriate for the issue presented by the supervisee's client or patient involved in the supervisory process,
2. Is consistent with the supervisee's knowledge and skill regarding use of the technology involved in providing supervision by telepractice, and
3. Is in the best interest of both the supervisee and the supervisee's client or patient involved in the supervisory process.

A licensee shall not provide supervision by telepractice unless all conditions of the risk analysis are met.

4 Arizona Admin. Code 26-111 Providing Supervision through Telepractice

Table 1

Permissibility of postdoctoral telesupervision in the U.S

State	Telesupervision Policy	Citation
Alabama	Not applicable; no postdoctoral experience required for licensure	
Alaska	Prohibited with exceptions	Alaska Admin. Code § 60.080
Arizona	Permitted	Ariz. Admin. Code § 4-26-111
Arkansas	Prohibited	Ark. Psy. Board Rules and Regs. 5.4
California	Permitted	Business and Professions Code § 2914
Colorado	Permitted	Code of Colo. Regs. § 721-1
Connecticut	Permitted	Correspondence with Board
Delaware	Permitted	Dele. Title 24 § 7.2
Florida	Permitted	Florida Admin. Code § 64B19-11.005
Georgia	Permitted	Georgia Admin. Code § 510-2-.05
Hawaii	Unclear	Unable to locate rule/statute
Idaho	Unclear	IDAPA § 24.12.01 / Correspondence with Board
Illinois	Prohibited	Fact Sheet for New Graduates in Psychology
Indiana	Prohibited	Ind. Admin. Code § 25-33.5-2-18
Iowa	Permitted	Iowa Admin. Code § 240.6
Kansas	Permitted	Kan. Admin. Regs. § 102-1-5a
Kentucky	Prohibited with exceptions	Kentucky Admin. Regs. § 26-171
Louisiana	Prohibited with exceptions	Louisiana Professional and Occupational Standards §1409
Maine	Unclear	Consolidated Rules § 02-415-4 / Correspondence with Board
Maryland	Prohibited with exceptions	Code of Maryland Regs. § 10.36.01.04-3
Massachusetts	Permitted	Code Mass. Regs. § 3.05
Michigan	Permitted	General Rule § 338.2553
Minnesota	Permitted	Minn. Stat. § 148.925
Mississippi	Not applicable; no postdoctoral experience required for licensure	
Missouri	Unclear	Mo. Revised Statute § 337.025 / Correspondence with Board
Montana	Permitted	Montana Admin. Rule § 37-2-305
Nebraska	Permitted	Provisional Psychologist License Requirements Application Information Form
Nevada	Permitted	Nevada Admin. Code § 641
New Hampshire	Unclear	N.H. Code Amin. R. § 302.05 / Correspondence with Board
New Jersey	Unclear	N.J. State Board of Psychological Examiners FAQ
New Mexico	Permitted	N.M. Admin. Code § 16.22.6.9
New York	Permitted	NYS Education Law § 7605

North Carolina	Prohibited	Correspondence with Board
North Dakota	Permitted	N.D. Century Code § 43-32-20.1
Ohio	Permitted	Ohio Admin. Code § 4732-13-04
Oklahoma	Permitted	Ok. Admin Code. § 575:10-1-2 (sunsetting policy)
Oregon	Permitted	Procedural Rule § 858-010-0036
Pennsylvania	Permitted	Penn. Admin Code. § 41.101
Rhode Island	Unclear	R.C. Code of Regs. § 40-05-15
South Carolina	Permitted with restrictions	Correspondence with Board
South Dakota	Permitted	Correspondence with Board / September 2023 Board Meeting Minutes
Tennessee	Permitted with restrictions	Tenn. Admin. Rule § 1180-020.01
Texas	Permitted	Texas Admin. Rule § 465.2
Utah	Permitted	Psychologist Licensing Act Rule § 156-61-102
Vermont	Permitted	Board of Psychological Examiners Policy Regarding Remote Pre-Degree Internships and Practicums, On-Campus Presence, and Post-Degree Supervision (sunsetting policy)
Virginia	Prohibited with exceptions	Virginia Admin. Code § 125-20-65
Washington	Permitted	Virtual Supervision for Psychology Internships and Pre Internships during and following the COVID-19 Declared Emergency | Policy Number: EBOP-20-02.2 (sunsetting policy)
West Virginia	Prohibited with exceptions	W.V. Board of Examiners of Psychologists Supervision Contract Doctoral Degree - 2018 Version
Wisconsin	Unclear	Wisc. Admin. Rule Psy 2.10 / Correspondence with Board
Wyoming	Unclear	Post-Doctoral Supervision Agreement Form
Washington, D.C.	Permitted	Policy No. 23-002: Guidance on Telepsychology and Remote Supervision During the (Former) COVID-19 Health Emergency Extended Permanently

Figure 1

Map of postdoctoral telesupervision regulations in the U.S.