Clinical Social Work Supervision Form
For Level C Licensure Only (LCSW or LCSWA)
This form is used to document hours previously acquired

Applicant Name _____________________________________________ Date_____________________________________________
Supervisor Name________________________________________________________________________________________
___________________________________________________________________________________

TO BE COMPLETED BY THE CLINICAL SUPERVISOR

The above named individual is applying for clinical social work licensure. Your candor in completing this form would be appreciated. Please print legibly or type. Carefully answer each question. Please return this form to the applicant in an envelope with your signature over the seal. He or she will return your sealed envelope to the Board with the completed application packet. You may write or call the Board directly if you have any questions or concerns.

1. Title of applicant’s position: ____________________________________________________________________________
2. Describe applicant’s clinical social work duties and responsibilities with information about population served, problems addressed, assessment and treatment modalities used for treatment and diagnosis of mental and emotional disorders:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
(If more space is needed, use back of this form.)

3. Where did the applicant work? __________________________________________________________________________
4. Dates applicant was employed (MM/DD/YYYY): __________________________ to __________________________
5. Total number of hours employed __________________________________________________________________________
   Dates supervision was provided (MM/DD/YYYY): __________________________ to __________________________
6. Hours of individual supervision provided by you: ________________________________________________________
7. Hours of group supervision provided by you: (Maximum of 25 hours): __________________________
8. Total combined hours of individual and group hours provided: ____________________________________________
_____________________________________________________________________________________________________________________________________

I hereby certified that the above information is correct, and that I am Certified/Licensed/Registered as a Clinical Social Worker with a graduate degree in social work from a program accredited by the Council on Social Work Education (CSWE) and have at least two years of clinical social work experience post licensure.

Signed___________________________________________________________ Date_______________________________________
Name (Print)____________________________________________________________________________________________
Title_________________________License Number__________________________
Address____________________________________________________________________________________________________
City, State, Zip________________________________________________________________________________________________
Phone(s)___________________________________________________________________________________________________

Please return this form to the applicant in a sealed envelope with your signature over the sealed closure.
Thank you for your assistance