Current Form

Verification of Post-Graduate Supervised Experience

Each supervisor must complete a separate form.

APPLICANT INFORMATION

To be completed by the applicant.

Full Legal Name: _____
First *Middle* *Last*

Mailing Address: _____
Street/PO Box *City* *State/Zip*

EMPLOYMENT INFORMATION

To be completed by the LCSW Supervisor.

Name of Establishment: _____

Name of Supervisor: _____ **License Number:** _____

Establishment Address: _____
Street/PO Box *City* *State/Zip*

Telephone Number: _____ **Email:** _____

Dates of Employment/Supervision: _____ to _____
MM/DD/YYYY *MM/DD/YYYY*

Hours of supervised practice of mental health therapy: _____

Hours of supervised social work practice: _____

Hours of direct supervision: _____

Total of all supervised clinical social work training: _____

Describe the applicant's duties: _____

_____

_____

Did the applicant and supervisor work in the same place of employment? ☐ Yes ☐ No

If "no", describe how you were able to provide supervision: _____

_____

I do hereby certify that the applicant for licensure as a licensed clinical social worker has successfully completed the above hours of post-graduate supervised experience as a W-2 employee of the facility listed. I certify that the experience supervised meets the requirements outlined in R156-60a-302c, 302e and 601.

I further certify that the applicant is qualified and competent to practice as a licensed clinical social worker.

Signature of Supervisor: _____ **Date:** _____

Verification of Post-Graduate Supervised Experience

Each supervisor must complete a separate form. The hours from all forms must total 4,000.

APPLICANT INFORMATION

To be completed by the applicant.

Full Legal Name: _____
First *Middle* *Last*

Mailing Address: _____
Street/PO Box *City* *State/Zip*

EMPLOYMENT INFORMATION

To be completed by the Supervisor.

Name of Establishment: _____

Name of Supervisor: _____ **License Number:** _____

Establishment Address: _____
Street/PO Box *City* *State/Zip*

Telephone Number: _____ **Email:** _____

Dates of Employment/Supervision: _____ to _____
MM/DD/YYYY *MM/DD/YYYY*

Supervised experience of face-to-face mental health therapy with clients: _____

Other hours of clinical mental health counseling training: _____

Hours of direct supervision: _____

Total hours of clinical mental health counselor training: _____

Describe the applicant's duties: _____

_____

_____

Did the applicant and supervisor work in the same place of employment? ☐ Yes ☐ No

If "no", describe how you were able to provide supervision: _____

_____

I do hereby certify that the applicant for licensure as a clinical mental health counselor has successfully completed the above hours of post-graduate supervised experience as a W-2 employee of the facility listed. I certify that the experience supervised meets the requirements outlined in R156-60c-302b and 401.

Signature of Supervisor: _____ Date: _____

I further certify that the applicant is qualified and competent to practice as a clinical mental health counselor.

___Yes ___No If you mark "No" please attached a letter explaining in detail your concerns and how you have addressed them with the supervisee.

Signature of Supervisor: _____ **Date:** _____