VERIFICATION OF
MSW SUPERVISED PRACTICE

____
Applicant's Name

____
Agency/Institution

Dates of supervision: From ________/________thru ________/________ (Month / Year)

Type of clinical practice: ____

Number of hours of supervised clinical social work experience _______________________

Number of hours of supervision: Individual ____________ Group _____________

NOTE: Applicants must participate in a minimum of 150 hours of face-to-face clinical supervision with a supervisor approved by the board. Not more than 50 hours of supervision may be group supervision.

SUPERVISOR INFORMATION:

_____________________________________	_____________________________________
Name	Agency/Institution
Address	E-mail Address
Work Phone	Home Phone

Highest Degree Earned ____

School of Highest Degree ____

Years of post-degree clinical experience ____

I hereby affirm that I directly supervised the above named applicant, for a minimum of 1 hour per week, and that the information I have provided is correct to the best of my knowledge.

____ _____________
Signature Credentials Date

Supervision involves weekly accountability to a clinical supervisor who is an LCSW with at least two years post-master's clinical social work experience, an LICSW, a licensed clinical psychologist or a licensed psychiatrist.

Do you recommend this person for LICSW Licensure? ________Yes ________ No

If the answer is no, please attach a written explanation.

01/04