NORTH DAKOTA BOARD OF SOCIAL WORK EXAMINERS

PO Box 914 - Bismarck, ND 58502-0914
Phone 701-222-0255 Fax 701-224-9824
www.ndbswe.com ndbswe@aptnd.com

VERIFICATION OF MSW EMPLOYMENT

This should be signed by the supervisee's employer. The employer should be the owner, director, CEO or president of the facility/business, or the head of the department in which the supervisee practices. This may or may not be the same person as the supervisor.

I, _____, do hereby verify that
Supervisor/Managers Name

_____ was employed from
Applicants Name

_____/_____ to _____/_____ at
Month Year Month Year

_____
Agency/Organization

as a _____ full-time _____ part-time Clinical Social Worker.

If part-time, please indicate number of hours worked. _____

I verify the supervisee completed this plan in my facility or department.

_____ _____
Employer's Signature Date

_____ _____
Title Facility

Please return this form to the Board Office:
NDBSWE
PO Box 914
Bismarck, ND 58502

3/2015