



Board of Behavioral Sciences
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www.bbs.ca.gov



CLINICAL SOCIAL WORKER IN-STATE EXPERIENCE VERIFICATION

Have your supervisor complete this form as follows:

- Use a separate form for each supervisor and employer
- Provide an original signature in ink and have the signer initial any changes
- Make sure this form is complete and correct prior to signing
- Submit with your *Application for Licensure and Examination*

APPLICANT NAME: _____ **ASW Number:** _____

APPLICANT'S EMPLOYER INFORMATION

Name of Applicant's Employer:		Telephone		
Address:	Number and Street	City	State	Zip Code
<p>1. Did this setting lawfully and regularly provide clinical social work, mental health counseling or psychotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Did this setting provide oversight to ensure the ASW's work met the experience requirements and was within the scope of practice? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>				

SUPERVISOR INFORMATION

Supervisor's Name		Telephone		Email Address (OPTIONAL)	
License Type	License Number	State		Date First Licensed	
<p>If a physician, were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p style="text-align: center;">If YES, provide certificate number: _____</p>					

APPLICANT NAME: _____ ASW#: _____

SUPERVISOR INFORMATION (continued)

Were you (the supervisor) employed by the supervisee's employer? Yes No

If NO, did you and the supervisee's employer sign a letter of agreement wherein you agreed to take supervisory responsibility for the associate's social work services? Yes No

EXPERIENCE INFORMATION: Dates of experience: From _____ to _____
(mm/dd/yyyy) (mm/dd/yyyy)

1. Total supervised weeks <i>(Minimum 104 overall)</i> :	
2. Total hours in individual supervision <i>(Minimum 52 overall)</i> :	
3. Total hours in group supervision:	
4. Average hours worked per week <i>(Maximum 40)</i> :	
5. Total hours of clinical psychosocial diagnosis, assessment, and treatment, including individual or group psychotherapy / counseling <i>(Minimum 2,000 overall)</i> :	A.
6. Of the above hours, how many were gained performing face-to-face individual or group psychotherapy/counseling <i>(Minimum 750 overall)</i> :	
7. Total hours of client-centered advocacy, consultation, evaluation, research, workshops, seminars, training sessions or conferences and direct supervisor contact* <i>(Maximum 1,200 overall)</i> :	B.
8. Total hours of experience <i>(Minimum 3,200 overall)</i> : (A + B = C)	C.
9. Was one (1) <u>additional</u> hour of face-to-face individual OR two (2) <u>additional</u> hours of face-to-face group supervision provided for every week in which <u>more than</u> 10 hours of face-to-face psychotherapy was performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

*A maximum of six (6) hours of direct supervisor contact per week may be counted toward the 1,200 hours.

NOTE: Knowingly providing false information or omitting pertinent information may be grounds for denial of the application. The Board may take disciplinary action on a licensee who helps an applicant obtain a license by fraud, deceit or misrepresentation. All information on this form is subject to verification.

Signature of Supervisor: _____ Date: _____

ORIGINAL SIGNATURE REQUIRED