

OUT- OF - STATE VERIFICATION:

THIS FORM IS TO BE USED BY APPLICANTS TO DOCUMENT PREVIOUS SUPERVISION WHICH WAS RECEIVED (ALL OR PART) FROM ANOTHER STATE.

NOTE: APPROVAL OF ANY OR ALL PREVIOUS CLINICAL PRACTICE & SUPERVISION HOURS IS AT THE BOARD'S DISCRETION. MAKE ADDITIONAL COPIES OF THIS FOR AS NEEDED.

SECTION H: ~ PREVIOUS WORK & SUPERVISION HOURS COMPLETED IN ANOTHER JURISDICTION

APPLICANT NAME:
Last Name, First Name Middle Initial

SUPERVISOR #1 NAME:

SUPERVISOR'S LICENSE #: **ISSUE DATE:** 

SUPERVISION COMPLETED IN THE STATE OF:

TOTAL INDIVIDUAL SUPERVISION HOURS WITH THIS SUPERVISOR: **TOTAL GROUP SUPERVISION HOURS WITH THIS SUPERVISOR:**

TOTAL NUMBER OF WORK HOURS: **TOTAL NUMBER OF DIRECT CLIENT HOURS:**

START DATE: **END DATE:**

BRIEFLY DESCRIBE SUPERVISION SESSIONS:

SUPERVISOR #2 NAME:

SUPERVISOR'S LICENSE #: **ISSUE DATE:** 

SUPERVISION COMPLETED IN THE STATE OF:

TOTAL INDIVIDUAL SUPERVISION HOURS WITH THIS SUPERVISOR: **TOTAL GROUP SUPERVISION WITH THIS SUPERVISOR:**

TOTAL NUMBER OF WORK HOURS: **TOTAL NUMBER OF DIRECT CLIENT HOURS:**

START DATE: **END DATE:**

BRIEFLY DESCRIBE SUPERVISION SESSIONS:

CERTIFYING STATEMENT (SUPERVISORS IN ANOTHER JURISDICTION:

BY MY SIGNATURE BELOW, I CERTIFY THAT THE INFORMATION PROVIDED IN THIS DOCUMENT IS TRUE & CORRECT TO THE BEST OF MY KNOWLEDGE.

BE SURE THAT ALL SIGNATURES ARE IN PLACE BEFORE SUBMITTING YOUR APPLICATION. UNSIGNED FORMS WILL BE RETURNED, THEREBY CAUSING A DELAY IN PROCESSING YOUR APPLICATION & ISSUING YOUR CERTIFICATE. NO HOURS WILL COUNT TOWARD YOUR PLAN UNTIL APPROVED BY THE BOARD.

SECTION I: ~ CERTIFYING STATEMENT

SUPERVISOR #1

(CLINICAL SUPERVISOR)

(Print Name of LCSW Supervisor)

(Credentials / License #)

(Signature of LCSW Supervisor)

SIGN HERE

(Date)

(Email)

(Telephone)

INDIVIDUAL:

GROUP:

BOTH:

SUPERVISOR #2

(CLINICAL SUPERVISOR)

(Print Name of LCSW Supervisor)

(Credentials / License #)

(Signature of LCSW Supervisor)

SIGN HERE

(Date)

(Email)

(Telephone)

INDIVIDUAL:

GROUP:

BOTH: