OREGON BOARD OF LICENSED SOCIAL WORKERS

CLINICAL SOCIAL WORKER ASSOCIATE
6 MONTH EVALUATION REPORT

FOR OFFICE USE ONLY ~ RECEIVED ON:

If you have more than one supervisor, have each of them complete a separate report, but only document work hours and client hours on one report so your hours are not duplicated. To remain in compliance with the Board's Statutes and Rules, CSWA's are required to meet with their supervisor, no less than (2) two times per month, for (1) one hour each meeting.

If you have two supervisors, this can be met with at least (1) meeting each month with each supervisor. Six month reports are due within (30) days of the due date. Incomplete forms will be returned for completion.

CSWA NAME: _____ **CERTIFICATE #** A _____

Last Name, First Name Middle Initial

Reporting Period: _____ **TO** _____ **Report:** ☐ ☐ ☐ ☐ ☐ ☐

(Start Date) (End Date) *(#1) (#2) (#3) (#4) (Other #) **(FINAL)***

SUPERVISION:

TOTAL WORK HOURS *this reporting period:* _____ ***TOTAL DIRECT CLIENT HOURS*** *this reporting period:* _____

*# of **INDIVIDUAL SUPERVISION HOURS** for this report:* _____ *# of **GROUP SUPERVISION HOURS** for this report:* _____

1. BRIEFLY DESCRIBE YOUR SUPERVISION SESSIONS:

2. WHAT THEORY BASE OR THERAPY DOES THE CSWA USE IN THEIR PRACTICE?:

3. EVALUATE THE STRENGTHS AND WEAKNESSES OF THE CSWA:

4. DESCRIBE THE CSWA'S PROFESSIONAL GROWTH OVER THE LAST SIX MONTH PERIOD:

5. DESCRIBE GOALS FOR THE NEXT SIX MONTH PERIOD:

6. DOES THE CSWA DEMONSTRATE AN UNDERSTANDING OF THE BOARD OF LICENSED SOCIAL WORKER'S STATUTES & RULES THAT GOVERN THE SOCIAL WORK PRACTICE IN OREGON? YES ☐ NO ☐

7. DOES THE CSWA ROUTINELY PRACTICE THE CODE OF ETHICS: YES ☐ NO ☐

8. DO YOU ROUTINELY DISCUSS THESE TWO TOPICS DURING YOUR SUPERVISION? YES ☐ NO ☐

9. HOW MANY CASE FILES DID YOU REVIEW WITH THE CSWA?

10. DOES THE CSWA DEMONSTRATE AN UNDERSTANDING OF DIAGNOSIS & TREATMENT PLANNING? YES ☐ NO ☐
IF (NO), BRIEFLY DESCRIBE YOUR CONCERNS:

11. DO YOU HAVE ANY CONCERNS ABOUT THE CSWA'S PRACTICE OR BECOMING LICENSED? YES ☐ NO ☐
IF (YES), BRIEFLY DESCRIBE YOUR CONCERNS:

L.C.S.W. SUPERVISOR

(Print Name of Supervisor) (License #) (Signature of LCSW Supervisor)

(Date) (Email) (Telephone)

C.S.W.A

(Print Name of CSWA) (Signature of CSWA)

(Date)

Mail this form to: OREGON STATE BOARD OF LICENSED SOCIAL WORKERS
ATTN: CSWA COORDINATOR
3218 PRINGLE ROAD S.E., SUITE #240
SALEM, OR 97302-6310

QUESTIONS? ☎: 503.378.5735
✉: Oregon.BLSW@state.or.us

APPROVED BY: _____ DATE: _____

CSWA (6) Month Eval Form Updated: MAY 2013