Board of Behavioral Sciences
1625 North Market Blvd., Suite S200, Sacramento, CA 95834
Telephone: (916) 574-7830 TTY: (800) 326-2297
www.bbs.ca.gov

LICENSED CLINICAL SOCIAL WORKER
IN-STATE EXPERIENCE VERIFICATION

Have your supervisor complete this form as follows:

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

1. Did this setting lawfully and regularly provide clinical social work, mental health counseling or psychotherapy? ☐ Yes ☐ No
2. Did this setting provide oversight to ensure the ASW's work met the experience requirements and was within the scope of practice? ☐ Yes ☐ No

SUPERVISOR INFORMATION

Supervisor's Name	Telephone	Email Address **(OPTIONAL)**

License Type	License Number	State	Date First Licensed

If a physician, were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision? ☐ Yes ☐ No ☐ N/A

If YES, provide certificate number:_____

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 _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

1. Total supervised weeks *(Minimum 104 overall)*:	
2. Total hours in individual supervision *(Minimum 52 overall)*:	
3. Total hours in group supervision:	
4. Average hours worked per week *(Maximum 40)*:	
5. Total hours of clinical psychosocial diagnosis, assessment, and treatment, including individual or group psychotherapy / counseling *(Minimum 2,000 overall)*:	**A.**
6. Of the above hours, how many were gained performing face-to-face individual or group psychotherapy/counseling *(Minimum 750 overall)*:	
7. Total hours of client-centered advocacy, consultation, evaluation, research, workshops, seminars, training sessions or conferences and direct supervisor contact* *(Maximum 1,200 overall)*:	**B.**
8. Total hours of experience *(Minimum 3,200 overall)*: **(A + B = C)**	**C.**
9. Was one (1) additional hour of face-to-face individual OR two (2) additional hours of face-to-face group supervision provided for every week in which more than 10 hours of face-to-face psychotherapy was performed?	☐ Yes ☐ 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