OUT- OF - STATE VERIFICATION:

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

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.

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 #)

SIGN HERE

(Signature of LCSW Supervisor)

(Date) | (Email) | (Telephone)

INDIVIDUAL: ☐ GROUP: ☐ BOTH: ☐

SUPERVISOR #2 (CLINICAL SUPERVISOR)

(Print Name of LCSW Supervisor) | (Credentials / License #)

SIGN HERE

(Signature of LCSW Supervisor)

(Date) | (Email) | (Telephone)

INDIVIDUAL: ☐ GROUP: ☐ BOTH: ☐