

## REMITTANCE FORM

Use the enclosed envelope and this remittance form to send in your fees listed below, this will help us identify to which applicant these funds belong. The funds are sent to our financial center and they will forward to our office after processing. If the envelope has been left out please submit your fee to the following address:

### MAIL FEES with this form to:

**Oregon Board of Clinical Social Workers**  
**Unit 03**  
**P. O. Box 4395**  
**Portland, OR 97208-4395**

AMOUNT ENCLOSED \_\_\_\_\_

CHECK NUMBER \_\_\_\_\_

### **LCSW APP FEE-\$150, INITIAL LICENSE FEE-\$130, FBI FEE-\$50 = \$330.00**

\*\*If you have completed all your hours for licensure and taken the ASWB Clinical exam or if licensed in another state as an LCSW please pay this amount.

### **CSWA APP FEE-\$150, INITIAL CERTIFICATE FEE-\$60, FBI FEE-\$50 = \$260.00**

\*\*If you are working toward licensure or have not completed all of your supervision, work and client hours please pay this amount.

NO APPLICATION CAN BE PROCESSED WITHOUT THE ABOVE FEES. IF YOU DOWNLOAD THE APPLICATION **YOU MUST** CALL THE BOARD OFFICE FOR THE FBI FINGERPRINT FORM.

BIRTH DATE \_\_\_\_\_ Month/Day/Year

NAME \_\_\_\_\_

### MAIL FORMS

Send your **application forms and transcript** to the following address for processing:

*State Board of Clinical Social Workers*  
*3218 Pringle Road SE, Suite 240,*  
*Salem, OR 97302-6310*

Be sure your forms are complete. Incomplete information causes delays in approving your Plan which will affect your Plan dates. Be sure to request an **official Transcript** be sent directly to this office. It would be wise to copy the application for your records. If you have any questions, please feel free to call the Board office at 503-378-5735 or e-mail to pam.johansen@state.or.us.

Upon Board approval, official notification will be sent to you within the week following the Board meeting with specific instructions for follow-up.



STATE OF OREGON
STATE BOARD OF CLINICAL SOCIAL WORKERS
APPLICATION FOR CERTIFICATION OR LICENSE

FORM 1

IDENTIFYING INFORMATION

SSN \_\_\_\_\_ DOB \_\_\_\_\_

While this information is required, it is used only for purpose of identification as related to licensure issues, reciprocity, and discipline.

Legal Name \_\_\_\_\_

Home Address \_\_\_\_\_
(Street) (City) (State) (Zip)

Mailing Address if different
from above \_\_\_\_\_

Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_

Optional: E-mail address \_\_\_\_\_
(If you would like to receive the Newsletter or Administrative Rule Changes)

WHICH OF THE FOLLOWING APPLIES TO YOU? (Select One)

\_\_\_\_\_ Working toward licensure fill out (Forms 1 and 2).

\_\_\_\_\_ If you are requesting credit for previous hours received in another state but have not completed the licensing requirements fill out (Forms 1, 2, 4 & 5). Approval of any or all previous practice and supervision hours is at the discretion of the Board. If you have completed all supervision hours in another state complete but have not taken the ASWB Clinical exam fill out (Forms 1,4 &.5).

\_\_\_\_\_ Licensed in another state \_\_\_\_\_ (Forms 1 and 6).

Current Employer \_\_\_\_\_

Employer Address \_\_\_\_\_
(Street) (City) (State) (Zip)

Beginning Date # of Weekly
Of Employment \_\_\_\_\_ Work Hours \_\_\_\_\_ F/T [ ] P/T [ ]

Number of Direct Client Hours per week \_\_\_\_\_ Job Title \_\_\_\_\_

Name of LCSW Supervisor(s) \_\_\_\_\_

Name of Administrative Supervisor(s) \_\_\_\_\_

Duties (Describe Briefly) \_\_\_\_\_

Client Population \_\_\_\_\_

**GRADUATE EDUCATION INFORMATION**

University or University

Dates Attended

Date MSW Degree Received

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**PROFESSIONAL EXPERIENCE** List *previous Post-Masters* clinical practice experience consecutively, with the exact dates. Please submit complete information on all positions using additional paper as necessary using the same format.

1. Employer Name and Address \_\_\_\_\_ Position \_\_\_\_\_

Employment Dates (From/To) \_\_\_\_\_

Total Number of Work Hours Per Week \_\_\_\_\_ Total Number of Face-to-Face Client Hours Per Week \_\_\_\_\_

Clinical Supervisor \_\_\_\_\_ Degree \_\_\_\_\_ Phone \_\_\_\_\_

Administrative Supervisor (if applicable) \_\_\_\_\_

2. Employer Name and Address \_\_\_\_\_ Position \_\_\_\_\_

Employment Dates (From/To) \_\_\_\_\_

Total Number of Work Hours Per Week \_\_\_\_\_ Total Number of Face-to-Face Client Hours Per Week \_\_\_\_\_

Clinical Supervisor \_\_\_\_\_ Degree \_\_\_\_\_ Phone \_\_\_\_\_

Administrative Supervisor (if applicable) \_\_\_\_\_

3. Employer Name and Address \_\_\_\_\_ Position \_\_\_\_\_

Employment Dates (From/To) \_\_\_\_\_

Total Number of Work Hours Per Week \_\_\_\_\_ Total Number of Face-to-face Client Hours Per Week \_\_\_\_\_

Clinical Supervisor \_\_\_\_\_ Degree \_\_\_\_\_ Phone \_\_\_\_\_

Administrative Supervisor (if applicable) \_\_\_\_\_

4. Employer Name and Address \_\_\_\_\_ Position \_\_\_\_\_

Employment Dates (From/To) \_\_\_\_\_

Total Number of Work Hours Per Week \_\_\_\_\_ Total Number of Face-to-Face Client Hours Per Week \_\_\_\_\_

Clinical Supervisor \_\_\_\_\_ Degree \_\_\_\_\_ Phone \_\_\_\_\_

Administrative Supervisor (if applicable) \_\_\_\_\_

**ADDITIONAL INFORMATION**

Yes No If you answer **YES** to any of the questions below, you must submit a detailed explanation (signed and dated) on a separate sheet of paper and include it with this application.

- 1. Have you ever used any name other than the one you are using to make this application? If *yes* please list every other name you have ever used.
- 2. Have you ever been convicted of a felony, any sexual offense, or any offense involving a controlled substance or alcohol?
- 3. Have you ever been reprimanded or suspended from practice by any agency, employer, board, tribunal, etc.?
- 4. Have you ever been denied licensure/registration or certification to practice in this or any other state?
- 5. Have you ever been the subject of a complaint to a self-regulated professional organization, licensing board or agency?
- 6. Have you ever been found to have violated any professional organization rules, by-laws, etc.?
- 7. Has a judgment been entered against you in a civil court for a practice related complaint?
- 8. Are there any professional complaints against you currently pending or under investigation?
- 9. Have you ever received any driving under the influence of intoxicants (DUII) arrests?
- 10. Have you ever received any in-patient mental health care for a psychological, addiction, or chemical dependency issue that affected your ability to safely practice?

**CERTIFICATION**

I hereby submit this application to the Oregon State Board of Clinical Social Workers. I understand that the Board of Clinical Social Workers may deny my application for certification or license for any of the reasons listed under ORS 675.540.

I certify that if I have checked "**yes**" to any of the above questions, a full and truthful explanation is submitted in writing with this application.

I certify that all representations made in this application are true and correct to the best of my knowledge. If I am applying for licensure, I certify that I have met all the requirements for clinical practice and supervision as defined in OAR 877-020-0000. I acknowledge that any incorrect or untrue information provided on this form may constitute grounds for denial of my application.

My fees have been sent to PO Box 4395, Portland OR with the Remittance Form. You will be issued a license or certificate once the Board has approved your application and processed fees and when all criteria has been met to complete the application process. I understand that all fees are non-refundable.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

**\*\*NOTE\*\***

**REQUEST FOR VOLUNTARY INFORMATION**

**FORM 1**

It is the Board's desire to be as helpful as possible when requests for specific information are made.

During the 2001 Legislative Session, Senate Bill 786 (Chapter 973) was passed which requires regulatory boards to request and maintain records of the racial and ethnic makeup of applicants and professionals regulated by the Board. However, the request for this type of information is voluntary and not required.

Your response to this request is appreciated. If you have any questions, please feel free to call the Board office at (503) 378-5735. Thank you.

**ETHNIC BACKGROUND**

- Asian/Pacific Islander
- Black (not Hispanic)
- Hispanic
- American Indian/Alaskan Native
- White (not Hispanic)
- Other: (Identify)\_\_\_\_\_

**LANGUAGES**

- Bilingual?  Yes  No
- American Sign Language
  - Chinese  Laotian
  - French  Spanish
  - German  Thai
  - Japanese  Vietnamese
  - Korean  Russian
  - Other\_\_\_\_\_

**COMMENTS** (We appreciate any suggestions or comments.)

If you have questions regarding this application please feel free to contact our office by phone, mail or e-mail at the following:

**Office:** State Board of Clinical Social Workers  
3218 Pringle Rd SE Ste 240  
Salem OR 97302-6310

**E-mail:** [pam.johansen@bcsw.state.or.us](mailto:pam.johansen@bcsw.state.or.us)

**Fax:** 503-373-1427

**Phone:** 503-378-5735 or 1-866-355-7050

# ATTENTION

## SOCIAL SECURITY NUMBER (Federal Requirement)

As part of your application for an initial certificate or license, or renewal of the same, issued by the State Board of Clinical Social Workers, you are required to provide your Social Security Number to this agency. **This is a mandatory requirement.** The authority for this requirement is ORS 25.785, ORS 305.385 (Oregon law), 42 USC § 405(c) (2) (C) (i), and 42 USC § 666(a) (13) (federal law).

Failure to provide your Social Security Number will be a basis to refuse to issue or renew the certificate or license you seek. This record of your Social Security Number will be used for child support enforcement and tax administration purposes (including identification), unless you authorize other uses of the number. It will also be used to report any final adverse actions against you by the Board to the United States Department of Health and Human Services as required by 42 USC § 1320a-7e and 45 CFR 61.7. Although a number other than your Social Security Number appears on the face of the certificate or license issued by the State Board of Clinical Social Workers, your Social Security Number will remain on file with this agency.

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Social Security Number

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Signature

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Date

## VOLUNTARY CONSENT TO USE YOUR SOCIAL SECURITY NUMBER

Oregon Revised Statutes authorizes the State Board of Clinical Social Workers to request that you voluntarily allow the Board to use your Social Security Number for identification purposes *in maintaining records, reporting grades or exam scores, collection purposes, or for verification of licensure, employment, and/or insurance.* Failure to allow your Social Security Number to be used for any of these purposes will not be used as a basis to deny you any right, benefit, or privilege provided by law. If you consent to this use, it will be used only for the purposes described above and not given to the general public. By signing this consent to use your Social Security Number, you authorize the State Board of Clinical Social Workers to use it for the purposes stated above.

I hereby consent to disclose my Social Security Number to the State Board of Clinical Social Workers for the use(s) described above.

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(Sign here for consent to use SSN)

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Date