STATE BOARD OF CLINICAL SOCIAL WORKERS

PLAN CHANGE OR MODIFICATION **Form 8**

ASSOCIATE'S NAME____ **Cert. No**. ______________

REASON(s) FOR REQUEST (Check all that apply)

[ ] Change in Employment/Same Supervisor
(Do Form 8 only update information below)
[ ] Change in Employment/New Supervisor
(Do Forms 2 & 8 for new supervisor)
[ ] Adding Individual/New Supervisor
(Do Forms 2 & 8 for new Supervisor)

[ ] Adding Group/New Supervisor
(Do Forms 2 & 8 for new Supervisor)
[ ] Adding Individual/Same Supervisor (Do Form 8)
[ ] Adding Group/Same Supervisor (Do Form 8)
Number of supervisee's in Group_________

Briefly describe the reason(s) for requesting this change:____

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*** EMPLOYMENT INFORMATION**

Total Number of Work Hrs. Per Week ______________

Are Your Working FT? or PT?

Number of Direct Client Hours Per Week__________

Employer Name ____________________________________Telephone ______________________________

Address ____

Beginning Date of this Employment ____________________ Job Title _______________________________

Describe Client Population and Your Duties ____

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All changes **must be approved at a Board meeting before any hours can count**. You will receive a formal letter following the Board meeting confirming the change. The Board meets normally the second Tuesday of each month. All forms must be received in the Board office no later than the **Friday** before the Board meeting.

If your Clinical Supervisor and Administrative Supervisor are the same, please have them sign on both lines.

Signature of Clinical Supervisor ____
(Person who does your Supervision)

Signature of Administrative Supervisor ____
(Person you report to for work)

Associates Signature ____

Mail form to: State Board of Clinical Social Workers
3218 Pringle Rd SE Suite 240
Salem OR 97302-6310
Questions call – 503-378-5735