

STATE BOARD OF LICENSED SOCIAL WORKERS
PLAN CHANGE OR MODIFICATION

Form 8

ASSOCIATE'S NAME _____ Cert. No. _____

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

- | | |
|--|--|
| <input type="checkbox"/> Change in Employment/Same Supervisor
(Do Form 8 only update information below) | <input type="checkbox"/> Adding Group/New Supervisor
(Do Forms 2 & 8 for new Supervisor) |
| <input type="checkbox"/> Change in Employment/New Supervisor
(Do Forms 2 & 8 for new supervisor) | <input type="checkbox"/> Adding Individual/Same Supervisor (Do Form 8) |
| <input type="checkbox"/> Adding Individual/New Supervisor
(Do Forms 2 & 8 for new Supervisor) | <input type="checkbox"/> Adding Group/Same Supervisor (Do Form 8)
Number of supervisee's in Group _____ |

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

*** 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 _____

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.

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 Licensed Social Workers
3218 Pringle Rd SE Suite 240
Salem OR 97302-6310
Questions call – 503-378-5735