



OREGON BOARD OF LICENSED SOCIAL WORKERS

APPLICATION INSTRUCTIONS CLINICAL SOCIAL WORK ASSOCIATE

CLINICAL SOCIAL WORK ASSOCIATE (CSWA)

Applicants working toward completing their two year post MSW supervision will complete the Clinical Social Work Associate application. See ORS 675.530(3). The Statutes and Rules for the Clinical Social Work Associate (CSWA), is contained in ORS Chapter 675 and OAR Chapter 877. You can access these *Statutes* and *Rules* on our website at www.oregon.gov/blsw.

Please send only original applications and signatures to the Board.

Incomplete information will cause delays in processing your application. A complete file must have transcript, completed application and fees before the board can review your file. We encourage you to keep a copy of the application for your records. If you have any questions feel free to contact the Board office at 503-378-5735 or e-mail Oregon.blsw@state.or.us.

ABOUT THE BOARD

The Board office is located in the Morrow Crane Building at 3218 Pringle Road SE, Suite 240, Salem, OR 97302-6310. Most questions can be answered by visiting our website at www.oregon.gov/blsw. Our office is normally staffed Monday-Friday from 8-5. Due to Budget cuts and mandatory furlough days office hours may vary. Please contact the Board office to confirm that someone will be in the office if you would like to drop off or pick up materials. An answering machine is used to record messages when staff is unavailable. Please allow at least 60 days for completion of the application process.

TRANSCRIPT

All applicants must submit an official transcript documenting your degree in social work which is accredited by the Council on Social Work Education. LMSW's, CSWA's, and LCSW's submit documentation for the Masters of Social Work Degree. RBSW's submit documentation for the Baccalaureate Social Work Degree

APPLICATION FORMS

CSWA Form 1 - Initial Application This form must be completed by all applicants. Your mailing address will be the address to which **ALL** correspondence from the Board office will be sent. Licensing information is subject to public disclosure under ORS 192.420. Your work address and work telephone number will be published on our website. If your home address is listed as your work address then this will be the address published on the BLSW website. It is your responsibility to notify this Board **in writing within 30 days** of any changes in address for work, home or mailing address and phone numbers. There is a change of address form on the boards website, please mail a hard copy of the changes to our office at 3218 Pringle Road SE, Suite 240, Salem OR 97302-6310. Failure to receive a renewal from the Board shall not constitute an excuse for failure to pay the renewal fee or to renew one's license.

Form 2 – CSWA Plan of Supervision If your Plan involves more than one supervisor, submit a Plan of Supervision form for each supervisor. Be sure all required signatures are in place including your administrative supervisor. You can complete the requirements in no less than 24 months and no longer than 60 months per plan. After the Board has approved your application and Plan of Supervision, you will be sent an approval packet in the week following the Board meeting.

******IMPORTANT NOTES**

Be aware that **No** work, client hours or supervision hours will count toward your Plan of supervision **prior** to receiving Board approval of the application, see Rule 877-020-0009(2). Upon Board approval of a Plan, an official approval packet will be mailed to you within the week following the meeting. Your plan begins after it has been approved by the board, **not** when you begin employment or meeting with your supervisor.

Criminal Records Check

All applicants must have a criminal background check completed prior to the approval of an application. The front page of the website www.oregon.gov/blsw has information and a downloadable form to begin the fingerprint process; or you can contact the Board office for a fingerprint packet.

To expedite processing of your application have your fingerprints taken as early in the process as possible to allow ample time for Oregon State Police (OSP) to complete the background check. If your prints are rejected due to poor legibility a new card will be mailed to you for a retake. If you are especially concerned about the turn-around time for this process, consider having your fingerprints scanned electronically at a location that offers that service. The scan will be sent to OSP for processing and the results are sent directly to the Board. You can download the Live Scan Form on our website with other fingerprint materials and instructions.

CSWA APPLICATION REMITTANCE FORM

Please send this remittance invoice along with your fee to Board of License Social Workers, PO Box 4395, Portland, OR 97302. You can download the Fingerprint ID Form from the Board website www.oregon.gov/blsw.

NAME _____ **BIRTH DATE** _____

FEES: Fingerprint background check \$50 (Send this fee with your fingerprint packet)

CSWA Application \$150

Initial CSWA Certificate \$60

Annual renewal \$60



OREGON BOARD OF
LICENSED SOCIAL WORKERS
APPLICATION
CLINICAL SOCIAL WORK ASSOCIATE

CSWA -FORM 1

IDENTIFYING INFORMATION

Date of Birth

Name

Home Address

(Street) (City) (State) (Zip)

Mailing Address (if different from above)

Home Telephone: Optional: E-mail address

(Used only for Board communications, will not be published/sold)

Optional: Second, public E-mail address (may be published/released)

NOTE: The work address will be posted on the board website as public information. If you use your home address for business this will be the address posted on the website. If you do not want your home address posted you may supply the board with a P.O. Box or alternative mailing address for public release.

EMPLOYMENT INFORMATION NOTE: This information will be posted on the Board website.

Current Employer

Address

(Street) (City) (State) (Zip)

Date Of Employment F/T [] P/T [] Job Title

Number of work hours each week Number of direct client hours you will receive each week

Name of LCSW Clinical Supervisor(s) (This is the person who will be supervising your clinical hours)

Name of Administrative Supervisor(s) (This is the person you report to for work)

Briefly Describe Duties:

Briefly Describe Client Population

GRADUATE EDUCATION INFORMATION

CSWA-FORM 1

University or College

Conferred Date MSW Degree

PROFESSIONAL EXPERIENCE - List Post-Masters clinical practice experience with the dates. Please submit as complete information as possible on all positions use additional paper as necessary.

1. Employer Name and Address _____

Position _____ Employment Dates _____

Work Hours Direct Client Hours
Per Week Per Week Phone _____

Supervisor _____ Credentials _____

2. Employer Name and Address _____

Position _____ Employment Dates _____

Work Hours Direct Client Hours
Per Week Per Week Phone _____

Supervisor _____ Credentials _____

3. Employer Name and Address _____

Position _____ Employment Dates _____

Work Hours Direct Client Hours
Per Week Per Week Phone _____

Supervisor _____ Credentials _____

4. Employer Name and Address _____

Position _____ Employment Dates _____

Work Hours Direct Client Hours
Per Week Per Week Phone _____

Supervisor _____ Credentials _____

HISTORY

CSWA-FORM 1

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. All the questions are directed toward your past conduct.

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 charged with, or convicted of, a felony, any sexual offense, child abuse or elder abuse in any state or jurisdiction, including jurisdictions outside the United States?
3. Have you ever been charged with, or convicted of, any offense involving a controlled substance or alcohol?
4. Have you ever been reprimanded, suspended or restricted from practice in any profession or by any agency, employer or professional association?
5. Have you ever been reprimanded, suspended or restricted from practice by any licensed health care facility?
6. Have you ever had your rights to participate in Medicare, Medicaid or other state or federal health care reimbursement program restricted or revoked?
7. Have you ever had licensure, registration or certification to practice denied, revoked, suspended or restricted, in any profession?
8. Are you currently under investigation, or is disciplinary action pending against you, as a result of an action or investigation against you by any board or tribunal in this or any other state, or foreign jurisdiction?
9. Have you ever been the subject of a complaint to a self-regulated professional organization, licensing board or agency, in any profession?
10. Have you ever surrendered your license, certification or registration while under investigation in lieu of discipline (including revocation), in any profession?
11. Have you ever been found in violation of any professional organizations rules or by-laws?
12. Have you ever had a malpractice carrier or confidential impairment program monitor or restrict your practice of any profession?
13. Have you ever had a judgment entered against you in a civil court for a practice (of any profession) related complaint, or have you received notice of a lawsuit in connection with a complaint related to your practice of any profession?
14. Have you ever been arrested for driving under the influence of intoxicants (DUII)?
15. Have you received any in-patient treatment for a psychological condition, addiction, or chemical dependency issue within the last 10 years?
16. Are you currently in treatment for a serious medical condition? Your response will be evaluated by the Board as to whether or not your current medical condition could impact your ability to practice social work safely.

CERTIFICATION

CSWA-FORM 1B

I hereby certify that I have read this application and further certify that the information provided on this form is true and correct. I am aware that falsifying an application, supplying misleading information or withholding information is grounds for denial of an application or revocation of license or certification. I am aware that the Oregon Board of Licensed Social Workers will conduct a criminal records check.

I have read and agree to abide by the laws and administrative rules of the Oregon Board of Licensed Social Workers found in Oregon Revised Statutes, Chapters 675 and 676, and Oregon Administrative Rule, Chapter 877 (<http://www.oregon.gov/BLSW/laws.shtml>). I am aware that failure to observe these laws and rules may result in disciplinary action taken against my application and/or future license/certification. I understand that all fees are non-refundable.

Signature of Applicant _____ **Date** _____

REQUEST FOR VOLUNTARY INFORMATION

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 that requires regulatory boards to request and maintain records of the racial and ethnic makeup of applicants and professionals regulated by the Board. However, your compliance with providing this type of information is voluntary.

ETHNIC BACKGROUND

LANGUAGES

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

- Bilingual Yes No
- American Sign Language
 - Chinese Laotian
 - French Spanish
 - Japanese Vietnamese
 - Korean Russian
 - Other _____

Feel free to contact the Board office if you have any questions regarding the certification process www.oregon.gov or e-mail questions to Oregon.blsw@state.or.us.

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 Licensed 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 Licensed Social Workers, your Social Security Number will remain on file with this agency.

Social Security Number

Signature

Date

VOLUNTARY CONSENT TO USE YOUR SOCIAL SECURITY NUMBER

Oregon Revised Statutes authorizes the State Board of Licensed 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 Licensed Social Workers to use it for the purposes stated above.

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

(Sign here for consent to use SSN)

Date

PLAN OF SUPERVISION

CSWA Name: _____ [] Individual and/or [] Group

CLINICAL SUPERVISOR (To be completed by the Supervisor)

Supervisor's Name _____ Work Phone: _____
(Must be an Oregon LCSW)

License #: _____ Initial Date of License _____ Expires On _____

Employer: _____
Name Address City/State/Zip

Supervisor Requirements: OAR 877-020-0012(8) requires LCSW's to have 2 years of post license experience and taken at least six hours of continuing education courses specific to Supervision **prior** to supervision with a CSWA. These supervision continuing education hours are good for 5 years from the completion date. **Please list your supervision course and attach a copy of the completion certificate to this plan of supervision. If you are not current on your supervision continuing education, please do begin supervision.**

Course/Workshop Title Date taken # of hours

How long have you known this supervisee? _____ (Yrs) _____ (Mo.) Describe **any** previous relationship between you and the supervisee personal and/or professional (use additional sheets of paper if necessary).

To your knowledge, has the applicant ever been convicted of substance abuse, any offense involving a controlled substance or alcohol, or a felony in a state or federal court? [] Yes [] No

If **yes**, please describe briefly: _____

Where will supervision take place? [] Supervisor's office [] Supervisee's office [] other

The fee for supervision will be \$_____ per hour \$_____ per week \$_____ per month.

Please specify other arrangements: _____

DESCRIPTION OF SUPERVISION

CSWA-FORM 2

****Counting of hours for this Plan of supervision may only begin after the date approved by the Board. The Board usually meets the second Tuesday of each month. All hours accrued prior to Board approval will be denied.**

INDIVIDUAL

Supervision must occur at least 2 times a month with a supervisor identified in the plan as required in OAR 877-020-0009 (3) (d).

Number of times scheduled to meet with this Associate per week _____ per month _____

Proposed Individual Supervision is scheduled to begin **after** Board approval on _____
(No hours may count until the Board has approved the supervisee’s application and plan of supervision).

Briefly describe the proposed supervision _____

GROUP

Proposed number in the Group _____(cannot exceed five members in the group at any time)

Number of times scheduled to meet with the Associates per week _____ or per month _____

Proposed Group Supervision is scheduled to begin **after** Board approval on _____
(No hours may count until the Board has approved the supervisee’s application and plan of supervision)

Briefly describe the proposed supervision _____

ALL PLANS require signatures of the Clinical Supervisor (Your LCSW Clinical Supervisor) and Administrative Supervisor (The person you report to for work in the agency) and the Applicant.

CERTIFICATION

I certify by my signature below that the information provided in this document is true and correct to the best of my knowledge.

SIGNATURES

Applicant _____ **Date** _____

LCSW Clinical Supervisor _____ **Date** _____

This person could be both Clinical and Administrative supervisor. If so please sign on both lines.

Administrative Supervisor _____ **Date** _____

This is the person that supervises your work.

RESPONSIBILITIES

Keep this copy for your files and review regularly

Please review the responsibilities regularly to remain within compliance with the Laws and Rules for Oregon Social Workers.

APPLICANT

I understand that my title will be *Clinical Social Work Associate* and that I am **not** permitted, under Oregon Law, to be called or represent myself as a Licensed Clinical Social Worker.

I will follow the Code of Ethics for Social Workers as defined in Oregon Administrative Rules Chapter 877, Division 30.

I will meet with each supervisor and send in **timely** evaluation reports every 6 months to inform the Board of my progress. I will send in a final evaluation after all requirements have been met for the completion of the Plan of Supervision.

I understand I must meet with a Supervisor who is approved in my Plan of Supervision at least two times a month for at least 1 hour each meeting where my clinical work will be discussed, evaluated, and directed.

I understand it is my responsibility to obtain Board approval prior to any change to my Plan of Supervision and to keep the Board office informed of any name or address changes within 30 days of the change.

I understand that the Plan of Supervision cannot be completed in less than 24 months of post MSW supervision and no more than 60 months to complete each Plan. Please refer to Rule 877-020-0010(3) (A).

I will maintain client confidentiality at all times, including, supervision sessions.

LCSW SUPERVISOR

I will closely review the Associates cases with attention to diagnostic evaluation, treatment planning, case management, emergency intervention, record keeping, and termination.

I will review case records, billing records, appointment book, and client population as appropriate.

I will determine the appropriate client populations to be served by the Associate and direct the Associate to refer inappropriate clients to other therapists.

I will maintain confidentiality of all client and supervisory materials.

I will review with the Associate the Oregon Laws and Administrative Rules related to ethical principles of Clinical Social Workers, with specific attention to Division 30, the Code of Ethics.

I will communicate to the Board any interruptions, concerns, or proposed termination of the Plan.

ADMINISTRATIVE SUPERVISOR

I agree to facilitate and encourage the Supervision Plan between the Applicant and the Clinical Supervisor.

I agree to inform the Board of any changes in agency practices or policies which may adversely affect the successful completion of the Plan of Supervision.