

CUSTODIAN OF RECORD – DESIGNATION FORM

(Documentation of compliance with OAR 877-030-0100)

Name of LCSW: _____ License #: _____

1) I currently have a private practice or I have had a private practice within the last seven (7) years.

Yes (If yes then you must complete question 2.)

No (If no then please sign and return to the Board office.)

2) I have a private practice or have had a private practice in the last seven (7) years and I have named a qualified person to intercede for my clients welfare, and to make necessary referrals in case of my death or incapacity to provide services to these clients. The name of the Licensed Clinical Social Worker, licensed mental health professional or professional records Management Company as my custodian of record in the case of my death or incapacity to practice is:

Name: Designated Custodian of Record, License number #, type of license.

Address _____ Phone number _____

Signature of Custodian of Record (Required if appropriate)

Date

Further I understand that I must promptly inform the Board of any change to this custodian of record. I swear/affirm that the information provided above is accurate.

Signature (required)

Date (required)

Please return the completed and signed form to the Board office, you may send the form by mail, facsimile, or as an attachment to an email message. If in the future you need to make changes to the Custodian of Record, this form is located on the Board's website www.Oregon.gov/BLSW

Mail to: Board of Licensed Social Workers
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Salem, OR 97302-6310

FAX: 503-373-1427

Email: oregon.blsw@state.or.us