



**Oregon Board of Licensed Social Workers**  
**3218 Pringle Road SE, Suite 240**  
**Salem, Oregon 97302-6310**  
**(503) 378-5735**  
[Oregon.BLSW@state.or.us](mailto:Oregon.BLSW@state.or.us)  
[www.Oregon.gov/BLSW](http://www.Oregon.gov/BLSW)

SECTION A		APPLICANT INFORMATION	
<b>Legal Last Name</b>	<b>First</b>	<b>Middle</b>	
Street Address			SSN
City	State	Zip	Birth Date MM/DD/YY
Mailing address for license/certificate <b>renewals and board correspondence</b>		<b>Home</b> <input type="checkbox"/>	<b>Work</b> <input type="checkbox"/>
<b>Other</b> <input type="checkbox"/> <b>Please specify</b>			
Home Phone (    )	Cell Phone (    )		
( <b>Public</b> ) E-Mail Address <i>optional</i>			
( <b>Private</b> ) E-Mail Address <i>Board Use Only</i>			

If you are unsure of the license/certificate in which you are applying for, read the description following each license or certification requirements for Oregon. Please be sure that you are sending in the appropriate fees as **all fees are non-refundable**.  
*Mail all fees and original applications to: **Board of Licensed Social Workers, 3218 Pringle Rd. SE, Suite 240, Salem, OR 97302-6310.***

<input type="checkbox"/> Licensed Clinical Social Worker ( <b>LCSW</b> )  <b>\$330</b> - Fees cover Application, Criminal Background Check, and Initial License	Have a clinical license in another jurisdiction in which substantially equivalent requirements for Oregon have been met, and passed the ASWB Clinical Exam. <b>Complete Pages 1-5, and Page 9</b>  <b>**If you have <u>not</u> taken the ASWB Clinical Exam, apply for the CSWA.</b>
<input type="checkbox"/> Clinical Social Work Associate ( <b>CSWA</b> )  <b>\$260</b> - Fees cover Application, Criminal Background Check, and Initial Certificate	All LCSWs licensed in another state, but who <b>have not</b> completed the ASWB Clinical Exam, must apply for the CSWA and work under a revised plan of supervision until all licensure criteria has been met.  MSWs interested in working toward a clinical license. MSWs that have completed significantly equivalent requirements for Oregon in another state, but who have not passed the ASWB Clinical Exam.  <b>Complete Pages 1-7, and Pages 8 &amp; 9 where applicable</b>
<input type="checkbox"/> Licensed Masters Social Worker ( <b>LMSW</b> )  <b>\$200</b> - Fees cover Application, Criminal Background Check, and Initial License	This is a <b>non-clinical</b> license for MSWs, and requires no supervision hours.  <b>Complete Pages 1-5, and Page 9 where applicable</b>
<input type="checkbox"/> Registered Baccalaurate Social Worker ( <b>RBSW</b> )  <b>\$150</b> - Fees cover Application, Criminal Background Check, and Initial Certificate	This is a <b>non-clinical</b> license for BSWs, and requires no supervision hours.  <b>Complete Page 1-5, and 9 where applicable</b>

SECTION B				CURRENT EMPLOYMENT	
Agency			Date of Employment MM/DD/YY		
Address			Phone ( )		
City		Job Title			
State	Zip Code	Administrative Supervisor			
Number of hours worked each week _____			Number of direct client hours each week _____		

SECTION C		EDUCATION	
Please have an <b>official transcript sent directly from your college or university</b> to the board office, 3218 Pringle Road SE, Suite 240, Salem, OR 97302-6310.			
<b>MSW</b> Degree programs must be accredited by the Council on Social Work Education (CSWE) at the time of your graduation.			
<b>BSW</b> Degree programs must be accredited or in Candidacy status by CSWE at the time of your graduation.			
University or College Attended			
Conferred Degree Date		CSWE Accredited YES <input type="checkbox"/> NO <input type="checkbox"/>	
Please check degree(s) completed BSW <input type="checkbox"/> MSW <input type="checkbox"/> DSW <input type="checkbox"/>			

SECTION D		PREVIOUS EMPLOYMENT	
(List any professional licenses or certifications held in this or any other state)			
<b>#1</b>			
Agency		Employment Dates MM/DD/YY From To	
Address		Phone ( )	
City	State	Zip	Supervisor
List All Licenses or Certifications Current or Expired			
<b>#2</b>			
Agency		Employment Dates MM/DD/YY From To	
Address		Phone ( )	
City	State	Zip	Supervisor
List All Licenses or Certifications Current or Expired			
<b>#3</b>			
Agency		Employment Dates MM/DD/YY From To	
Address		Phone ( )	
City	State	Zip	Supervisor
List All Licenses or Certifications Current or Expired			

SECTION E  
PART 1

**FEDERAL REQUIREMENT FOR SOCIAL SECURITY NUMBER**

**ATTENTION**

**SOCIAL SECURITY NUMBER**

**(Federal Requirement - This is a mandatory 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. 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

SECTION E  
PART 2

**FEDERAL REQUIREMENT FOR SOCIAL SECURITY NUMBER**

**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***. If you choose to not allow your Social Security Number to be used for any of these purposes it 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 the SSN)

\_\_\_\_\_  
Date

**PLEASE READ & ANSWER EACH QUESTION CAREFULLY. NOTE: 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 copies of related official documentation (including all police reports, court documents, final actions, etc. in your possession) with this application form.**

<p><b>1)</b> Have you ever used any name other than the one you are using to make this application? If yes please list every name you have ever used.</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p><b>2)</b> Have you ever knowingly been the <b>suspect</b> in, <b>arrested</b> for, <b>charged</b> with, <b>cited</b> in lieu of custody or <b>convicted</b> of any of the following in any state or jurisdiction, including jurisdictions outside the United States? This includes any conditional discharge or postponed adjudications that have not been dismissed by any court at the time this application has been signed: <input type="checkbox"/> a felony <input type="checkbox"/> any sexual offense <input type="checkbox"/> child abuse <input type="checkbox"/> elder abuse <input type="checkbox"/> animal abuse</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p><b>3)</b> Have you ever knowingly been the <b>suspect</b> in, <b>arrested</b> for, <b>charged</b> with, <b>cited</b> in lieu of custody or <b>convicted</b> of any offense involving any controlled substance (to include marijuana) or alcohol? This includes any conditional discharge or postponed adjudications that have not been dismissed by any court at the time this application has been signed.</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p><b>4)</b> Have you ever knowingly been the <b>suspect</b> in, <b>arrested</b> for, <b>charged</b> with, <b>cited</b> in lieu of arrest/custody, or <b>convicted</b> of any offense or crime? This includes any conditional discharge or postponed adjudications by any court.</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p><b>5)</b> Have you ever been arrested for driving under the influence of intoxicants (DUII) in any state? <b>NOTE: You must disclose even if you were granted a diversion or conditional discharge.</b></p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p><b>6)</b> Are you currently on parole or probationary status with any court, law enforcement agency or other?</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p><b>7)</b> Have you ever been reprimanded, suspended or restricted from practice in any profession or by any agency, employer, professional association, health care facility, other?</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p><b>8)</b> Have you ever had your rights to participate in Medicare, Medicaid or other state or federal health care reimbursement programs restricted or revoked?</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p><b>9)</b> Have you ever had licensure, registration or certification to practice denied, revoked, suspended or restricted, in any profession?</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p><b>10)</b> 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?</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p><b>11)</b> Have you ever been the subject of a complaint to a self-regulated professional organization, licensing board or agency, in any profession?</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p><b>12)</b> Have you ever surrendered your license, certification or registration while under investigation in lieu of discipline or any action (including revocation), in any profession?</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p><b>13)</b> Have you ever been found in violation of any professional organization's rules or by-laws?</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p><b>14)</b> Have you ever been the subject of any employer disciplinary action where your practicing privileges were denied, reduced, restricted, suspended, revoked, or terminated (to include non-renewal of employment contacts)?</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p><b>15)</b> Have you ever had a malpractice carrier or a confidential impairment program monitor or restrict practicing privileges within any profession?</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>

<b>16)</b> Have you ever had any civil judgment or other court order for any of the follow: <input type="checkbox"/> <b>Lawsuit or complaint related to your practice of any profession</b> <input type="checkbox"/> <b>Stalking Order</b> <input type="checkbox"/> <b>Restraining Order</b> <input type="checkbox"/> <b>Other:</b> _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>17)</b> Are there any pending court proceeding against you ( <b>excluding the following:</b> divorce, custody and domestic partnership proceedings)?	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>18)</b> Have you received any <b>in-patient</b> treatment for a psychological condition, addiction, or chemical dependency issue within the last 10 years?	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>19)</b> Are you currently in treatment for any 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.	YES <input type="checkbox"/> NO <input type="checkbox"/>

**SECTION F CERTIFICATION AND SIGNATURE**  
**PART 2**

By the execution of my signature below, I hereby certify that I have read this application in its entirety and the information provided herein is true and complete to the best of my knowledge. I acknowledge that falsifying any information on this application, supplying misleading information or withholding information are grounds for denial of my application; or revocation of my license or certification. I am aware that the Oregon Board of Licensed Social Workers will conduct a criminal background check.

I have read and agree to adhere to the Oregon Board of Licensed Social Workers Oregon Revised Statutes (ORS), Chapters 675 and 676, Oregon Administrative Rules (OAR), Chapter 877, as well as any other applicable statutes or rules that are governing (<http://www.oregon.gov/BLSW/laws.shtml>). I am aware that failure to adhere to these statutes and rules may result in disciplinary action taken against my application and/or future license/certification.

**Applicant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**SECTION G REQUEST FOR VOLUNTARY INFORMATION**

It is the Boards 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, the request for this type of information is voluntary and not required.

ETHNIC INFORMATION	LANGUAGE	
A. <input type="checkbox"/> Asian/Pacific Islander	1. <input type="checkbox"/> ASL	8. <input type="checkbox"/> Spanish
B. <input type="checkbox"/> Black	2. <input type="checkbox"/> Chinese	9. <input type="checkbox"/> Thai
C. <input type="checkbox"/> Hispanic	3. <input type="checkbox"/> French	10. <input type="checkbox"/> Vietnamese
D. <input type="checkbox"/> American Indian/Native American	4. <input type="checkbox"/> German	11. <input type="checkbox"/> Russian
E. <input type="checkbox"/> White	5. <input type="checkbox"/> Japanese	12. <input type="checkbox"/> Other
F. <input type="checkbox"/> Other	6. <input type="checkbox"/> Korean	13. <input type="checkbox"/> English
G. <input type="checkbox"/> Prefer not to respond	7. <input type="checkbox"/> Laotian	66. <input type="checkbox"/> Prefer not to respond

**SECTION H CLINICAL SOCIAL WORK ASSOCIATE – PLAN OF SUPERVISION**

**Part 1**

**Supervisor Requirements:** OAR 877-020-0012(8) requires LCSW's to have 2 years of post license experience in this or any other state and completed six hours of continuing education courses specific to Supervision and/or Ethics. These hours are good for 5 years from the completion date. A copy of the completion certificate documenting the CE must be on file in the Board office before beginning supervision with a CSWA.

<b>INDIVIDUAL LCSW Supervisor/Lic #</b>	Phone (      )
---	----------------

Where will supervision take place? Supervisor's Office  CSWA's Office  Other  Specify on another sheet of paper

Is there a fee for Supervision? \$ \_\_\_\_\_  per hour  per month  part of employment

Title of Supervision Course:

Date course taken: \_\_\_\_\_ Number of CE hours received: \_\_\_\_\_

Briefly describe the proposed **group supervision**

<b>GROUP LCSW Supervisor/Lic #</b>	Phone (      )
--	----------------

Where will supervision take place? Supervisor's Office  CSWA's Office  Other  Specify on another sheet of paper

Is there a fee for Supervision? \$ \_\_\_\_\_  per hour  per month  part of employment

Title of Supervision Course:

Date course taken: \_\_\_\_\_ Number of CE hours received: \_\_\_\_\_

Briefly describe the proposed **group supervision**

**SECTION H CERTIFICATION SIGNATURES FOR CURRENT PLAN OF SUPERVISION**

**Part 2**

I certify that the information provided in this document is true and correct to the best of my knowledge. I agree to work with this Plan as described above. **ALL PLANS** require signatures of the **Clinical Supervisor, Administrative Supervisor, and the Applicant**. Be sure that all signatures are in place before submitting your application. Unsigned forms will be returned, thereby causing a delay in processing your application and issuing your certificate. No hours count toward your plan until approved by the Board.

_____ <b>CSWA Applicant</b> Signature	_____ Date	_____ Print Name Clearly
_____ LCSW <b>(Individual)</b> Supervisor Signature	_____ Date	_____ Print Name Clearly
_____ LCSW <b>(Group)</b> Supervisor Signature	_____ Date	_____ Print Name Clearly
_____ <b>Administrative</b> Supervisor Signature	_____ Date	_____ Print Name Clearly

SECTION I  
Part 3

**CSWA RESPONSIBILITIES**

**I understand** that my title will be *Clinical Social Work Associate* (CSWA) 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 understand** I must meet with my Supervisor(s) at least two times a month for a minimum of 1 hour each meeting where my clinical work will be discussed, evaluated, and directed. In the case of an individual and group supervisor one meeting with each supervisor will meet this requirement.

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

**I understand** that the Associate Plan cannot be completed in less than 24 months post MSW supervision and can take no longer than 60 months to complete each Associate Plan, as defined in Oregon Administrative Rules Chapter 877-020-0010 (3)(A).

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

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

**ADMINISTRATIVE SUPERVISOR RESPONSIBILITIES**

**I agree** to facilitate and encourage the Supervision Plan for supervision between the applicant (Associate) and the 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.

**LCSW SUPERVISOR RESPONSIBILITIES**

**I will** closely review and supervise representative and problem cases with attention to diagnostic evaluation, treatment planning, ongoing case management, emergency intervention, record keeping, and termination.

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

**I will** determine appropriate client populations to be served 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 the ethical principles of Clinical Social Workers, with specific attention to Division 30, the Code of Ethics.

**I will** submit **timely** Six-Month Evaluation reports to the Board of the Associate's progress and a final evaluation at the conclusion of the Plan.

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

I have read and understand my responsibilities as a **CSWA Applicant**

**Initial** \_\_\_\_\_

I have read and understand my responsibilities as a **LCSW Supervisor**

**Initial** \_\_\_\_\_

I have read and understand my responsibilities as an **Administrative Supervisor**

**Initial** \_\_\_\_\_

**SECTION J  
PART 1**

**PREVIOUS WORK AND SUPERVISION HOURS  
COMPLETED IN ANOTHER JURISDICTION**

This form is to be used by applicants to document previous supervision which was received (all or part) from another state.  
**NOTE:** Approval of any or all previous clinical practice and supervision hours is at the Board's discretion. Make additional copies of this form if needed.

**Applicant Name**

(Please print)

(Please print)

**Supervisor #1  
Name**

Supervision completed  
In the State of \_\_\_\_\_

Credentials  
License # \_\_\_\_\_

Issue  
Date \_\_\_\_\_

Phone ( ) \_\_\_\_\_

**Total Individual supervision**  
hours with this supervisor

**Total Group supervision**  
hours with this supervisor

Number of work hours per week

Number of direct client hours per week

Briefly describe supervision sessions

(Please print)

**Supervisor #2  
Name**

Supervision completed  
In the State of \_\_\_\_\_

Credentials  
License # \_\_\_\_\_

Issue  
Date \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Total Individual supervision  
hours with this supervisor

Total Group supervision  
hours with this supervisor

Number of work hours per week

Number of direct client hours per week

Briefly describe supervision sessions

**PART 2**

**CERTIFYING STATEMENT (SUPERVISORS IN ANOTHER JURISDICTION)**

I certify that the information provided in this document is true and correct to the best of my knowledge. Be sure that all signatures are in place before submitting your application. Unsigned forms will be returned, thereby causing a delay in processing your application and issuing your certificate. No hours will count toward your plan until approved by the Board.

**Supervisor #1**

(Clinical Supervisor) \_\_\_\_\_ Credentials/License # \_\_\_\_\_

Signature

Title \_\_\_\_\_

Phone \_\_\_\_\_

Individual  Group Both

**Supervisor #2**

(Clinical Supervisor) \_\_\_\_\_ Credentials/License # \_\_\_\_\_

Signature

Title \_\_\_\_\_

Phone \_\_\_\_\_

Individual  Group Both

Section K

**Verification of Social Work License/Registration/Certification  
In Another Jurisdiction**



**Board of Licensed Social Workers**  
**3218 Pringle Road SE, Suite 240**  
**Salem, Oregon 97302-6310**  
**(503) 378 -5735**  
[Oregon.blsw@state.or.us](mailto:Oregon.blsw@state.or.us)  
<http://oregon.gov/blsw>

This certifies that \_\_\_\_\_ has been licensed, certified, or registered in the  
 Applicant Name

State of	License Number	Original Date Of Licensure
----------	----------------	----------------------------

Applicant acquired a *minimum* of 24 months of full-time or 48 months of part-time, post masters supervised clinical social work experience that is substantially equivalent to Oregon requirements, 3500 work hours/2000 direct client hours. YES  NO

Applicant documented a *minimum* of 100 hours of LCSW or equivalent clinical supervision. Equivalent qualifications include clinical social workers who meet LCSW requirements, Licensed Psychologists, Board Certified Psychiatrists YES  NO

Applicant took and passed what Level examination given by the Association of Social Work Boards (ASWB)?

**Bachelors Exam**  **Masters Exam**

Date Taken \_\_\_\_\_ Pass Fail Date Taken \_\_\_\_\_ Pass Fail

**Advanced Exam**  **Clinical Exam**

Date Taken \_\_\_\_\_ Pass Fail Date Taken \_\_\_\_\_ Pass Fail

Any Legal/Disciplinary Actions? YES  NO

If "Yes", please attach a written explanation and include a copy of the disciplinary action document.

**I certify that the above information is correct and true to the best of my knowledge.**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

State of: \_\_\_\_\_

Date Completed: \_\_\_\_\_

Affix Official State Seal

**NOTE:** This form must be completed by each licensing Board where you have held a license, certification or registration and mailed directly to the Oregon Board. **Please include the Licensure Statutes and Rules in effect at the time of licensure for this applicant.**

**\*\*Contact your licensing agency to see if there is a charge for completing this verification of your license/certificate.**