

STATE BOARD OF LICENSED SOCIAL WORKERS
REVISED CANDIDATE PLAN

Form 9

ASSOCIATE'S NAME _____ Cert. No. _____

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

- Continue in same employment/Same supervisor (Do Form 9)
- Add Individual/New Supervisor (Do Forms 9 & 2)
- New Employment/Same Supervisor (Do Form 9)
- Add Group/Same Supervisor (Do Forms 9 & 2)
Number of supervisee's in Group _____
- New Employment/New Supervisor (Do Forms 9 & 2)

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

*** EMPLOYMENT INFORMATION (Volunteer hours are acceptable)**

Are you currently working in an Agency? Yes No Clinical Supervisor _____
Are you working F/T P/T License Number _____
Employer Name _____ Telephone _____
Address _____
Beginning Date of this Employment _____ Job Title _____

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