OREGON BOARD OF LICENSED SOCIAL WORKERS

APPLICATION

NAME:

Last Name, First Name Middle Initial

FOR OFFICE USE ONLY ~ RECEIVED ON:

☐ LCSW APPLICANT
☐ CSWA APPLICANT
☐ LMSW APPLICANT
☐ RBSW APPLICANT

SECTION A: ~ APPLICANT INFORMATION

OTHER NAMES USED:

SOCIAL SECURITY NUMBER: - -

DATE OF BIRTH: **GENDER: MALE** ☐ **FEMALE** ☐

HOME ADDRESS:

City State Zip Code

MAILING ADDRESS (IF DIFFERENT THAN HOME ADDRESS):

City State Zip Code

HOME ☎: **MOBILE ☎:**

PRIVATE EMAIL ADDRESS (BOARD USE ONLY):

PUBLIC EMAIL ADDRESS (OPTIONAL DISCLOSURE):

ADDRESS OF RECORD:
Oregon Administrative Rule 877-001-0009 [2013] requires all licensees, applicants, certificate or registration holders of the Board, to designate and keep current, an ADDRESS OF RECORD with the Board. You may designate, at your discretion, a current employment address, home address or P.O. Box address as the ADDRESS OF RECORD.

PLEASE CHECK THE BOX DESIGNATING YOUR ADDRESS OF RECORD FOR THE BOARD:

HOME ADDRESS: ☐ **MAILING ADDRESS:** ☐ **WORK ADDRESS:** ☐

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 & maintain records of the racial & ethnic makeup of applicants & professionals regulated by the Board. However, the request for this type of information is voluntary & not required.

ETHNIC INFORMATION:			LANGUAGE:					
A.	☐	ASIAN / PACIFIC ISLANDER	1.	☐	ASL	8.	☐	SPANISH
B.	☐	BLACK	2.	☐	CHINESE	9.	☐	THAI
C.	☐	HISPANIC	3.	☐	FRENCH	10.	☐	VIETNAMESE
D.	☐	AMERICAN INDIAN / NATIVE AMERICAN	4.	☐	GERMAN	11.	☐	RUSSIAN
E.	☐	WHITE	5.	☐	JAPANESE	12.	☐	OTHER
F.	☐	OTHER	6.	☐	KOREAN	13.	☐	ENGLISH
G.	☐	PREFER NOT TO RESPOND	7.	☐	LAOTIAN	66.	☐	PREFER NOT TO RESPOND

IF YOU ARE UNSURE OF THE LICENSE/CERTIFICATE IN WHICH YOU ARE APPLYING FOR, PLEASE 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.***

LICENSURE TYPE:	QUALIFICATIONS:
L.C.S.W. ☐ ***LICENSED CLINICAL SOCIAL WORKER*** ***$460.00 ~ FEES COVER APPLICATION, CRIMINAL BACKGROUND CHECK & 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.* ⇨ ***COMPLETE APPLICATION PAGES 1 – 7 & PAGE 13*** ****** IF YOU HAVE NOT TAKEN THE ASWB CLINICAL EXAM, YOU WILL NEED TO APPLY FOR THE CSWA***
C.S.W.A. ☐ ***CLINICAL SOCIAL WORKER ASSOCIATE*** ***$260.00 ~ FEES COVER APPLICATION, CRIMINAL BACKGROUND CHECK & INITIAL LICENSE***	*All LCSW's licensed in another state, but who* ***HAVE NOT*** *completed the ASWB Clinical Exam, must apply for the CSWA & work under a revised PLAN OF SUPERVISION until all licensure criteria have been met.* ***MSW's*** *interested in working toward a clinical license.* ***MSW's*** *that have completed significantly equivalent requirements for Oregon in another state, but who have not passed the ASWB Clinical Exam.* ⇨ ***COMPLETE APPLICATION PAGES 1 – 10 & PAGES 11 - 13 WHERE APPLICABLE***
L.M.S.W. ☐ ***LICENSED MASTERS SOCIAL WORKER*** ***$200.00 ~ FEES COVER APPLICATION, CRIMINAL BACKGROUND CHECK & INITIAL LICENSE***	*This is a* ***NON-CLINICAL*** *license for MSW's, & requires no supervision hours.* ⇨ ***COMPLETE PAGES 1 – 7 & PAGE 13 WHERE APPLICABLE***
R.B.S.W. ☐ ***REGISTERED BACCALAURATE SOCIAL WORKER*** ***$150.00 ~ FEES COVER APPLICATION, CRIMINAL BACKGROUND CHECK & INITIAL LICENSE***	*This is a* ***NON-CLINICAL*** *license for BSW's, & requires no supervision hours.* ⇨ ***COMPLETE PAGES 1 – 7 & PAGE 13 WHERE APPLICABLE***

SECTION B: ~ CURRENT EMPLOYMENT

NAME OF CURRENT EMPLOYER:

ADDRESS:

City *State* *Zip Code*

JOB TITLE:

DATE OF EMPLOYMENT (MM/DD/YYYY):

WORK ☎: ***WORK EMAIL:***

ADMINISTRATIVE SUPERVISOR:

NUMBER OF HOURS WORKED EACH WEEK: ***NUMBER OF DIRECT CLIENT HOURS EACH WEEK:***

SECTION C: ~ EDUCATION

OFFICIAL TRANSCRIPTS:

*Please have an **OFFICIAL TRANSCRIPT SENT DIRECTLY FROM YOUR COLLEGE OR UNIVERSITY** to the Board Office.*
***MSW** Degree programs must be accredited by the Council on Social Work Education (CSWE) at the time of your graduation.*
***BSW** Degree programs must be accredited or in Candidacy status by the CSWE at the time of your graduation.*

NAME OF UNIVERSITY OR COLLEGE ATTENDED:

CONFERRED DEGREE DATE: **CSWE ACCREDITED:** **YES:** ☐ **NO:** ☐

PLEASE CHECK DEGREE(S) COMPLETED: **BSW:** ☐ **MSW:** ☐ **DSW:** ☐

LIST ANY PROFESSIONAL LICENSES OR CERTIFICATIONS HELD IN THIS OR ANY OTHER STATE:

SECTION D: ~ PREVIOUS EMPLOYMENT

NAME OF EMPLOYER:

ADDRESS:

City State Zip Code

JOB TITLE:

EMPLOYMENT DATES (MM/DD/YYYY): **FROM:** **TO:**

WORK ☎:

ADMINISTRATIVE SUPERVISOR:

LIST ALL LICENSES OR CERTIFICATIONS, CURRENT OR EXPIRED:

NAME OF EMPLOYER:

ADDRESS:

City State Zip Code

JOB TITLE:

EMPLOYMENT DATES (MM/DD/YYYY): **FROM:** **TO:**

WORK ☎:

ADMINISTRATIVE SUPERVISOR:

LIST ALL LICENSES OR CERTIFICATIONS, CURRENT OR EXPIRED:

SECTION D: ~ PREVIOUS EMPLOYMENT (CONTINUED)

NAME OF EMPLOYER:

ADDRESS:

City | State | Zip Code

JOB TITLE:

EMPLOYMENT DATES (MM/DD/YYYY): FROM: **TO:**

WORK ☎:

ADMINISTRATIVE SUPERVISOR:

LIST ALL LICENSES OR CERTIFICATIONS, CURRENT OR EXPIRED:

NAME OF EMPLOYER:

ADDRESS:

City | State | Zip Code

JOB TITLE:

EMPLOYMENT DATES (MM/DD/YYYY): FROM: **TO:**

WORK ☎:

ADMINISTRATIVE SUPERVISOR:

LIST ALL LICENSES OR CERTIFICATIONS, CURRENT OR EXPIRED:

SECTION E: ~ SOCIAL SECURITY NUMBER FEDERAL REQUIREMENT (PART 1)

FEDERAL REQUIREMENT FOR SOCIAL SECURITY NUMBERS:

ATTENTION: 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 Oregon Revised Statute (ORS) 25.785, ors 305.385, 42 USC § 405 (c)(2)(C)(i), & 42 USC § 666(a)(13) (Federal Law).

Failure to provide your Social Security 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 & 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 & Human Services as required by 42 USC § 1320(a) – (7)(e) & 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: _____ SIGN HERE **DATE:** _____

SECTION E: ~ SOCIAL SECURITY NUMBER FEDERAL REQUIREMENT (PART 2)

FEDERAL REQUIREMENT FOR SOCIAL SECURITY NUMBERS:

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 & 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.

SIGNATURE FOR CONSENT TO USE SOCIAL SECURITY #: _____ SIGN HERE **DATE:** _____

PLEASE READ & ANSWER EACH MANDATORY QUESTION CAREFULLY

NOTE: IF YOU ANSWER "YES" TO ANY OF THE QUESTIONS BELOW, YOU MUST SUBMIT A DETAILED EXPLANATION (SIGNED & DATED) ON A SEPARATE SHEET OF PAPER.

YOU MUST INCLUDE COPIES OF RELATED OFFICIAL DOCUMENTATION (INCLUDING ALL POLICE REPORTS, COURT DOCUMENTS, FINAL ACTIONS, ETC.) WITH THIS APPLICATION, OR YOUR APPLICATION WILL BE CONSIDERED "INCOMPLETE."

SECTION F: ~ MANDATORY HISTORY QUESTIONS (PART 1)

		YES	NO
1.	***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 on a ***SEPARATE*** sheet of paper.	☐	☐
2.	***HAVE YOU EVER*** knowingly been the ***SUSPECT IN, ARRESTED FOR, CHARGED WITH, CITED IN LIEU OF PHYSICAL CUSTODY or CONVICTED*** 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: ☐ ~A Felony ☐ ~Any Sexual Offense ☐ ~Child Abuse ☐ ~Elder Abuse ☐ ~Animal Abuse	☐	☐
3.	***HAVE YOU EVER*** knowingly been the ***SUSPECT IN, ARRESTED FOR, CHARGED WITH, CITED IN LIEU OF CUSTODY or CONVICTED*** 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.	☐	☐
4.	***HAVE YOU EVER*** knowingly been the ***SUSPECT IN, ARRESTED FOR, CHARGED WITH, CITED IN LIEU OF PHYSICAL CUSTODY or CONVICTED*** of any offense or crime? This includes any conditional discharge or postponed adjudications by any court.	☐	☐
5.	***HAVE YOU EVER*** been arrested for ***DRIVING UNDER THE INFLUENCE of INTOXICANTS (DUII)*** in any state? ***NOTE: YOU MUST DISCLOSE EVEN IF YOU WERE GRANTED A DIVERSION OR CONDITIONAL DISCHARGE***	☐	☐
6.	Are you currently on parole or probationary status with any court, law enforcement agency or other?	☐	☐
7.	***HAVE YOU EVER*** been reprimanded, suspended or restricted from practice in any profession or by any agency, employer, professional association, health care facility or other?	☐	☐
8.	***HAVE YOU EVER*** had your rights to participate in Medicare, Medicaid or other state or federal health care reimbursement programs restricted or revoked?	☐	☐
9.	***HAVE YOU EVER*** had licensure, registration or certification to practice denied, revoked, suspended or restricted in any profession?	☐	☐
10.	***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?	☐	☐
11.	***HAVE YOU EVER*** been the subject of a complaint to a self-regulated professional organization, licensing board or agency, in any profession?	☐	☐
12.	***HAVE YOU EVER*** surrendered your license, certification or registration while under investigation in lieu of discipline or any action (including revocation), in any profession?	☐	☐

		YES	NO
13.	***HAVE YOU EVER*** been found in violation of any professional organization's rules or by-laws?	☐	☐
14.	***HAVE YOU EVER*** been the subject of any employer disciplinary action where your practicing privileges were denied, reduced, restricted, suspended, revoked, terminated (to include non-renewal of employment contracts)?	☐	☐
15.	***HAVE YOU EVER*** had a malpractice carrier or a confidential impairment program monitor or restrict your practicing privileges within any profession?	☐	☐
16.	***HAVE YOU EVER*** had any civil judgment or other court order for any of the following: ☐ ~***STALKING ORDER*** ☐ ~***RESTRAINING ORDER*** ☐ ~***LAWSUIT OR COMPLAINT RELATED TO YOUR PRACTICE OF ANY PROFESSION***	☐	☐
17.	***ARE THERE ANY*** pending court proceedings against you (***EXCLUDING*** divorce, custody & domestic partnership proceedings)?	☐	☐
18.	***HAVE YOU RECEIVED*** any ***IN-PATIENT*** treatment for a psychological condition, addiction, or chemical dependency issue within the last 10 years?	☐	☐
19.	***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.	☐	☐

SECTION F: ~ CERTIFICATION & SIGNATURE (PART 2)

BY THE EXECUTION OF MY SIGNATURE BELOW, I HEREBY CERTIFY THAT I HAVE READ THIS APPLICATION IN ITS ENTIRETY & THE INFORMATION PROVIDED HEREIN IS TRUE & 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 & AGREE TO ADHERE TO THE OREGON BOARD OF LICENSED SOCIAL WORKERS OREGON REVISED STATUTES (ORS), CHAPTERS 675 & 676, OREGON ADMINISTRATIVE RULES (OAR), CHAPTER 877, AS WELL AS ANY OTHER APPLICABLE STATUTES OR RULES THAT ARE GOVERNING.

I AM AWARE THAT FAILURE TO ADHERE TO THESE STATUTES & RULES MAY RESULT IN DISCIPLINARY ACTION TAKEN AGAINST MY APPLICATION AND/OR FUTURE LICENSE/CERTIFICATIONS.

PRINT APPLICANT'S NAME:

APPLICANT'S SIGNATURE: ***SIGN HERE*** ***DATE:***

CLINICAL SOCIAL WORK ASSOCIATE
PLAN OF SUPERVISION

SECTION G: ~ CLINICAL SOCIAL WORK ASSOCIATE ~ PLAN OF SUPERVISION

SUPERVISION REQUIREMENTS:

OAR 877-020-0012(8) *requires LCSW's to have (2) years of post license experience in this or any other state, and have completed (6) hours of continuing education courses specific to Supervision. These hours are good for (5) years from the completion date. A copy of the completion certificate documenting the CE's, must be on file in the Board office before beginning supervision with a CSWA.*

INDIVIDUAL LCSW SUPERVISOR NAME: _____ ***LICENSE #:*** _____

Last Name, First Name Middle Initial

TELEPHONE #: _____

WHERE WILL THE SUPERVISION TAKE PLACE? ***SUPERVISOR'S OFFICE:*** ☐ ***CSWA'S OFFICE:*** ☐

OTHER: _____

IS THERE A FEE FOR SUPERVISION? $ _____ ***PER HOUR:*** ☐ ***PER MONTH:*** ☐ ***PART OF EMPLOYMENT:*** ☐

TITLE OF SUPERVISION COURSE: _____

DATE COURSE TAKEN: _____ ***NUMBER OF C.E. HOURS RECEIVED:*** _____

BRIEFLY DESCRIBE THE PROPOSED ***INDIVIDUAL SUPERVISION ~***

GROUP LCSW SUPERVISOR NAME: _____ ***LICENSE:*** _____

Last Name, First Name Middle Initial

TELEPHONE: _____

WHERE WILL THE SUPERVISION TAKE PLACE? ***SUPERVISOR'S OFFICE:*** ☐ ***CSWA'S OFFICE:*** ☐

OTHER: _____

IS THERE A FEE FOR SUPERVISION? $ _____ ***PER HOUR:*** ☐ ***PER MONTH:*** ☐ ***PART OF EMPLOYMENT:*** ☐

TITLE OF SUPERVISION COURSE: _____

DATE COURSE TAKEN: _____ ***NUMBER OF C.E. HOURS RECEIVED:*** _____

BRIEFLY DESCRIBE THE PROPOSED ***GROUP SUPERVISION ~ (NO MORE THAN (5) INDIVIDUALS PER GROUP SESSION):***

CERTIFICATION SIGNATURES FOR CURRENT PLAN OF SUPERVISION:

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 CSWA 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.

INDIVIDUAL SUPERVISOR

(LCSW INDIVIDUAL)

(Print Name of LCSW Supervisor) (License #) (Signature of LCSW Supervisor) SIGN HERE

(Date) (Email) (Telephone)

GROUP SUPERVISOR

(LCSW GROUP)

(Print Name of LCSW Supervisor) (License #) (Signature of LCSW Supervisor) SIGN HERE

(Date) (Email) (Telephone)

ADMINISTRATIVE SUPERVISOR

(PERSON YOU REPORT TO FOR WORK)

(Print Name of Supervisor) (License #) (Signature of Administrative Supervisor) SIGN HERE

(Date) (Email) (Telephone)

C.S.W.A.

(Print Name of CSWA) (Signature of CSWA) SIGN HERE

(Date)

CSWA RESPONSIBILITIES:

- ☐ ***I UNDERSTAND…..*** that my title will be **CLINICAL SOCIAL WORK ASSOCIATE (CSWA)** and 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 (2) 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, (1) meeting with each supervisor will meet this requirement.
- ☐ ***I UNDERSTAND…..*** it is my responsibility to obtain, prior to Board approval, of changes 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 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*** (6) Month Evaluation Reports to the Board, of the Associate's progress, with 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 AN LCSW SUPERVISOR*** ***INITIAL:*** ☐

☐ ***I HAVE READ AND UNDERSTAND MY RESPONSIBILITIES AS AN ADMINISTRATIVE SUPERVISOR*** ***INITIAL:*** ☐

SUPERVISORS:

NO DIRECT CLIENT, WORK OR SUPERVISION HOURS CAN BE COUNTED FOR A PLAN OF SUPERVISION PRIOR TO BOARD APPROVAL.

CSWA'S: APPLICATIONS CANNOT BE APPROVED BY THE BOARD WITHOUT THE FOLLOWING:

- *Results from the Criminal Background Check, which takes approximately 2 to 3 weeks*
- *Completed Application with all appropriate signatures by the Applicant, Administrative Supervisor and Clinical Supervisor (If the Clinical and Administrative Supervisor are the same person, have them sign both areas)*
- *Official transcript in a sealed envelope documenting MSW degree accredited by the Council on Social Work Education at the time of conferred degree date*
- *Fees for Application, Criminal Background Check and Initial Certificate*

OUT- OF - STATE VERIFICATION:

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 & SUPERVISION HOURS IS AT THE BOARD'S DISCRETION. MAKE ADDITIONAL COPIES OF THIS FOR AS NEEDED.

SECTION H: ~ PREVIOUS WORK & SUPERVISION HOURS COMPLETED IN ANOTHER JURISDICTION

APPLICANT NAME:

Last Name, First Name Middle Initial

SUPERVISOR #1 NAME:

SUPERVISOR'S LICENSE #: **ISSUE DATE:** ☎:

SUPERVISION COMPLETED IN THE STATE OF:

TOTAL INDIVIDUAL SUPERVISION HOURS WITH THIS SUPERVISOR: **TOTAL GROUP SUPERVISION HOURS WITH THIS SUPERVISOR:**

TOTAL NUMBER OF WORK HOURS: **TOTAL NUMBER OF DIRECT CLIENT HOURS:**

START DATE: **END DATE:**

BRIEFLY DESCRIBE SUPERVISION SESSIONS:

SUPERVISOR #2 NAME:

SUPERVISOR'S LICENSE #: **ISSUE DATE:** ☎:

SUPERVISION COMPLETED IN THE STATE OF:

TOTAL INDIVIDUAL SUPERVISION HOURS WITH THIS SUPERVISOR: **TOTAL GROUP SUPERVISION WITH THIS SUPERVISOR:**

TOTAL NUMBER OF WORK HOURS: **TOTAL NUMBER OF DIRECT CLIENT HOURS:**

START DATE: **END DATE:**

BRIEFLY DESCRIBE SUPERVISION SESSIONS:

CERTIFYING STATEMENT (SUPERVISORS IN ANOTHER JURISDICTION:

BY MY SIGNATURE BELOW, I CERTIFY THAT THE INFORMATION PROVIDED IN THIS DOCUMENT IS TRUE & 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 & ISSUING YOUR CERTIFICATE. NO HOURS WILL COUNT TOWARD YOUR PLAN UNTIL APPROVED BY THE BOARD.

SECTION I: ~ CERTIFYING STATEMENT

SUPERVISOR #1 (CLINICAL SUPERVISOR)

(Print Name of LCSW Supervisor)

(Credentials / License #)

SIGN HERE

(Signature of LCSW Supervisor)

(Date)

(Email)

(Telephone)

INDIVIDUAL: ☐ GROUP: ☐ BOTH: ☐

SUPERVISOR #2 (CLINICAL SUPERVISOR)

(Print Name of LCSW Supervisor)

(Credentials / License #)

SIGN HERE

(Signature of LCSW Supervisor)

(Date)

(Email)

(Telephone)

INDIVIDUAL: ☐ GROUP: ☐ BOTH: ☐

MAIL THIS FORM TO:
OREGON BOARD OF LICENSED SOCIAL WORKERS
3218 PRINGLE ROAD S.E., SUITE #240
SALEM, OR 97302-6310
☎ 503.378.5735 | ☎ 866.355.7050
Email: Oregon.blsw@state.or.us | Web Address: http://www.oregon.gov/blsw

SECTION J: ~ VERIFICATION OF SOCIAL WORK CREDENTIALS IN OTHER JURISDICTION(S)

****NOTE**** This form must be completed by each licensing Board where you have held a license, certification or registration & mailed directly to the Oregon Board.

PLEASE INCLUDE THE LICENSURE STATUTES & 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*****

THIS CERTIFIES THAT _____
(APPLICANT'S NAME)

HAS BEEN LICENSED, CERTIFIED OR REGISTERED IN THE FOLLOWING:

STATE OF:	LICENSE NUMBER:	ORIGINAL DATE OF LICENSURE:

	YES	NO
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 of: **(3,500 work hours / 2,000 direct client hours)**.....	☐	☐
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:.....	☐	☐

APPLICANT TOOK & PASSED WHAT LEVEL EXAMINATION GIVEN BY THE ASSOCIATION OF SOCIAL WORK BOARDS (ASWB)?

		PASS:	FAIL:
BACHELORS EXAM DATE TAKEN:.....		☐	☐
MASTERS EXAM DATE TAKEN:.....		☐	☐
ADVANCED EXAM DATE TAKEN:.....		☐	☐
CLINICAL EXAM DATE TAKEN:.....		☐	☐

FOR OFFICE USE ONLY ~ RECEIVED ON:

	YES	NO
Any legal / disciplinary actions? If "YES," please attach a written explanation & include a copy of the disciplinary action document.	☐	☐

***** I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT & TRUE TO THE BEST OF MY KNOWLEDGE. *****

SIGNATURE: _____ SIGN HERE

PRINTED NAME: _____

** OFFICIAL STATE SEAL **

TITLE: _____

STATE OF: _____

DATE COMPLETED: _____