***Board of Behavioral Sciences***
1625 North Market Blvd., Suite S200, Sacramento, CA 95834
Telephone: (916) 574-7830
www.bbs.ca.gov

# CLINICAL SOCIAL WORKER
# IN-STATE EXPERIENCE VERIFICATION

Have your supervisor complete this form as follows:

- Use a separate form for each supervisor and employer
- Make sure this form is complete and correct prior to signing
- Provide an original signature in ink and have the signer initial any changes
- Submit with your *Application for Licensure and Examination*

**APPLICANT NAME: _____ ASW Number: _____**

## APPLICANT'S EMPLOYER INFORMATION

| Name of Applicant's Employer: | | | Telephone | |
|---|---|---|---|---|
| Address: Number and Street | | City | State | Zip Code |

1. Did this setting lawfully and regularly provide clinical social work, mental health counseling or psychotherapy? ☐ Yes ☐ No
2. Did this setting provide oversight to ensure the ASW's work met the experience and supervision requirements and was within the scope of practice? ☐ Yes ☐ No

## SUPERVISOR INFORMATION

| Supervisor's Name | Telephone | Email Address **(OPTIONAL)** | |
|---|---|---|---|
| License Type | License Number | State | Date First Licensed |

If a physician, were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision? ☐ Yes ☐ No ☐ N/A

If YES, provide certificate number:_____

**APPLICANT NAME:** _____ **ASW#:** _____

## SUPERVISOR INFORMATION (continued)

Were you (the supervisor) employed by the supervisee's employer? ☐ Yes ☐ No

If NO, did you and the supervisee's employer sign a written agreement pertaining to oversight of the supervisee? ☐ Yes ☐ No

**EXPERIENCE INFORMATION:** Dates of experience: From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

| | |
|---|---|
| 1. Total supervised weeks *(Minimum 104 overall)*: | |
| 2. Total hours in individual or triadic supervision *(Minimum 52 overall)*: | |
| 3. Total hours in group supervision: | |
| 4. Average hours worked per week *(Maximum 40)*: | |
| 5. Total hours of clinical psychosocial diagnosis, assessment, and treatment, including individual or group psychotherapy / counseling *(Minimum 2,000 overall)*: | **A.** |
| 6. Of the above hours, how many were gained performing face-to-face individual or group psychotherapy/counseling *(Minimum 750 overall)*: | |
| 7. Total hours of client-centered advocacy, consultation, evaluation, research, workshops, seminars, training sessions or conferences and direct supervisor contact* *(Maximum 1,000 overall)*: | **B.** |
| 8. Total hours of experience *(Minimum 3,000 overall)*: **(A + B = C)** | **C.** |
| 9. Was <u>one additional hour</u> of face-to-face individual or triadic supervision <u>OR two additional hours</u> of face-to-face group supervision provided for every week in which more than 10 hours of direct clinical counseling was performed? | ☐ Yes ☐ No |

**A maximum of six (6) hours of direct supervisor contact per week may be counted toward the 1,000 hours.*

***NOTE: Knowingly providing false information or omitting pertinent information may be grounds for denial of the application. The Board may take disciplinary action on a licensee who helps an applicant obtain a license by fraud, deceit or misrepresentation. All information on this form is subject to verification.***

Signature of Supervisor: _____ Date: _____
ORIGINAL SIGNATURE REQUIRED