FORM I - VERIFICATION OF SUPERVISION FOR CLINICAL SOCIAL WORKER (LCSW) LICENSURE APPLICANTS

Part of State Form 50325 (R11 / 8-22)

INSTRUCTIONS: All information on this form must be typed or clearly printed.

Complete the **SECTION** A section then forward this form to your previous or current supervisor(s) for completion of the **SECTION B**. You must submit at least twenty-four (24) month of clinical social work supervision after receiving a graduate degree in social work and under the supervision of an Indiana LCSW. The supervision must occur while you are employed for no less than twenty-four (24) months and under the Active Indiana LSW license. If you obtained your hours in another State, it will be reviewed by the Board. If you are no longer able to contact your previous supervisor(s), you may complete **SECTION C** *(on the reverse side of this form)* for each previous supervisor. Sign the form(s) and return the form to the Professional Licensing Agency at 402 W. Washington St, Room W072, Indianapolis, IN 46204.

SECTION A / APPLICANT INFORMATION

APPLICANT: Complete the top section of this form, then forward it to your supervisor. You are authorized to photocopy this form as necessary.

Name of applicant (*last, first, middle*)	Maiden or given surname	Date of birth (*month, day,year*)

Address (*number and street or rural route, city, state, and ZIP code*)

Name of supervisor	Name of business / institution

Supervisor title	Address (*number and street, or rural route, city, state, and ZIP cod*e)

I hereby authorize,_____to furnish to the Professional Licensing Agency with the information below.
(*Name of Supervisor*)

Signature of applicant	Date (*month, day, year*)

SECTION B / SUPERVISOR INFORMATION

SUPERVISOR: Complete the remainder of this form and return it directly to the Professional Licensing Agency,402 West Washington Street, Room W072, Indianapolis, IN 46204.

SUPERVISOR INFORMATION

Name of supervisor (*last, first, middle*)	Name of business / institution

State license / certificate number / type of license / certificate	License / certificate issued by	Business telephone number (*include area code*) ( )

Business address (*number and street or rural route, city, state, and ZIP code*)

Number of years of experience in Social Work or Clinical Social Work	E-mail address

APPLICANT EMPLOYMENT INFORMATION

Applicant's job title during the time of your supervision	Applicant's employer during the time of your supervision

Date supervision began (*month, day, year*)	Date supervision ended (*month, day, year*)

Number of hours applicant worked per week	Number of hours you supervised applicant per weekface to face	Number of face to face client contact hours per week

Brief description of how supervision was conducted:

I was present at the applicant's place of work. ☐ True ☐ False

The applicant's work requirement was at a different site but:

(1) There was an equivalent supervisor on site. ☐ True ☐ False

(2) The applicant was not engaged in independent private practice. ☐ True ☐ False

The applicant's virtual supervision was no more than fifty percent (50%) of the total supervision ☐ True ☐ False

The above indicated supervision was performed by me pursuant to my order, control, and full professional and legal responsibility as a supervisor. **I do hereby declare that the information contained herein is true and correct.**

Signature:_____

Title: _____

Date *(month, day, year)*: _____

(Continued on the reverse side.)

FORM I - VERIFICATION OF SUPERVISION FOR CLINICAL (LCSW) LICENSURE APPLICANTS *(continued)*

Part of State Form 50325 (R11 / 8-22)

SECTION B / SUPERVISOR INFORMATION

To be completed by applicant if your previous supervisor is no longer able to complete **SECTION B** *(on reverse side of this form)*. Please indicate below the reason why your previous supervisor is no longer able to complete **SECTION B** *(on the reverse side of this form)*. ***If you are affirming supervision received from more than one previous supervisor, this form may be duplicated but you must submit one AFFIRMATION OF SUPERVISION for each previous supervisor that is no longer able to complete SECTION B (on the reverse side of this form).***

Please indicate below the reason your previous supervisor is no longer able to complete SECTION B.

My previous supervisor named below is:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please briefly explain:

Supervision was provided by:

(Name of supervisor / last, first, middle, maiden)

Applicant's job title during the time of supervision	Applicant's employer during the time of supervision
Date supervision began *(month, day, year)*	Date supervision ended *(month, day, year)*
Number of hours applicant worked per week	Number of face to face supervised hours per week
Brief description of how supervision was conducted:	
I hereby swear or affirm, under the penalties of perjury, that the statements made are true, complete and correct.	
Signature of applicant	Date *(month, day, year)*

(Continued on reverse side)

FORM II - VERIFICATION OF EMPLOYMENT / EXPERIENCE FOR CLINICAL (LCSW) LICENSURE APPLICANTS

Part of State Form 50325 (R11 / 8-22)

INSTRUCTIONS: All information on this form must be typed or clearly printed.

Complete the SECTION A **section then forward this form to your previous or current employer(s) for completion of the** SECTION B**.** You must submit at least twenty-four (24) months of clinical social work experience after receiving a graduate degree in social work and under the supervision of an Indiana LCSW. This employment must be no less than twenty-four (24) months and while the applicant holds an Indiana Active LSW license. If you obtained your hours in another State, it will be reviewed by the Board. This form may beduplicated if your experience was completed at more than one place of employment**. If you are no longer able to contact your previous employer(s), you may complete** SECTION C ***(on the reverse side of this form)*** **for each previous employer. Sign the form(s) and return the form to the Professional Licensing Agency at 402 W. Washington St, Room W072, Indianapolis, IN 46204.**

SECTION A / APPLICANT INFORMATION

APPLICANT: Complete the top section of this form, then forward it to your employer. You are authorized to photocopy this form as necessary.

Name of applicant (*last, first, middle*)	Maiden or given surname
Address (*number and street or rural route, city, state, and ZIP code*)	Date of birth (*month, day, year*)
Name of business / institution	Address (*number and street, or rural route, city, state, and ZIP cod*e)
Date you began taking classes to complete your MSW degree: (month, day,year)	Date your MSW degree was granted: (month, day, year)

I hereby authorize,_____to furnish to the Professional Licensing Agency with the information below.
(*Name of Employer*)

Signature of applicant	Date (*month, day, year*)

SECTION B / EMPLOYER / EMPLOYMENT INFORMATION

EMPLOYER: Complete the remainder of this form and return it directly to the Professional Licensing Agency,402 West Washington Street, Room W072, Indianapolis, IN 46204.

EMPLOYER INFORMATION

Name of employer		
Name of business / institution where employed		E-mail address
Business address (*number and street or rural route, city, state, and ZIP code*)		
Business / Institute telephone number ( )	Date employment began (*month, day,year*)	Date employment ended (*month, day, year*) (*if currently employed, pleaseindicate*)
Position held		Number of hours applicant worked per week

Brief description of the responsibilities that the applicant had while in your employment:

The above indicated supervision was performed by me pursuant to my order, control, and full professional and legal responsibility as a supervisor. **I do hereby declare that the information contained herein is true and correct.**

Signature:_____

Title: _____

Date *(month, day, year)*: _____

(Continued on the reverse side.)

(Continued on reverse side)

FORM II - VERIFICATION OF EMPLOYMENT / EXPERIENCE FOR CLINICAL (LCSW) LICENSURE APPLICANTS *(continued)*

Part of State Form 50325 (R11 / 8-22)

SECTION C / AFFIRMATION OF EXPERIENCE

To be completed by applicant if the applicant's previous employer is no longer able to complete ***SECTION B*** *(on reverse side of this form). Please indicate below the reason why your previous employer is no longer able to complete* ***SECTION B*** *(on the reverse side of this form).* ***If you are affirming experience acquired through more than one previous employer this form may be duplicated but you must submit one AFFIRMATION OF EXPERIENCE for each previous employer that is no longer able to complete SECTION B (on the reverse of this form).***

I am unable to have my previous employer(s) complete SECTION B for the following reason:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please briefly explain:

Name of employer		
Name of business / institution where employed		E-mail address
Business address *(number and street, city, state, and ZIP code)*		
Telephone number of business / institution	Date employment began *(month, day, year)*	Date employment ended (month, day, year) If currentlyemployed, please indicate
Position held		Number of hours applicant worked per week
Provide a brief description of job duties:		
I hereby swear or affirm, under the penalties of perjury, that the statements made are true, complete and correct		
Signature of applicant		Date *(month, day, year)*

(Continued on reverse side)

FORM III - VERIFICATION OF GRADUATE COURSEWORK FOR LICENSURE AS A SOCIAL WORK (LSW) AND CLINCAL SOCIAL WORKER (LCSW)

Part of State Form 50325 (R11 / 8-22)

To be completed by all applicants for LCSW licensure who began taking classes to complete a MSW degree after July 1, 1997

Please list the course titles in the areas indicated below, of the graduate courses, exactly as they appear on your transcript, that in your opinion, meet the following requirements. If two or more courses combine meet the criteria, list all courses that may apply. Only graduate level courses are acceptable. The board will not accept coursework counted or credited toward an undergraduate degree.

Psychopathology

Educational Institution	Course Number	Course Title	Semester / Quarter Hours	Year

Clinical Practice with Diverse Populations

Educational Institution	Course Number	Course Title	Semester / Quarter Hours	Year

Clinical Theory and Practice

Educational Institution	Course Number	Course Title	Semester / Quarter Hours	Year

Family Practice

Educational Institution	Course Number	Course Title	Semester / Quarter Hours	Year

Group Practice

Educational Institution	Course Number	Course Title	Semester / Quarter Hours	Year

Human Behavior in the Social Environment

Educational Institution	Course Number	Course Title	Semester / Quarter Hours	Year

Practice Evaluation (Research)

Educational Institution	Course Number	Course Title	Semester / Quarter Hours	Year

I, the undersigned applicant for Clinical Social Worker's licensure, do hereby certify that I have also completed the following:

A supervised field placement that was a part of my advanced concentration in direct practice during which I provided clinical services directly to clients.

Signature of applicant	Date (*month, day, year*)
Printed name of applicant	