Reset Form

APPLICATION FOR LICENSURE AS A BACHELOR LEVEL SOCIAL WORKER (LBSW), A CLINICAL SOCIAL WORKER (LCSW), OR A SOCIAL WORKER (LSW)

State Form 50325 (R11 / 8-22)

Approved by State Board of Accounts, 2017

BEHAVIORAL HEALTH AND HUMAN SERVICES LICENSING BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2054
Email: pla8@pla.IN.gov

INSTRUCTIONS:
1. *The fee for this application is $50.00, payable to the Indiana Professional Licensing Agency, in accordance with 839 IAC 1-2-5.*
2. *If applying for a temporary permit, please include your fee of $25.00 in accordance with 839 IAC 1-2-5.*
3. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
4. *All fees are non-refundable and non-transferable.*
5. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.
** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

FOR OFFICE USE ONLY

Application Fee	Permit fee
Date fee paid *(month, day, year)*	Date fee paid *(month, day, year)*
Receipt number	Receipt number
License number issued	Permit number issued
License issuance date *(month, day, year)*	Permit issuance date *(month, day, year)*

BASIS FOR LICENSURE

License Type (check only one):
☐ Bachelor Level Social Worker (ASWB Bachelor Exam) ☐ Social Worker (ASWB Master Exam) ☐ Clinical Social Worker (ASWB Clinical Exam)

Obtained by Method:
☐ Examination ☐ Reciprocity

Do you wish to apply for a Temporary Permit? *Only Examination applicants are eligible to request the temporary permit. One permit allowed per applicant.*
☐ Yes ☐No

If you have passed the ASWB Examination, provide the following information:

Date *(month, day, year)*: State: Level of Examination:

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)			Social Security number*
Date of birth (*month, day, year*)	Gender** ☐Male ☐Female	Telephone number (*daytime*) ( )	E-mail address
Address of applicant (*number and street or rural route*)		City, state, and ZIP code	

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select one of the following.)*

☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 1641). ☐ I am authorized by the federal government to work in the United States.

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)* ☐ Yes ☐No

Are you an active duty member of the military? *(Optional)* ☐ Yes ☐No

UNDERGRADUATE AND GRADUATE EDUCATION

Name of academic institution:	Department	Program title
Location *(city and state)*	Dates attended (*month, year to month, year*)	Degree earned
Name of academic institution:	Department	Program title
Location *(city and state)*	Dates attended (*month, year to month, year*)	Degree earned
Name of academic institution:	Department	Program title
Location *(city and state)*	Dates attended (*month, year to month, year*)	Degree earned
Name of academic institution:	Department	Program title
Location *(city and state)*	Dates attended (*month, year to month, year*)	Degree earned
Name of academic institution:	Department	Program title
Location *(city and state)*	Dates attended (*month, year to month, year*)	Degree earned
Name of academic institution:	Department	Program title
Location *(city and state)*	Dates attended (*month, year to month, year*)	Degree earned

EMPLOYMENT HISTORY FOR THE PAST FIVE (5) YEARS

Please list all places of professional employment, including self-employment. You may add an additional sheet listing employment if more space is needed. LBSW applicants are not required to complete this section. All other applicants are required to complete the employment history.

Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed (*month, year to month,year*)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed (*month, year to month,year*)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed (*month, year to month,year*)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed (*month, year to month,year*)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location *(city and state)*	Dates employed (*month, year to month,year*)	Average hours per week
Duties or responsibilities		

STATES LICENSED

List all states and territories, ***including Indiana,*** in which you have been licensed to practice any regulated health occupation. Verification of all listed licenses must be submitted directly to the board from the state/territory that issued each license. *Licenses issued by the Indiana Professional Licensing Agency will not need verifications.*

Type of License / Certificate / Registration / Permit	State	Number	Date Issued *(month, day, year)*	Status

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No

2. Have you ever been denied license, certificate, registration or permit to practice any regulated health occupation in any state (*including Indiana*), country or U.S. Territory? ☐ Yes ☐ No

3. Do you have any condition or impairment *(including a history of alcohol or substance abuse)* that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner? ☐ Yes ☐ No

4. *Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*
   (1) have you ever been arrested; ☐ Yes ☐ No
   (2) have you ever entered into a prosecutorial diversion or deferment agre ment reç arding any offer se, misde neanor, or felony in any state; ☐ Yes ☐ No
   (3) have you ever been convicted of any offense, misdemeanor, or felony in any stae; ☐ Yes ☐ No
   (4) have you ever pled guilty to any offense, misdemeanor, or felony in an y state; o ☐ Yes ☐ No
   (5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state? ☐ Yes ☐ No

5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline of limitations? ☐ Yes ☐ No

6. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency or any of its authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency, and the Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I affirm, under penalties for perjury, that the foregoing representations are true.

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

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	