Reset a Form

APPLICATION FOR LICENSURE AS A CLINICAL SOCIAL WORKER (LCSW)

State Form 50325 (R2 / 2-06)
Approved by State Board of Accounts, 2006

SOCIAL WORKER, MARRIAGE AND FAMILY THERAPIST AND MENTAL HEALTH COUNSELOR BOARD
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room 072
Indianapolis, Indiana 46204
Telephone: (317) 234-2064
E-mail: pla5@pla.IN.gov

*** Your Social Security number is being requested by this state agency in accordance with I.C. 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.**

FOR OFFICE USE ONLY	
APPLICATION/PERMIT FEE:	
DATE FEE PAID:	
RECEIPT NUMBER:	
LICENSE NUMBER ISSUED:	
PERMIT NUMBER ISSUED:	
DATE LICENSE ISSUED:	

Attach Two Passport Quality Photographs Here (*See Instructions*)

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ALL INFORMATION ON THIS FORM MUST BE TYPED OR CLEARLY PRINTED.

What date (*month, day, year*) did you begin taking classes to complete your MSW degree?	I am applying for a temporary permit: ☐ Yes ☐ No
I have previously made application for this profession in the State of Indiana under the name of:	

APPLICANT INFORMATION		
Name (*last, first, middle, maiden or previous*)		
Current address (*number and street or rural route*)		
City	State	ZIP code
Permanent address (*IF DIFFERENT FROM ADDRESS ABOVE*)		
City	State	ZIP code
Work telephone number (*include area code*) ( )	Home telephone number (*include area code*) ( )	
E-mail address		
Date of birth (*month, day, year*)	Place of birth (*city, state*)	
Social Security number *		

Please check all that apply:

☐ I am applying for licensure by examination.

☐ I am applying for licensure by exemption from the examination (ENDORSEMENT).

☐ I am currently licensed / certified in another state.
Type of licensure / certification _____
Issued by _____

☐ I successfully passed the ASWB examination.
Date _____ State _____
Level of Examination _____

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.

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
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Location (*city and state*)	Dates employed (*month, year to month, year*)	Average hours per week
Duties or responsibilities		

OTHER STATE LICENSURE / CERTIFICATION

Do you now hold, or have you ever held, a license / certification / registration / permit to practice any regulated health profession by a state licensing board? ☐ Yes ☐ No

(*If yes, list all states below, including Indiana, in which you have held a license / certification / registration / permit to practice any state regulated health occupation.*)

TYPE OF LICENSE / CERTIFICATE / REGISTRATION / PERMIT	STATE	LICENSE NUMBER	DATE ISSUED	STATUS
1.				
2.				
3.				
4.				
5.				

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a 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 a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state *(including Indiana)* or country? ☐ Yes ☐ No
3. Are you now being, or have you ever been treated for drug or alcohol abuse? ☐ Yes ☐ No
4. Have you ever been convicted of, pled guilty or *nolo contendre* to:
   A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? ☐ Yes ☐ No
   B. Any offense, misdemeanor or felony in any state? *(Except for minor violations of traffic laws resulting in fines)* ☐ 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 or 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
7. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

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

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, corporation, association, organization or institution to release to the Professional Licensing Agency, or Indiana Social Worker, Marriage and Family Therapist and Mental Health Counselor Board, any files, documents, records or other information pertaining to the undersigned requested by the Agency, or the Board, or any of their authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, officers, 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, or the Indiana Social Worker, Marriage and Family Therapist and Mental Health Counselor Board, 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 hereby swear or affirm, that I have read the above statements and agree to same.

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

FORM I - VERIFICATION OF SUPERVISION FOR LSW / LCSW LICENSURE APPLICANTS

State Form 50324 (R2 / 2-06)

ALL INFORMATION ON THIS FORM MUST BE TYPED OR CLEARLY PRINTED.

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
Address (*number and street or rural route, city, state, and ZIP code*)		
Social Security number *	Date of birth (*month, day, year*)	Telephone number (*daytime*) ( )
Name of supervisor	Name of business / institution	
Supervisor title	Address (*number and street, or rural route, city, state, and ZIP code*)	

I hereby authorize, _____ to furnish to the Professional Licensing Agency with the information below.
(*Supervisor's Name*)

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

SUPERVISOR: Complete the remainder of this form, have the form notarized and return it directly to the Professional Licensing Agency, 402 West Washington Street, Room 072, 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 week face 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 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.**

SEAL OF NOTARY PUBLIC

Signature: _____

Title: _____

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

FORM II - VERIFICATION OF EMPLOYMENT / EXPERIENCE FOR LSW / LCSW LICENSURE APPLICANTS

State Form 50324 (R2 / 2-06)

ALL INFORMATION ON THIS FORM MUST BE TYPED OR CLEARLY PRINTED.

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*)		
Social Security number *	Date of birth (*month, day, year*)	Telephone number (*daytime*) ( )
Name of business / institution	Address (*number and street, or rural route, city, state, and ZIP code*)	
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.
(*Employer's Name*)

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

EMPLOYER: Complete the remainder of this form, have the form notarized and return it directly to the Professional Licensing Agency, 402 West Washington Street, Room 072, 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, please indicate*)
Position held	Number of hours applicant worked per week	

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

The applicant pursuant to my order, control, and full professional and legal responsibility as an employer has performed the above-indicated experience.
I do hereby declare that the information contained herein is true and correct.

SEAL OF
NOTARY PUBLIC

Signature: _____

Title and Printed Name: _____

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

FORM III - MSW CLINICAL COURSEWORK

State Form 50324 (R2 / 2-06)

To be complete 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 the title of the course you are wishing to apply towards these requirements does not clearly reflect these content areas, you should also submit additional supporting documentation, such as course descriptions from your college or university's catalog. A total of twenty four (24) semester hours or thirty seven (37) quarter hours of graduate coursework is required and must include at least three (3) credit hours in each of the following seven (7) content areas. A course may only be credited once in identifying courses taken in the seven (7) content areas.

Psychopathology

Educational Institution	Course #	Course Title	Semester Hours	Quarter Hours

Clinical Practice with Diverse Populations

Educational Institution	Course #	Course Title	Semester Hours	Quarter Hours

Clinical Theory and Practice

Educational Institution	Course #	Course Title	Semester Hours	Quarter Hours

Family Practice

Educational Institution	Course #	Course Title	Semester Hours	Quarter Hours

Group Practice

Educational Institution	Course #	Course Title	Semester Hours	Quarter Hours

Human Behavior in the Social Environment

Educational Institution	Course #	Course Title	Semester Hours	Quarter Hours

Practice Evaluation (Research)

Educational Institution	Course #	Course Title	Semester Hours	Quarter Hours

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	Social Security number *