



# APPLICATION FOR LICENSURE AS A CLINICAL SOCIAL WORKER (LCSW)

State Form 50325 (R4 / 3-13)  
Approved by State Board of Accounts, 2013

BEHAVIORAL HEALTH AND HUMAN SERVICES LICENSING BOARD  
PROFESSIONAL LICENSING AGENCY  
402 West Washington Street, Room 072  
Indianapolis, Indiana 46204  
Telephone: (317) 234-2064  
E-mail: pla5@pla.IN.gov

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

\* Your Social Security number is being requested by this state agency in accordance with IC 25-1-5-11. Disclosure is mandatory, and this record cannot be processed without it.

FOR OFFICE USE ONLY	
APPLICATION/PERMIT FEE:	
DATE FEE PAID (month, day, year):	
RECEIPT NUMBER:	
LICENSE NUMBER ISSUED:	
PERMIT NUMBER ISSUED:	
DATE LICENSE ISSUED (month, day, year):	

Attach  
One  
Passport  
Quality  
Photograph  
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(See Instructions)

What date (month, day, year) did you begin taking classes to complete your MSW degree?	I am applying for a temporary permit: <input type="checkbox"/> Yes <input type="checkbox"/> 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 ( <i>city and state</i> )		Dates attended ( <i>month, year to month, year</i> )	Degree earned
Name of academic institution:		Department	Program title
Location ( <i>city and state</i> )		Dates attended ( <i>month, year to month, year</i> )	Degree earned
Name of academic institution:		Department	Program title
Location ( <i>city and state</i> )		Dates attended ( <i>month, year to month, year</i> )	Degree earned
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Location ( <i>city and state</i> )		Dates attended ( <i>month, year to month, year</i> )	Degree earned
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Name of academic institution:		Department	Program title
Location ( <i>city and state</i> )		Dates attended ( <i>month, year to month, year</i> )	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 ( <i>city and state</i> )		Dates employed ( <i>month, year to month, year</i> )	Average hours per week
Duties or responsibilities			
Name of employer		Position or title	Name of supervisor
Location ( <i>city and state</i> )		Dates employed ( <i>month, year to month, year</i> )	Average hours per week
Duties or responsibilities			
Name of employer		Position or title	Name of supervisor
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Duties or responsibilities			
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Location ( <i>city and state</i> )		Dates employed ( <i>month, year to month, year</i> )	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 (month, day, year)	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 social work, clinical social work, or any regulated health occupation in any state *(including Indiana)* or country?       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 as clinical social worker in a competent and professional manner?       Yes    No
4. Have you ever been convicted of, pled guilty or *nolo contendere* 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)
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**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 the Behavioral Health and Human Services Licensing 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 Behavioral Health and Human Services Licensing 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)
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# FORM I - VERIFICATION OF SUPERVISION FOR LSW / LCSW LICENSURE APPLICANTS

Part of State Form 50324 (R4 / 3-13)

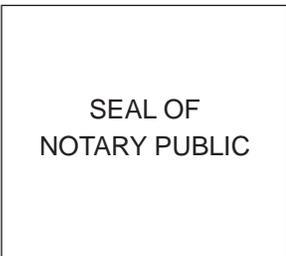
**INSTRUCTIONS:** All information on this form must be typed or clearly printed.

<b>APPLICANT:</b> 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 ( <i>last, first, middle</i> )		Maiden or given surname
Address ( <i>number and street or rural route, city, state, and ZIP code</i> )		
Social Security number *	Date of birth ( <i>month, day, year</i> )	Telephone number ( <i>daytime</i> ) (       )
Name of supervisor		Name of business / institution
Supervisor title	Address ( <i>number and street, or rural route, city, state, and ZIP code</i> )	
I hereby authorize, _____ to furnish to the Professional Licensing Agency with the information below. <i>(Supervisor's Name)</i>		
Signature of applicant		Date ( <i>month, day, year</i> )

<b>SUPERVISOR:</b> 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.		
<b>SUPERVISOR INFORMATION</b>		
Name of supervisor ( <i>last, first, middle</i> )		Name of business / institution
State license / certificate number / type of license / certificate	License / certificate issued by	Business telephone number ( <i>include area code</i> ) (       )
Business address ( <i>number and street or rural route, city, state, and ZIP code</i> )		
Number of years of experience in Social Work or Clinical Social Work		E-mail address

<b>APPLICANT EMPLOYMENT INFORMATION</b>	
Applicant's job title during the time of your supervision	Applicant's employer during the time of your supervision
Date supervision began ( <i>month, day, year</i> )	Date supervision ended ( <i>month, day, year</i> )
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. <input type="checkbox"/> True <input type="checkbox"/> False	
The applicant's work requirement was at a different site but:	
(1) There was an equivalent supervisor on site. <input type="checkbox"/> True <input type="checkbox"/> False	
(2) The applicant was not engaged in independent private practice. <input type="checkbox"/> True <input type="checkbox"/> 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*): \_\_\_\_\_

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

Part of State Form 50324 (R4 / 3-13)

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

<b>APPLICANT:</b> 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 ( <i>last, first, middle</i> )		Maiden or given surname
Address ( <i>number and street or rural route, city, state, and ZIP code</i> )		
Social Security number *	Date of birth ( <i>month, day, year</i> )	Telephone number ( <i>daytime</i> ) (       )
Name of business / institution	Address ( <i>number and street, or rural route, city, state, and ZIP code</i> )	
Date you began taking classes to complete your MSW degree: ( <i>month, day, year</i> )	Date your MSW degree was granted: ( <i>month, day, year</i> )	
I hereby authorize, _____ to furnish to the Professional Licensing Agency with the information below. ( <i>Employer's Name</i> )		
Signature of applicant		Date ( <i>month, day, year</i> )

<b>EMPLOYER:</b> 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 ( <i>number and street or rural route, city, state, and ZIP code</i> )		
Business / Institute telephone number (       )	Date employment began ( <i>month, day, year</i> )	Date employment ended ( <i>month, day, year</i> ) ( <i>if currently employed, please indicate</i> )
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.**

<div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>SEAL OF NOTARY PUBLIC</p> </div>	Signature: _____
	Title and Printed Name: _____
	Date ( <i>month, day, year</i> ): _____

# FORM III - MSW CLINICAL COURSEWORK

Part of State Form 50324 (R4 / 3-13)

**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 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 / Quarter Hours	Year

**Clinical Practice with Diverse Populations**

Educational Institution	Course #	Course Title	Semester / Quarter Hours	Year

**Clinical Theory and Practice**

Educational Institution	Course #	Course Title	Semester / Quarter Hours	Year

**Family Practice**

Educational Institution	Course #	Course Title	Semester / Quarter Hours	Year

**Group Practice**

Educational Institution	Course #	Course Title	Semester / Quarter Hours	Year

**Human Behavior in the Social Environment**

Educational Institution	Course #	Course Title	Semester / Quarter Hours	Year

**Practice Evaluation (Research)**

Educational Institution	Course #	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)
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Printed name of applicant