Reset Form

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

Part of State Form 50325 (R12 / 8-24)

GENERAL INSTRUCTIONS: *All information on this form must be typed or clearly printed. You are authorized to photocopy this form as necessary. Sign the form and upload to your (the applicant's) online application as applicable or mail them to the address provided in the top right corner of the first page of this application.*

SECTION A / APPLICANT INFORMATION

SECTION A INSTRUCTIONS FOR APPLICANT: *Complete this section and then forward this form to your direct supervisor(s) of your previous or current employer(s) for completion of* ***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 an "Active" Indiana LSW license. If you obtained your hours in another state or jurisdiction, it will be reviewed by the Board. If you are no longer able to contact your direct supervisor(s) of your previous employer(s), a professional colleague of your previous employer(s) should complete* ***SECTION C*** *(on the reverse side of this form) for each previous direct supervisor.*

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 code*)	

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

SECTION B INSTRUCTIONS FOR APPLICANT'S DIRECT SUPERVISOR: *Complete this section. All supervision may be completed either in person or virtual. However, any completed virtual supervision is required to meet the definition of "virtual supervision" under IC 25-23.6-5-3.5.*

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

I affirm that the supervision is true and correct to the best of my knowledge and belief including that any virtual supervision completed met the definition under IC 25-23.6-5-3.5.

Signature, [please provide your professional credential (i.e., LCSW): _____

Title: _____

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

(Continued on the reverse side.)

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

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SECTION C / AFFIRMATION OF SUPERVISION [UNABLE TO CONTACT DIRECT SUPERVISOR(S)]

SECTION C INSTRUCTIONS FOR PROFESSIONAL COLLEAGUE OF APPLICANT'S EMPLOYER: *This section is to be completed by a professional colleague of the applicant's previous employer, if the applicant's previous direct supervisor is no longer able to complete* ***SECTION B*** *(on reverse side of this form). Please indicate below the reason why the applicant's previous direct 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 direct supervisor of a previous employer, this form may be duplicated but you must submit one AFFIRMATION OF SUPERVISION for each previous direct supervisor that is no longer able to complete SECTION B (on the reverse side of this form).***

Please indicate below the reason the applicant's direct supervisor is no longer able to complete SECTION B.

The applicant's direct 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 professional colleague	Date *(month, day, year)*

(Continued on reverse side)