

# FORM II - VERIFICATION OF EMPLOYMENT / EXPERIENCE FOR CLINICAL (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) 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 or jurisdiction, it will be reviewed by the Board. This form may be duplicated if your experience was completed at more than one place of employment. 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	
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 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. (Name of Employer)			
Signature of applicant			Date (month, day, year)

## SECTION B / EMPLOYER / EMPLOYMENT INFORMATION

**SECTION B INSTRUCTIONS FOR APPLICANT'S DIRECT SUPERVISOR:** Complete this section.

### EMPLOYER INFORMATION

Name of direct supervisor/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 above indicated supervision was performed by me pursuant to my order, control, and full professional and legal responsibility as a supervisor. <b>I do hereby declare that the information contained herein is true and correct.</b>		
Signature: _____		
Title: _____		
Date (month, day, year): _____		

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(continued)**

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**SECTION C / AFFIRMATION OF EXPERIENCE [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 experience received from more than one previous direct supervisor of a previous employer, this form may be duplicated but you must submit one AFFIRMATION OF EXPERIENCE for each previous direct supervisor that is no longer able to complete SECTION B (on the reverse side of this form).*

The applicant's direct supervisor is unable to 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 currently employed, 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 professional colleague		Date (month, day, year)

(Continued on reverse side)