Licensed Clinical Social Worker Form 4B

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Assigned No.
(From Form 4)

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Certification of Experience for Licensed Clinical Social Worker

Applicant Instructions

1. Complete Section I. In item 3, enter your name exactly as it appears on your Application for Licensure (Form 1). Be sure to sign and date item 7. Use the psychotherapy log to document your hours of practice and supervision completed after November 15, 2007. This log must be completed by you and your supervisor. All pages of the log must be submitted along with this form.
2. Send the entire form along with a copy of Appendix A to your supervisor (if your supervisor is unavailable, you must provide the supervisor's qualifications and your experience may be verified by a licensed colleague) and ask him/her to complete Section II and forward the entire form directly to the Office of the Professions at the address at the end of this form. **This form will not be accepted if submitted by the applicant.**

Section I: Applicant Information

1 Social Security Number ☐☐☐ ☐☐ ☐☐☐☐
(Leave this blank if you do not have a U.S. Social Security Number)

2 Birth Date Month ☐☐ Day ☐☐ Year ☐☐

3 Print Name as It Appears on Your Application for Licensure (Form 1)

Last

First

Middle

4 Mailing Address (You must notify the Department promptly of any address or name changes.)

Line 1

Line 2

Line 3

City

State Zip Code

Country/
Province

5 Telephone/E-Mail Address

Daytime phone

Area Code Phone

E-mail Address (please print clearly)

6 Complete this item to verify that you have completed the required supervised experience necessary for licensure as an LCSW. You must complete 3 years of full-time post-MSW supervised experience in diagnosis, psychotherapy and assessment-based treatment plans. Full-time is defined as 20 client contact hours per week (45 minute session); part-time is no less than 10 client contact hours per week over a period not to exceed six years. You must have been supervised by a licensed clinical social worker, licensed psychologist or physician who meets the requirements of section 74.3 of the Commissioner's Regulations.

Name of clinical supervisor: ____________________

Title of supervisor: ____________________

Name of employing Agency: ____________________

Employing Agency address: ____________________

LMSW License Number: ☐☐☐☐☐☐ Date LMSW License issued: Month ☐☐ Day ☐☐ Year ☐☐

Psychotherapy client contact hours per month: __________

From: _______ / _______ / _______ to: _______ / _______ / _______ please indicate a date no later than today's
mo. day yr. mo. day yr.

7 Attestation

I declare and affirm that the statements made in the foregoing application, including accompanying statements are true, complete and correct. I understand that any false or misleading information in, or in connection with my application may be cause for denial of qualification and may lead to a filing of charges of professional misconduct.

______________________________ ________ / ________ / ________
Applicant's Signature mo. day yr.

Section II: Supervisor's Verification of Experience

Instructions For Completing Section II: Please complete Section II, be sure to sign the affidavit, have your signature notarized by a Notary Public and return the entire form directly to the Office of the Professions at the address at the end of this form. This form will not be accepted if returned by the applicant. By completing Section II and the psychotherapy log, the supervisor is certifying that the person named in Section I received supervision that meets the requirements specified in Education Law and the Commissioner's Regulations.

1. Name of applicant: ______________________________
(Item 3 on page 1)

2. Name of supervisor: ______________________________
(Supervisor must complete Form 4Q if not already approved by Department)

Title: ______________________________
(attach copy of supervisor's license)

Supervisor's Qualifications:

☐ Licensed Clinical Social Worker

Years of Psychotherapy Experience: __________

License number: __________________________

MSW Degree from: ______________________________ Degree date: _______ / _______
mo. yr.

☐ Licensed Psychologist

Degree Date: ________ / _______
mo. yr.

License number: __________________________

State: ___________________________________

☐ Psychiatrist

Psychiatric Residency/Training: ______________________________

Medical degree from: ______________________________ Degree Date: _______ / _______
mo. yr.

Board certified in psychiatry? ☐ Yes ☐ No

License number: __________________________

State: ___________________________________

Read this section before completing the remainder of this form.

Part 74.3 of the Commissioner's Regulations requires that the applicant receive supervision of a duration and frequency acceptable to the department for the purpose of improving skills and the assurance of ongoing review of patient/client treatment. The applicant must receive a minimum of four hours of in-person supervision each month. The supervision must be in sessions of no less than one hour per week or two hours every other week. At least two hours each month must be individual supervision and the remaining two hours may be group clinical supervision.

Psychotherapy client contact hours provided by applicant each month: __________________

Applicant was supervised from _______ / _______ / _______ to _______ / _______ / _______ *(please indicate a date no later than today's)*
mo. day yr. mo. day yr.

Applicant received __________ hour(s) per month of individual supervision

Applicant received __________ hour(s) per month of group supervision

Section II: Supervisor's Verification of Experience (Continued)

Attestation of Supervisor or Licensed Colleague

NOTE: If you are a licensed colleague attesting to the supervision provided by a qualified supervisor who is not available, and the experience has been completed, you must provide in section II, item 2 of this form:

- the name and qualifications of the supervisor;
- the client contact hours in psychotherapy provided during the supervised experience;
- the dates of supervision provided to the applicant; and
- the frequency and type of supervision sessions.

I hereby certify that to the best of my knowledge and belief the foregoing is a true statement of the professional experience of the individual named in Section I of this form and that I have read Appendix A and that the experience meets the requirements for the psychotherapy privilege issued by the New York State Education Department.

Signature: ______________________________ Date: _______ / _______ / _______
mo. day yr.

Print name: ______________________________

Agency: ______________________________

Address: ______________________________

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Note: If supervisor was not employed by the agency, please provide a copy of the signed agreement between the employer, supervisor and applicant indicating that third-party supervision was authorized and patients were informed as to the sharing of confidential information.

Phone: ____________________ Fax: ____________________

E-mail: ______________________________

Licensed as: ______________________________

Licensed in the State of: ______________________________

License number: ____________________

Notary

State of ______________________________ County of ______________________________

On the ___________ day of ______________ in the year __________ before me, the undersigned, personally appeared ____________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature ______________________________

Notary ID number ____________________

Notary Stamp

Expiration date __________ / __________ / __________
Month Day Year

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Social Work Unit, 89 Washington Avenue, Albany, NY 12234-1000

Psychotherapy Log: Use this weekly log to document your hours of practice and supervision for Licensed Clinical Social Worker after November 15, 2007. **All** pages of this log must be submitted along with Form 4B. Please photocopy this log as needed.	**Page**
Applicant name: ______________________ Supervisor name: ______________________	_____ **of** _____

Week starting date for psychotherapy (mm/dd/yy)	Client Contact Hours/Week*	Applicant Initials	Supervision Type (Individual, Group, Peer, Case)**	Supervision Hours/Week**	Supervisor Initials
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***Contact hour = 45 Minutes of psychotherapy (minimum of 10 hours/week; maximum of 20 hours/week)**

****Supervision = at least 4 hours/month of individual or group supervision, in sessions of one hour per week or two hours every other week; at least two hours of the minimum four hours per month must be individual supervision.**