Licensed Master Social Worker Form 4

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

DEPARTMENT USE ONLY

Experience:

☐ **Approved**

☐ **Disapproved**

_____ _____ / _____ / _____
Initials **mo.** **day** **yr.**

APPLICANT EXPERIENCE RECORD UNDER GRANDPARENTING PROVISION

This form is only for applicants with a Masters Social Work degree and at least five years of social work experience prior to September 1, 2004.

APPLICANT INSTRUCTIONS

1. Complete **Form 4** in ink. Be sure to sign and date the attestation below and send this form directly to the Office of the Professions at the address at the end of this form.
2. You must also complete Section I of **Form 4B** and forward it to each employer with whom experience is claimed for completion and submission directly to the Office of the Professions at the address at the end of **form 4B**.
3. This form may only be used before September 1, 2005.

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 Exactly As It Appears On Your Licensure Application (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 Number

E-Mail Address (Please print clearly)

6 Have you ever changed your name? ☐ Yes ☐ No

If Yes, please print former name(s): _____

7 **Experience** List the employers or colleagues who will verify your five years of full-time social work employment.

Name and Address of Employer	Job Title	Dates of Employment	
		From	To

8 **Attestation**

I declare and affirm that the statements made in this application, including accompanying documents, 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 or loss of licensure and may result in criminal prosecution.

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

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.