

Licensed Master 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
89 Washington Avenue
Albany, NY 12234-1000

CERTIFICATION OF EXPERIENCE UNDER GRANDPARENTING PROVISION

THIS FORM MUST BE COMPLETED BY THE EMPLOYER OR LICENSED COLLEAGUE AND MAILED DIRECTLY TO THE ADDRESS AT THE END OF THIS FORM

Applicant Instructions

Complete Section I and forward to your Employer/Licensed Colleague to complete Section II. This form may be photocopied, but all forms **must bear an original notarized signature of the employer/licensed colleague and date. This form will not be accepted if returned by the applicant.**

Section I: Applicant Information

Applicant's Name: Print Name Exactly As It Appears On Your Licensure Application (Form 1)

Last

First

Middle

Social Security Number:

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

Birth Date:
mo. day yr.

Name at time of employment (if different from above): _____

Section II: Numbers 1-8 And Certification To Be Completed By Employer or Licensed Colleague

I am furnishing the following information to the New York State Education Department to determine whether the applicant satisfies the experience requirement for licensing without examination as a licensed master social worker pursuant to the Commissioner's Regulations.

1 I am (Check one) a licensed social worker in New York State or an employer of the applicant
 Other: _____

Name _____ Firm or organization _____ Position or title _____
License number _____ State in which certified _____ Date certified _____

(If you are no longer employed by the organization from which the applicant is claiming experience or were not the direct supervisor for the full period claimed, please have your former employer confirm in writing to the Department the dates and positions the applicant held relative to the time periods of the applicant's service.)

2 Address of applicant as shown on employer's records:
Street _____ City _____ State _____ Zip Code _____

3 Applicant's place of employment to which I am attesting:
Firm Name _____ City _____ State _____ Zip Code _____
Dates of Employment: From _____ / _____ / _____ To _____ / _____ / _____ Present

4 This employment was (check one): full-time part-time (If part time, complete number 5)

5 If the employment was part-time, list the number of hours worked per week and the number of weeks or months of the part-time service included in the total experience claimed.

6 Applicant's job classification while in our employment:

Job Classification	Dates	
	From	To

7 The practice of licensed master social work is described in the categories below. The applicant's duties are best described as follows:

Practice of licensed master social work during employment	Percentage of time	Department Approval
The professional application of social work theory, principles, and the methods to present, assess, evaluate, formulate and implement a plan of action based on client needs and strengths, and intervene to address mental, social, emotional, behavioral, developmental, and addictive disorders, conditions and disabilities, and of the psychosocial aspects of illness and injury experienced by individuals, couples, family, groups, communities, organizations, and society.		
The administration of tests and measures of psychosocial functioning, social work advocacy, case management, counseling, consultation, research, administration and management, and teaching.		
Providing supervision or consultation to individuals, groups, institutions and agencies, other than supervision of the practice of licensed clinical social work.		
Practicing licensed clinical social work under supervision.		

8 AFFIDAVIT WITH ACKNOWLEDGMENT (Notarization required.)

EMPLOYER/LICENSED COLLEAGUE

I declare and affirm that the statements made in the foregoing application, including any attached statements, are true, complete and correct.

Check here if you are attaching additional information.

Signature: _____ Date: _____ / _____ / _____
Month Day Year

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 _____

Expiration date _____ / _____ / _____
Month Day Year

Notary Stamp

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.