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)

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. This log must be completed by you and your supervisor. All pages of the log must be retained by the supervisor, in the event the State Board requests clarification.
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

5 **Telephone/E-Mail Address**

Daytime phone
Area Code Phone

E-mail Address (please print clearly)

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

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 and 2000 client contact hours in diagnosis, psychotherapy and assessment-based treatment plans 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 74.6 of the Commissioner's Regulations.

Name of clinical supervisor: _____ Assigned number from Form 4 _____

Name of setting: _____

Setting address: _____

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

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, 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)

Setting where the applicant provided diagnosis and psychotherapy services under your supervision:

Name of facility or private practice: _____

Address: _____

The facility is a (check one and attach copy of authorization to provide services):

☐ Private practice owned by supervisor (LCSW, Licensed psychologist or psychiatrist)

☐ Sole proprietorship owned by supervisor

☐ Professional entity (PLLC, PLLP, P.C.) owned by supervisor

☐ Professional Partnership

☐ Program approved by the New York State Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD), Office of Alcoholism & Substance Abuse Services (OASAS), Office of Children & Family Services (OCFS), Department of Corrections, State Office for the Aging, Department of Health, or local social service or mental hygiene district (attach operating certificate)

☐ Psychotherapy institute chartered by Board of Regents and authorized to provide psychotherapy to the public (attach copy of Regents Charter)

☐ Elementary, middle, high school or college or educational corporation authorized to provide psychotherapy services to students (attach copy of authorization)

☐ Not-for-profit or other entity authorized by certificate of incorporation or waiver from SED to employ licensed professionals and provide services (attach certificate of incorporation)

Supervisor must initial each section to verify appropriate supervision of the applicant:

_____ Education Law and Commissioner's Regulations define acceptable experience as 2000 client contact hours in diagnosis, psychotherapy and assessment-based treatment planning. The supervisor is responsible for the assessment, evaluation and treatment of patients seen by the applicant and for delegating to the applicant those activities he/she is competent to perform. Failure to provide appropriate supervision could result in charges of unprofessional conduct against the licensed supervisor.

_____ Acceptable supervision is defined as the applicant apprising the supervisor of the diagnosis and treatment of each client, cases are discussed, the supervisor provides oversight and guidance to the applicant in diagnosis and treatment, the supervisor reviews and evaluates the applicant's work and provides at least 100 hours in person supervision.

_____ A record of client contact hours and supervision hours has been completed and retained by the supervisor for the following period:

starting: _____ / _____ / _____ ending: _____ / _____ / _____
mo. day yr. mo. day yr.

Total number of client contact hours of psychotherapy provided during the period you supervised the applicant: _____

Total number of supervision hours you provided: _____

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 licensure as an LCSW in New York State. **This form must be signed and dated in the presence of a Notary Public.**

Signature: _____ Date: _____ / _____ / _____
mo. day yr.

Print name: _____

Agency: _____

Address: _____

_____

Phone: _____ Fax: _____

E-mail: _____

Licensed as: _____

Licensed in the State of: _____

License number: _____

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.

Notary

State of _____ County of _____

On the _____ day of _____ in the year _____ before me, the above signed, 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 the applicant's hours of practice and supervision for Licensed Clinical Social Worker. **All** pages of the log must be retained by the supervisor, in the event the -State Board requests clarification. Please photocopy this log as needed.

Page

_____ **of** _____

Applicant name: ___________________________________ Supervisor name: ___________________________________

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
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					
_______ / _______ / _______					

***Contact hour = 45 Minutes of psychotherapy (shorter sessions may be combined)**

****Supervision = at least 100 hours of in person supervision over the period of at least 36 months and not more than 72 months.**