Licensed Clinical Social Worker Form 4F
Certification of Licensed Experience

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

This form is for applicants seeking licensure in New York State by endorsement of a license to practice clinical social work issued in another jurisdiction. You must have at least 10 years of licensed experience in clinical social work, in the 15 year period prior to applying for licensure in New York State

Applicant Instructions | Assigned Number (from Form 4E): ____

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.
2. Send the entire form along to your colleague to complete Section II. The colleague must return both pages of the form directly to the Office of the Professions at the address at the end of the form. **This form will not be accepted if returned by the applicant.**

Section I - Applicant Information

1. Social Security Number ☐☐☐☐☐☐☐☐☐ 2. Birth Date Month ☐☐ Day ☐☐ Year ☐☐☐☐

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

3. Print Your Name Exactly 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. Name at time of employment (if different than above) _____

6. Name of colleague _____ Assigned number from Form 4E _____

I practiced licensed clinical social worker as defined below:

"The practice of clinical social work encompasses the scope of practice of licensed master social work and, in addition, includes the diagnosis of mental, emotional, behavioral, addictive and developmental disorders and disabilities and of the psychosocial aspects of illness, injury, disability and impairment undertaken within a psychosocial framework; administration and interpretation of tests and measures of psychosocial functioning; development and implementation of appropriate assessment-based treatment plans; and the provision of crisis oriented psychotherapy and brief, short-term and long-term psychotherapy and psychotherapeutic treatment of individuals, couples, families and groups, habilitation, psychoanalysis and behavior therapy; all undertaken for the purpose of preventing, assessing, treating, ameliorating and resolving psychosocial dysfunction with the goal of maintaining and enhancing the mental, emotional, behavioral, and social functioning and well-being of individuals, couples, families, small groups, organizations, communities and society."

Jurisdiction where I practice licensed clinical social work _____

Date of Licensure ____ ____ ____ License number _____
mo. day yr.

7. I request and give my permission to the individual listed in item 5 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure. I also 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's Signature Date

Section II - Certification of Experience

Instructions to Colleague: Complete Section II, sign and date the attestation and send both pages of this form directly to the Office of the Professions at that address at the end of this form. This form will not be accepted if returned by the applicant.

Name of the applicant _____
(see Section I, item 3)

I am a licensed _____ in _____
Professional title *Jurisdiction*

License number (attach a copy of your license if other than New York State) _____ Date licensed ___ ___ ___
mo. day yr.

I am attesting that the above named applicant practiced licensed clinical social work (as defined below) at the following setting:

Name of setting where the licensed clinical social work took place

_____

Address of setting where the licensed clinical social work took place

_____

Dates of licensed practice From ___ ___ ___ To ___ ___ ___ ☐ Present
mo. day yr. mo. day yr.

"The practice of clinical social work encompasses the scope of practice of licensed master social work and, in addition, includes the diagnosis of mental, emotional, behavioral, addictive and developmental disorders and disabilities and of the psychosocial aspects of illness, injury, disability and impairment undertaken within a psychosocial framework; administration and interpretation of tests and measures of psychosocial functioning; development and implementation of appropriate assessment-based treatment plans; and the provision of crisis oriented psychotherapy and brief, short-term and long-term psychotherapy and psychotherapeutic treatment of individuals, couples, families and groups, habilitation, psychoanalysis and behavior therapy; all undertaken for the purpose of preventing, assessing, treating, ameliorating and resolving psychosocial dysfunction with the goal of maintaining and enhancing the mental, emotional, behavioral, and social functioning and well-being of individuals, couples, families, small groups, organizations, communities and society."

Attestation

I declare and affirm that the statements made in the foregoing application, are true, complete and correct and that the experience I am attesting to meets the definition of licensed clinical social work practice. I understand that any false or misleading information on this form, or related to verification of this applicant's experience, may be cause for charges of misconduct and/or criminal prosecution.

_____ _____
Signature Date

Print Name _____

Address _____

_____

☐ Check here if you are attaching additional information

Telephone _____ Fax _____

Email _____

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.

Reset Form