**Licensed Clinical Social Worker Form 4Q**

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

# Approval of Qualifications to Supervise Psychotherapy

## Applicant Instructions

**Note: A supervisor who is not licensed in New York State or has not previously been approved by the State Education Department to supervise LMSW's who provide psychotherapy services must complete this form.**

Complete Section I and forward the entire form to the supervisor (LCSW, psychiatrist, or psychologist) who supervised your work experience. Ask the supervisor to complete Section II and send the entire form directly to the Office of the Professions at the address at the end of the form. **This form will not be accepted if submitted by the applicant.**

This form may be submitted prior to the experience to confirm the eligibility of the supervisor.

## Section I: To be Completed by the Licensed Clinical Social Worker Applicant

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

Last

First

Middle

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

3 New York State Licensed Master Social Worker License Number:

4 Supervisor's Name

______________________ ______________________ ______________________
Last First Middle

## Section II: To be Completed by the Supervisor

**Complete this section and return all pages of this form to the Office of the Professions at the address at the end of the form. Your signature on this form must be notarized by a Notary Public.**

1 Were you licensed and registered in the State of New York at the time you supervised the applicant? ☐ Yes ☐ No

a. N.Y.S. License number: Date license issued Month Day Year

Profession: ______________________

b. Other State licenses:

| Profession | State | License Number | Date of License |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

c. Check degree: ☐ Ph.D./DSW ☐ Ed.D. ☐ Psy.D. ☐ M.S.W. ☐ M.D.

d. Title of degree: ______________________

e. Date of receipt of degree: ______________________

Name of school: ______________________

f. Board certification? ☐ No ☐ Yes If yes, title of certification: ______________________

**Section II: To be Completed by the Supervisor (continued)**

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**ADDITIONAL QUALIFYING CRITERIA: (Complete all that apply for your profession)**

**Licensed Psychologist:**

a. ABPP Diplomate In: ☐ Counseling ☐ Clinical ☐ School

Year received ______________________________

b. Doctorate in clinical or counseling or school psychology? ☐ Yes ☐ No

If "yes," was it from a program which was New York State registered or APA approved? ☐ Yes ☐ No

c. Did you complete a formal internship which included psychotherapy training? ☐ Yes ☐ No

If yes, name of program: ________________________________________ Date completed: ______ / ______ / ______
mo. day yr.

Was the internship accredited by the APA at that time? ☐ Yes ☐ No

d. If your doctorate was in a field other than clinical or counseling or school psychology, did you take a formal respecialization program in clinical or counseling or school psychology? ☐ Yes ☐ No

If yes, name of program: ________________________________________ Date completed: ______ / ______ / ______
mo. day yr.

**Physicians:**

Have you completed a psychiatric residency? ☐ Yes ☐ No

If yes, name of program: ________________________________________ Date completed: ______ / ______ / ______
mo. day yr.

**LCSW:**

A qualified supervisor must have at least three years of full-time, post-MSW supervised experience in **diagnosis and psychotherapy**, prior to supervising the applicant.

Please note that other direct practice with clients does not qualify under New York State Law. In order to determine if you are qualified to supervise, we must have the following information to evaluate your post-degree supervised experience in diagnosis and psychotherapy.

| Dates of Post-MSW Experience | Weekly Client Contact Hours | Hours of Individual Supervision/Month | Hours of Group Supervision/Month | Supervisor Name | Supervisor License and Jurisdiction |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Have you earned the "R" Psychotherapy Privilege? ☐ Yes ☐ No Date conferred: ______ / ______ / ______
mo. day yr.

**All Supervisors:**

Have you completed a prescribed postgraduate program in psychotherapy in an institute **chartered by the New York State Board of Regents** or one in another jurisdiction, which might be considered equivalent as determined by the State Board? ☐ Yes ☐ No

If yes, name of Institute: ____________________________________________

Date completed: _______ / _______ / _______
mo. day yr.

Attach a copy of license and Curriculum Vitae.

**Section II: To be Completed by the Supervisor (continued)**

**Attestation**

I hereby certify that I have read Appendix A and that I meet the requirements to supervise experience for LCSW's. I understand that the above information will be used to determine my eligibility as a supervisor of LMSWs seeking licensure as an LCSW and that the answers given are truthful and accurate to the best of my ability. **This form must be signed and dated in the presence of a Notary Public.**

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

Print name : ______________________________

Address: ______________________________

______________________________

Phone: ____________________ Fax: ____________________

E-mail: ______________________________

If the supervisor is not an employee of the same agency as the applicant, please provide information about the applicant's employer:

Name of Agency/Employer: ______________________________
*(Where supervised experience took place)*

Agency Address: ______________________________

______________________________

Phone: ____________________ Fax: ____________________

E-mail: ______________________________

The patient will be notified that the agency has authorized a third-party supervisor with access to the patient's records.

Name of Agency Representative: ______________________________

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

Print name: ______________________________

**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 ____________________

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**