



**Section II: Supervisor's Certification of Employment**

A limited permit may be issued to an applicant who has met all requirements for licensure except the licensing examination. The permit is valid for one year, and may not be extended. An LMSW permit holder may not practice clinical social work except under the supervision of an LCSW.

The applicant named in Section I is seeking a limited permit to practice as an LMSW in New York State. Complete the information below to certify that the applicant will be supervised at the setting named below.

Applicant's name: \_\_\_\_\_  
(Section I, item 4)

Supervisor's name (print full name - no initials): \_\_\_\_\_

Licensed as an:  LMSW  LCSW New York State license number: \_\_\_\_\_

Setting name: \_\_\_\_\_

Address: \_\_\_\_\_

**The above facility is a (check one, attach a copy of operating certificate or certificate of incorporation):**

- Office of Mental Health (OMH) approved setting
- Office for People with Developmental Disabilities (OPWDD) approved setting
- Office of Alcoholism and Substance Abuse Services (OASAS) approved setting
- Department of Health (DOH) approved setting
- Office of Children & Family Services (OCFS) approved setting
- Department of Correctional Services (DOCS) approved setting
- State Office for the Aging approved setting
- Not-for-profit or educational corporation issued a waiver by the State Education Department
- Public health agency or setting approved by the social services district
- Office of a licensed clinical social worker or licensed master social worker
- Professional corporation, PLLC, PLLP, professional partnership
- Other setting: \_\_\_\_\_

**Attestation of Supervisor**

I declare that the statements made in the foregoing certification are true, complete and correct. Any false or misleading information in or in connection with this certification may be the cause for denial of permit and licensure.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo. day yr.

Print name : \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.**