Licensed Clinical Social Worker
Form SWCOP-1

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

Department Use Only

Received

Notification of Supervised Clinical Social Work Practice

For Licensed Master Social Workers who have employed a clinical supervisor in a private practice or other authorized setting for the purpose of practicing clinical social work in New York and who are seeking consideration of such experience under the determination of the Committee on the Professions (COP). Experience must start prior to February 2, 2009 and be completed by February 2, 2015.

Applicant Instructions

1. Complete Section I. Be sure to sign and date item 7.
2. Send the entire form to the clinical supervisor who supervised/is supervising your practice of clinical social work and ask that they complete Section II and forward all pages of the 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.**

This form should be submitted as soon as possible to notify the Department that you are practicing under supervision. Failure to provide information will delay the evaluation of your eligibility. An LMSW who is determined by the State Board to be eligible for consideration under the COP decision may practice only under supervision until licensed. All experience completed under this determination must be completed by February 2, 2015 and submitted on Form 4B to the State Board for evaluation as part of the LCSW license application. If it is necessary to change supervisors, a new form should be submitted.

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 Exactly As You Wish It To Appear On Your License**

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 **Telephone/E-Mail Address**

Daytime phone

Area Code Phone

E-mail Address (please print clearly)

Please indicate that you are applying for (check one):

- ☐ Initial Consideration of Eligibility
- ☐ Additional Supervisor
- ☐ Additional Setting
- ☐ Change of Supervisor (after February 2, 2009)
- ☐ Change of Setting (after February 2, 2009)

6 Your Licensed Master Social Worker License Number: _____ Date issued: _____ / _____ / _____
mo. day yr.

Clinical Supervisor name: _____

Supervised experience starting: _____ / _____ / _____ (must be prior to February 2, 2009)
mo. day yr.

7 Attestation

I declare and affirm that the statements made in the foregoing application are true, complete and correct. Any false or misleading information in, or in connection with, my application may be cause for denial of licensure and may result in criminal prosecution.

_____ _____
Applicant's Signature Date

Section II: Certification of Experience

Instructions to the Clinical Supervisor: Complete A, B and C, sign and date the attestation and return all pages of this form directly to the Office of the Professions at the at the end of the form. Your signature on this form must be notarized by a Notary Public. This form will not be accepted if returned by the applicant.

Note: You are responsible for the assessment, evaluation and treatment of the patients to be 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.

Definition of acceptable supervision: Section 74.3 of the Regulations of the Commissioner of Education defines acceptable supervision as: the applicant apprises the supervisor of the diagnosis and treatment of each client, cases are discussed, the supervisor provides oversight and guidance to the applicant in diagnosing and treating clients, the supervisor reviews and evaluates the work of the applicant and provides at least 4 hours of in-person supervision each month.

Applicant Name: _____
(Section I, item 3)

A. Clinical Supervisor

Name: _____

Profession: _____ License number: _____
(attach a copy of your license)

Jurisdiction where licensed: _____ Date licensed: _____ / _____ / _____
mo. day yr.

B. Setting where the applicant is providing clinical social work to the public 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 applicant
- ☐ Private practice owned by licensed supervisor **(LCSW, Psychologist or Physician)**
- ☐ Program defined as exempt under Chapter 420 of Laws of 2002 (regulated, funded, operated or approved by OMH, OMRDD,OASAS, OCFS, local social service district or local mental hygiene district) and authorized to provide clinical social work services **(attach copy of operating certificate)**
- ☐ Professional entity registered with the State Education Department and authorized to provide psychotherapy and clinical social work services **(attach certificate of incorporation)**.
- ☐ Department of Health (DOH) approved hospital or nursing home (attach copy of operating certificate)
- ☐ Psychotherapy institute chartered by Board of Regents **(name)**: _____
- ☐ Other **(attach copy of authorization to provide services)**: _____

The applicant was supervised starting: _____ / _____ / _____
mo. day yr.

C. Payment for supervision of the applicant

Please indicate how you are paid for supervising the practice of clinical social work by the applicant:

☐ I was contracted by the applicant to supervise private practice.
Please indicate where supervision is provided and how you ensure appropriate practice (e.g. direct supervision/notification to clients):

_____

_____

☐ I was contracted by the applicant to provide supervision in an agency, with the consent of the agency and notification to clients. (Please attach a copy of any signed agreement for such supervision.)

Section II: Certification of Experience (continued)

Attestation

Clinical Supervisor

I have supervised or will supervise the applicant named on this form in accordance with Education Law and Commissioner's Regulations. I am responsible for clinical social work services provided to each patient by the applicant practicing under my supervision consistent with Section 74.3 of the Regulations of the Commissioner of Education. 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 experience for licensure of the applicant and for charges of unprofessional conduct against me as a licensee.

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

Print name: _____

Address: _____

_____

Phone: _____

Fax: _____

E-mail: _____

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, State Board for Social Work, 89 Washington Avenue, Albany, NY 12234-1000.**