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

Licensed Clinical Social Worker Psychotherapy "R" Privilege
Form 4SWPR
Certification of Experience for Licensed Clinical Social Worker Psychotherapy "R" Privilege

Applicant Instructions

1. Complete Section I. In item 3, enter your name exactly as it appears on your Application for LCSW Psychotherapy "R" privilege (Form 1SWPR). Be sure to sign and date item 9.
2. Send the entire form along with a copy of Appendix A to your supervisor (LCSW with the "R" privilege, licensed psychologist or psychiatrist. 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 the form. **This form will not be accepted if submitted by the applicant. Note: If the experience being certified on this form was completed outside New York State, you must also have a Form 4Q submitted by this supervisor.**

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 Last

First

Middle

5. Telephone/Email Address
Daytime Phone
☐ Home or ☐ Business

Area Code Phone

Email Address (please print clearly)
☐ Home or ☐ Business

Licensee business address, phone and email address are public information. Failure to indicate business or home on this form for each item will deem it public information.

4. Mailing Address ☐ Home or ☐ Business
(You must notify the Department within 30 days of any address or name changes)

Line 1

Line 2

Line 3

City

State ZIP Code

Country/ Province

6. New York State DMV ID Number (Driver or Non-Driver ID)
(Leave this blank if you do not have a New York State DMV ID Number)

7. New York State LCSW license number M.S.W. degree date mo. day yr.

Date LCSW license issued mo. day yr. Date registration ends mo. day yr.

8. You must complete a total of 2,400 client contact hours and 36 months of experience with no less than 400 client contact hours per year after licensure as a LCSW. The supervisor must be qualified, as defined in section 74.5 of the Commissioner's Regulations.

Name of clinical supervisor

Name of setting

Setting address

Experience completed in NYS after January 1, 2011 must be under a plan previously approved by the State Board. **Attach a copy of the Board's approval letter for this supervisor.**

9. 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 licensure and may lead to a filing of charges of professional misconduct. .

Signature Date

Section II: Supervisor's Certification of Supervised Experience for Psychotherapy "R" Privilege

Instructions to the Registrar: Read the attached Appendix A and complete all of Section II. Be sure to sign the affidavit 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.

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

2. Supervisor Name _____

I am licensed and currently registered to practice in New York State as a (check all that apply)

☐ Licensed Clinical Social Worker with "R" Privilege License number ☐☐☐☐☐☐ License date ___ mo. ___ day ___ yr.

☐ Licensed Psychologist License number ☐☐☐☐☐☐ License date ___ mo. ___ day ___ yr.

☐ Licensed Psychiatrist License number ☐☐☐☐☐☐ License date ___ mo. ___ day ___ yr.

Are you ABPN certified in psychiatry? ☐ Yes ☐ No If "yes", ABPN certificate number _____

3. Please identify the employment setting below and attach the operating certificate, NYSED waiver or certificate of incorporation that authorizes the entity to employ LCSWs

Agency/Practice Name _____

Type of Setting (check one)

☐ Private practice owned by LCSW (the applicant)

☐ Private practice owned by supervisor (LCSW with "R" privilege, Licensed psychologist or psychiatrist)

☐ Professional entity (PLLC, PLLP, P.C.) owned by supervisor (attached consent from SED)

☐ Sole proprietorship or other entity authorized under law (attach certificate of corporation)

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

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

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

☐ Not-for-profit or other entity authorized by waiver from the State Education Department to employ licensed professionals and provide services (attach 6503-a or 6503-b waiver and certificate of incorporation)

☐ Other (describe) _____

Agency/Practice address _____

Agency/Practice Phone _____ Fax _____ Email _____

Agency/Practice web site _____

Total number of supervised client contact hours of psychotherapy by the applicant at this Agency/Practice _____

Applicant was supervised from ___ mo. ___ day ___ yr. to ___ mo. ___ day ___ yr.

4. Was the supervised experience for the above named applicant completed outside of New York State? ☐ Yes ☐ No

Attestation

I hereby certify that I have read Appendix A and that I meet the requirements to supervise a LCSW practicing psychotherapy. I understand that the information above will be used to review the applicant's experience, all answers given are truthful and accurate to the best of my ability.

_____ _____
Supervisor Signature Date

Print Name _____

Address _____

_____

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.